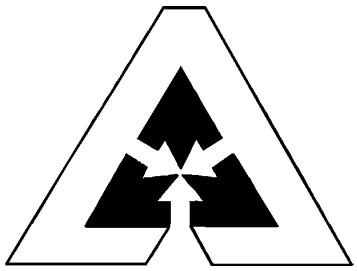

The National Alliance to End Homelessness

Toolkit for Ending Homelessness

Featuring the Ten Essentials for Ending Homelessness in Your Community

The National Alliance to End Homelessness believes that ending homelessness is well within the nation's grasp, and we have developed a plan to do so. This toolkit describes the essential requirements for preventing and ending homelessness in your community.

No one in America should have to be homeless

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US Conference Of Mayors
Winter Meeting
January 23, 2003
Plenary Remarks – Philip Mangano

Thank you, Mayor Menino.

I had the pleasure of working with your President, Mayor Menino, when he was a City Councilor and Mayor. One thing I learned. He's can do. His emphasis on housing means that there will be movement. Thank you, Mr. Mayor.

And thanks to Mayors Brown and Purcell for their continuing commitment and leadership.

Forty-eight hours ago I participated in a press conference in Chicago with Mayor Daley. I had visited him and his staff several times in the summer and we talked about the 10-year plan to end homelessness that his administration was creating with the business community and homeless providers and advocates. I promised him that when he approved the Plan I would join him at the announcement. He signed. I went.

Our nation's third largest city under the leadership of Mayor Daley became one of a small, but growing number of cities creating and implementing ten year plans to end homelessness. It began with Mayor Menino in Boston and Mayor Bart Peterson in Indianapolis and shortly thereafter the Mayors of Memphis and others joined the list.

What was unthinkable just a few years ago is now emerging as common sense. What seemed naïve is now sound policy. What was thought of as intractable is now subject to strategies.

After 20 years of response, we now realize that homelessness won't go away on its own. If it's ignored, it only gets worse.

Now, just a few years ago, such plans were thought to be risky and naïve. But with the new technologies and an emphasis on ending homelessness, maybe the new naïveté is not to have a plan. Naïve to think you don't need a plan. The risk may be in not creating a plan.

When we recognize a problem in our cities, we make a plan to address it. So when Richard Daley in Chicago unveils a ten-year plan to end homelessness, that makes sense. There's nothing naïve about it. There's a recognition that what we've done so far hasn't given us the performance outcomes we're looking for.

Plans in Philadelphia and Miami reduced the street populations. A street ordinance combined with increased street service, an 800 number, rapid response, and sensitized police made a difference.

Why are such plans more viable now? Why are the CEO's of cities adopting what once seemed like an orphaned enterprise?

There are reasons.

First, we have new research not available just a few years ago that tells us that most homeless people move out of homelessness with only a small amount of assistance. But there is 10% of the population, those who are experiencing chronic homelessness, who have mental illness or addiction or physical disability and who have been homeless for over a year, often inhabiting the streets or encampments. That 10% consumes more than half of all homeless resources. That's why the President and Secretary Martinez have made this population a priority. The research sent them there. And that's why Mayor Menino and this Conference have endorsed that effort. And why the Interagency Council is finding the strategies that work for that population.

The research helps us to be strategic in planning and investment. And we're going to support the research and data collection needed to equip us to create policy that makes sense and is strategic, including policy focused on discharge planning failures that leave many with no place to go.

Second, we have new technologies in housing and street engagement that give us new tools to bring in people off the streets. From New York to San Francisco and places in between these new so called "housing first" strategies are moving people off the streets into supportive housing that provides the services needed for stable tenancies.

And the research tells us that 90% stay housed. The "housing first" model is a centerpiece in Mayor Daley's Chicago Plan.

Third, there's a new spirit of partnership on this issue that transcends partisanship. When Mayor Menino and Mayor Purcell announced the hunger/homeless findings last month, they sounded the chords of working together. We pledged that on this issue, partnership trumps partisanship. Can I get an amen? There's no D or R or I or G on this issue. We're all together.

Fourth, after the research, and technologies, and partnership, we need new resources. Anyone who studied the President's budget for 03 knows that new resources were on the table to help – new housing resources in the Section 8 and HOME programs, new funds for re-entry of ex-prisoners, new funding for those aging out of foster care, increases in nearly every targeted homeless program including healthcare.

And soon, very soon, a $35 million funding initiative will hit the streets. Unprecedented collaboration between 3 federal agencies will offer housing and service funding in one NOFA targeted to make a difference on the streets of our country. That's why those street counts are so necessary.

Fifth, we are now interviewing to hire 10 regionally based homeless specialists across the country to replicate the work of the Council in bringing together federal agencies, state agencies, and cities and community and faith based organizations to collaborate in the effort to end homelessness. These specialists will help cities and work with your regional housing coordinators.

Finally, we have a new standard of expectation. We're not going to be satisfied any longer moving homeless people from one side of town to the other. From on city to another. Our work together is to create that new standard of expectation: we want visible, measurable, quantifiable change - on our streets, in homeless programs, in the life of our neighborhoods, and most importantly, in the lives of homeless people.

We're no longer satisfied with managing the problem or maintenancing the effort, or accommodating the response. We have a new standard. Abolishing homelessness.

There's not a person in this room who doesn't know that homelessness is a disgrace. And whether it's systems failures or personal failures, no one should be on the cold streets of our country or our cities. No child should be consigned to a shelter. No veteran should be eating out of dumpsters.

As the Indianapolis Plan tells us, such images are unworthy of this great and affluent nation and not worthy of the cities you govern.

There is increasing hope on this issue now, even in the face of rising numbers. Not illusory, ethereal hope spun on anecdote and conjecture and one-dimensional plans. But a hope that is fashioned on data, research, technology, performance outcomes, and resources.

I've asked the Mayors in the 100 largest cities in the country to name a point person in their administration who will be our contact person to disseminate information whether funding opportunities, research, or best practices. If you're not in the largest 100 and want to be part of the network, just have your staff person contact ich@hud.gov. That's all the address you need – ich@hud.gov.

And I'm asking Mayor Menino to challenge this Conference. By the next winter meeting of this Conference, through our partnership, can we have 100 cities who

have followed the example of Chicago, Indianapolis, Boston, Memphis and others in creating a plan to end homelessness in their city. One hundred cities.

The spirit of our work is this:

- Partnership, not partisanship
- Planning, not posturing
- Solving, not managing
- Preventing, not permitting
- Abolishing, not accommodating

Like the abolitionists of old, we are faced with social evil: Our neighbor has no place to live. For how long can we resign ourselves to this disgrace before we stand as Americans to keep the promise – to draft the plans and get the job done: A Home for Every American.

Developing a Plan to End Homelessness: Why Now?

Leaders across the country are echoing the growing consensus that homelessness can be ended and the time to do it is now.

" 'Supportive housing' – permanent housing with attendant social services – was in the past often considered prohibitively expensive, but has emerged as a good investment because it is shown to substantially reduce the use of other publicly funded services. For those placed in the permanent supportive housing program (in New York City), the reduced use of acute care services nearly offset the costs of the supportive housing."
Dennis Culhane, University of Pennsylvania Researcher

In cities that have planned and acted on their plans to end homelessness, "incentives are being reversed so that we are preventing homelessness before it happens, private-public partnerships are developing and growing, and proof that this is working is inspiring new commitments."
Nan Roman, President,
National Alliance to End Homelessness

The federal government, including the Administration and Congress, have gotten on board and new resources are on the table to help. "It is time for the federal government to stop simply maintaining the status quo and invest in more permanent solutions to the challenge of homelessness."
HUD Secretary Mel Martinez

"There's a recognition that what we've done so far hasn't given us the performance outcomes we're looking for. We have new research not available just a few years ago that is helping us find the strategies that work…"
Interagency Council on Homelessness
Executive Director Philip Mangano

"We have to do more than just manage homelessness. The intent of this plan is to move from a system focused on providing temporary shelter to a system that moves people quickly into permanent housing and provides social services to address the problems that caused them to become homeless."
Chicago Mayor Richard M. Daley

"The plight of these vulnerable [homeless] families affects the broader community and all concerned citizens. Homelessness and the lack of affordable housing contribute to children failing in school, family violence and loss of employment." *Indianapolis Mayor Bart Peterson*

City of Memphis Mayor Willie W. Herenton and former Shelby County Mayor Jim Rout have created new policies and programs "in recognition of the tremendous short- and long-term consequences and costs of allowing homelessness in Memphis and Shelby County to continue, and in the sure knowledge that this community can – and must – marshal the resources necessary to reverse that trend."

The Mayor's Checklist

Step-by-Step Process for Planning to End Homelessness

- ✓ CONSIDER creating and implementing a plan to end homelessness.
- ❑ CONVENE department or agency heads in a Task Force. Include human services, housing, law enforcement, employment, community development, health, mental health, welfare and other relevant agencies.
- ❑ SELECT a chair (or co-chairs) who report directly to the Mayor. The chair can be an agency or department head, or a civic leader.
- ❑ DEFINE the parameters of the problem, the goals, the resources currently available to address the problem, and the gaps.
- ❑ LAY OUT how the goals are to be met over the coming years.
- ❑ OBTAIN input from and involve state and federal programs in the planning and implementation.
- ❑ ASK for input and support from homeless, housing and service agencies and other nonprofits (housing, health, etc.). Options include an advisory board, public hearings, participation in the task force, etc.
- ❑ IDENTIFY tools to educate and involve the public.
- ❑ CREATE a time line with specific steps, clear responsibilities and outcome requirements for agencies and contractors.
- ❑ IMPLEMENT the plan.

NATIONAL ALLIANCE TO END HOMELESSNESS
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FACT SHEET ON HOMELESSNESS

Who's homeless?

Over the course of a year, as many as 3.5 million people become homeless. That is nearly 11% of the poor population per year.

Domestic violence is the second leading cause of homelessness among women.

"A Status Report on Hunger and Homelessness in America's Cities 2002," a 25-city survey published by the U.S. Conference of Mayors documented a 19% increase in homelessness in 2002, the steepest rise in a decade.

Each year 5,000 runaway and homeless youth die from assault, illness and suicide.

Research allows us to break homelessness into manageable pieces and populations. Most people who experience homelessness (80%) are homeless for a short period of time, and usually need help finding housing or a rent subsidy. A small portion of the homeless population (20%) is homeless for long periods of time or cycle in and out of homelessness. They need permanent supportive housing.

Why are they homeless?

In 1970, there were 300,000 *more* affordable housing units available, nationally, than there were low-income households that needed to rent them. By 1995, there were 4.4 million *fewer* affordable units than low-income households that needed them.

Many people experiencing homelessness work every day, but do not earn enough income to pay for housing. A minimum wage worker would have to work 114 hours each week to afford a two-bedroom apartment (according to HUD standards for affordability).

As of 1999, 4.9 million very low-income households paid more than half their income for rent or lived in severely substandard housing.

A GAO study found that, for TANF recipients, even when barriers to employment were identified, recipients often did not receive services designed to address those barriers and help them secure employment.

What can we do?

Two studies in New York City found that 92 percent of families who exit shelter with subsidized housing placements remain housed two years after placement.

Shelter Plus Care and the Supportive Housing Program have proven to have powerful impacts, ending homelessness for the most chronically homeless people with severe disabilities, such as schizophrenia, addiction and HIV/AIDS. This model relieves taxpayers of the expensive round of emergency services they now require. For homeless people with disabilities in their first year in permanent supportive housing:

- Emergency room use in Baltimore dropped by over 75%
- Medicaid costs per treated individual in Connecticut dropped by 42%
- Emergency detoxification days in Minnesota dropped by 84%
- Mental health hospitalizations in Seattle dropped by 89%, while arrests and incarcerations dropped by 93%

NATIONAL ALLIANCE TO END HOMELESSNESS

THE TEN ESSENTIALS

What Your Community Needs To Do To End Homelessness

The National Alliance to End Homelessness has created the following checklist as a guide to help communities identify the minimum requirements for an effective permanent solution to prevent and end homelessness.

The essentials are based on the Alliance's Ten Year Plan to End Homelessness, which draws from over twenty years of research and experience with communities around the country.

No essential is more important than another. All require participation from every sector of the community.

PLAN

Your community has a set of strategies focused on ending homelessness. A wide range of players (government programs, elected officials, homeless providers, etc.) has made funding and implementation commitments to these strategies.

DATA

Your community has a homelessness management information system that can be analyzed to assess how long people are homeless, what their needs are, what the causes of homelessness are, how people interact with mainstream systems of care, the effectiveness of interventions, and the number of homeless people.

EMERGENCY PREVENTION

Your community has in place an emergency homelessness prevention program that includes rent/mortgage/utility assistance, case management, landlord/lender intervention, and other strategies to prevent eviction and homelessness.

SYSTEMS PREVENTION

I. Mainstream programs (mental health, substance abuse, TANF, child welfare, etc.) that provide care and services to low-income people consistently assess and respond to their housing needs.

II. There is placement in stable housing for all people being released from public institutions.

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WEB www.endhomelessness.org

OUTREACH

Your community has an outreach and engagement system designed to reduce barriers and encourage homeless people so that they enter appropriate housing (including safe havens) linked with appropriate services.

SHORTEN HOMELESSNESS

The shelter and transitional housing system in your community is organized to reduce or minimize the length of time people remain homeless, and the number of times they become homeless. Outcome measures will be key to this effort.

RAPID RE-HOUSING

Your community has skilled housing search and housing placement services available to rapidly re-house all people losing their housing or who are homeless and who want permanent housing.

SERVICES

When households are re-housed, they have rapid access to funded services, and mainstream programs provide the bulk of these services.

PERMANENT HOUSING

I. Your community has a sufficient supply of permanent supportive housing to meet the needs of all chronically homeless people.

II. Your community is implementing a plan to fully address the permanent housing needs of extremely low-income people.

INCOME

When it is necessary in order to obtain housing, your community assists homeless people to secure enough income to afford rent, by rapidly linking them with employment and/or benefits. It also connects them to opportunities for increasing their incomes after housing placement (opportunities provided primarily by mainstream programs).

CREATING A PLAN TO END HOMELESSNESS

GOAL: Your community has a set of strategies focused on ending homelessness. A wide range of players (government programs, elected officials, homeless providers, etc.) has made funding and implementation commitments to these strategies.

As Interagency Council on Homelessness Director Philip Mangano said in his address to the U.S. Conference of Mayors in January 2003, "When we recognize a problem in our cities, we make a plan to address it." This is what cities like Indianapolis, Chicago and New York have done, and many more are presently doing, in regard to the problem of homelessness. These cities have taken a serious look at the homeless assistance system as well as broader public systems and are moving beyond efforts to manage this costly problem toward strategies that will prevent and end it. Such strategies address:

- prevention of homelessness (particularly among those who are already clients of other social service systems and public institutions)
- re-housing options that improve cost-efficiency and ensure long-term stability
- improving the availability of affordable housing, livable incomes, and necessary support services for people at the lowest end of the economic spectrum
- collection of accurate data in order to improve system-wide effectiveness in preventing and ending homelessness.

The strategies with the most momentum are those that have been built with support and input from a broad range of partners - public, private and nonprofit. They have been based on independent research and effective practices both within and beyond their jurisdictions. They have the endorsement of top city officials and entail the commitments of all relevant resources and partners. Through such coordination and planning, these cities are changing homelessness from being a permanent fixture embedded in the current economic and social climate to a finite and solvable problem that can be ended in ten years.

Examples

Getting Housed, Staying Housed: A Collaborative Plan to End Homelessness
(Chicago, Illinois) – Chicago Mayor Richard Daly has officially endorsed this citywide

plan to end homelessness in ten years. The Chicago Continuum of Care led the process of developing the plan, involving a comprehensive array of stakeholders from the public, private and nonprofit sectors. The plan includes major strategies, five-year initiatives and initial action steps. For more detail, go to:
http://www.endhomelessness.org/localplans/chicago.pdf

The Blueprint to End Homelessness (Indianapolis, Indiana) – Indianapolis Mayor Bart Peterson personally initiated the development process for this plan to end homelessness citywide in ten years. He commissioned a task force that engaged approximately 450 people and over 150 organizations representing all relevant stakeholders. The plan includes detailed strategies, recommendations and action steps, as well as preliminary timelines for the first five years of the plan. For more information, go to:
http://www.endhomelessness.org/localplans/indianapolis.pdf

Resources

- *A Plan: Not A Dream. How to End Homelessness in Ten Years,* National Alliance to End Homelessness, 2000. http://www.endhomelessness.org/pub/tenyear/index.htm

- Burt, Martha R., *What Will It Take To End Homelessness?* Urban Institute, Washington, D.C., September 2001. http://www.urban.org/UploadedPDF/end_homelessness.pdf

- Culhane, Dennis P., "New Strategies and Collaborations Target Homelessness," *Housing Facts & Findings,* Vol. 4 Issue 5 (2002). http://www.fanniemaefoundation.org/programs/hff/v4i5-strategies.shtml

- Fosburg, Linda B., and Dennis, Deborah L., (Editors), *Practical Lessons: The 1998 National Symposium on Homelessness Research*, U.S. Department of Housing and Urban Development and the U.S. Department of Health and Human Services, August 1999. (For an overview of the symposium findings and brief summaries of each research paper, see http://aspe.hhs.gov/progsys/homeless/symposium/overview.htm)

- *Homelessness: Key Findings and Grantmaking Strategies*, Charles and Helen Schwab Foundation, June 2002. http://www.SchwabFoundation.org/files/homeless/Homelessness.pdf

- Mangano, Philip, *U.S. Conference of Mayors Winter Meeting Plenary Remarks*, January 23, 2003. http://www.ich.gov/library/mayors.pdf

- Peterson, Bart, "The Faces of Homelessness Prompt a Call to Action in Indianapolis," *Housing Facts & Findings,* Vol. 4 Issue 5 (2002). http://www.fanniemaefoundation.org/programs/hff/v4i5-perspectives.shtml

- Roman, Nan, "Why America Can End Homelessness in Ten Years," *Housing Facts & Findings,* Vol. 4 Issue 5 (2002). http://www.fanniemaefoundation.org/programs/hff/v4i5-homeless.shtml

Best Practice -- Planning

Chicago, Illinois

Plan: Getting Housed, Staying Housed: A Collaborative Plan to End Homelessness

Scope: Citywide

Goal/ Timeframe: To end all homelessness in the city by 2012

Development Process
The collaborative planning process was coordinated and facilitated by a governing board, which was designated by the Chicago Continuum of Care to oversee both the plan's development and execution. The Governing Board consists of members representing every type of organization that can help end homelessness in Chicago, including homeless service providers, consumers, and advocates; city, county, and state agencies; and business and foundation leaders. The development of the plan took place over a twenty-two-month period, ending in November 2002.

Endorsements
The governing board has adopted the plan, and city agencies and nonprofit service providers alike are implementing its strategies. Furthermore, Mayor Richard Daly has endorsed it, and all City departments have it as part of their charge to ensure its success.

Level of Detail
Includes major strategies, five-year initiatives, and initial action steps.

Strategies of Note
- Implementing a homeless management information system to assess families in crisis, identify permanent housing resources, and track the use of services, as well as provide data by which to evaluate the success of the entire system.
- Constructing a prevention and response system infrastructure that will facilitate access to prevention, housing and supportive service resources for both people at risk of losing their housing and people leaving institutional care.
- Implementing a housing first approach that helps people back into permanent housing as quickly as possible, then links them with mainstream service to support them in maintaining their new housing and achieving self-sufficiency.
- Transitioning the current homeless shelter system into an interim housing system that facilitates rapid access to permanent housing with appropriate supports.
- Expanding permanent housing resources, with a mix of rent subsidies, scattered site housing and project-based permanent supportive housing units.
- Strengthening community connectedness through linkages to employment and community resources.

For More Information, Contact

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View the complete plan at: http://www.endhomelessness.org/localplans/chicago.pdf

Best Practice -- Planning

Indianapolis, Indiana

Plan: The Blueprint to End Homelessness

Scope: Citywide

Goal/ Timeframe: To end homelessness in Indianapolis in 10 years.

Development Process
In December 2000, Indianapolis Mayor Bart Peterson publicly endorsed the creation of a long-range strategy for ending homelessness and designated a subcommittee of the City's Housing Task Force to develop the plan. National experts such as the Corporation for Supportive Housing were contracted to assist in the development of the plan, and work commenced in March 2001.

Approximately 450 people and over 150 organizations participated in the yearlong planning process, which incorporated:

- Surveys of homeless people and local homeless service providers.
- Work teams of Blueprint committee members, service providers and others.
- Focus groups of families and individuals in homeless assistance programs, on the street and/or receiving public aid.
- Meetings with representatives of about 150 organizations and programs, including members of the private, public and nonprofit sectors.

The plan progressed through five widely circulated drafts, culminating in the release of the final plan in April 2002. The plan's unveiling ceremony received vast support from the community with over 300 in attendance, including Mayor Peterson and an array of citizens from the public, private and nonprofit sectors.

Endorsements
Mayor Peterson has endorsed the Blueprint and all relevant City departments have it as part of their charge to ensure its success.

Level of Detail
Includes detailed strategies, recommendations and action steps as well as preliminary timelines for the first five years of the plan. The initial five-year housing plan includes estimated costs and proposed funding sources. For some goals, the plan recommends the development of action plans with further specificity. Details for carrying out the initiatives and measuring community success are also included.

Strategies of Note

- Developing and managing a homeless management information system to collect and analyze data to improve community-wide planning efforts and coordination of services.

- Neighborhood-based prevention initiative that provides rental subsidies and other services to help people especially vulnerable to becoming homeless

- Assembling a crisis response team and crisis stabilization programs to help mentally ill and chronically addicted people keep their housing

- Providing supportive housing to people at risk of homelessness who are leaving the criminal justice system, treatment institutions and the foster care system

- Appointing entities to coordinate street outreach that emphasizes moving people off the street and links them with housing and an array of support services

- Integrating "housing first" and "housing plus" (housing + intensive services) approaches to shorten homelessness and match the level of services to the intensity of the need

- Hiring housing specialists to secure access to rental housing managed by private landlords

- Making 1,700 additional rental units affordable to people with the very lowest incomes over five years – moving toward an ultimate goal of 12,500 affordable units over ten years

- Providing support services for 2,100 households over five years - to be funded the Community Development Block Grant, Medicaid and Medicaid Waiver programs, through Housing Opportunities for Persons With AIDS, Temporary Assistance to Needy Families and other sources

- Increasing opportunities for people to find and maintain employment to boost their income

Implementation
The plan designates a lead entity – the Coalition for Homelessness Intervention and Prevention (CHIP) – that will focus its energies on mobilizing the community's resources to ensure the plan's successful implementation.

For More Information, Contact
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Website: http://www.chipindy.org
View the complete plan at: http://www.endhomelessness.org/localplans/indianapolis.pdf

CREATING A DATA SYSTEM TO HELP YOU END HOMELESSNESS

GOAL: Your community has a homelessness management information system that can be analyzed to assess how long people are homeless, what their needs are, what the causes of homelessness are, how people interact with mainstream systems of care, the effectiveness of interventions, and the number of homeless people.

Good data is essential for communities to plan to end homelessness, to evaluate programs, and to properly allocate resources. There are two typical methods of collecting data on homelessness, and both have their uses. The first is point-in-time data that is collected during a brief time period (typically a single night but sometimes as much as a week). It can identify the number of people who are homeless at any one time, as well as some of their characteristics. It is a good way to identify both people who live in shelters and people living on the streets.

The second source of information is administrative data, data that is continuously collected by programs. This data can be collated on a community-wide basis, and is then usually called a homelessness management information system – HMIS. An HMIS is an indispensable tool for communities seeking to end homelessness. It can be used to assess cost (would the cost of housing mentally ill homeless people, for example, be offset by the savings to treatment systems?); to plan solutions (how many supportive housing units would a community require to meet the needs of all chronically homeless people?); to implement prevention measures (how many people become homeless because of a utility shut-off? discharge from a prison? emancipation from foster care?); and to measure outcomes (what packages of services is most effective in reducing recidivism to homelessness?).

Most programs already collect data on their clients. Collating and analyzing administrative data is, however, a significant task. Three areas in which decisions must be made are:

- choosing and providing universal hardware and software
- reaching an agreement within the community (providers and governments) about how and what information will be shared
- setting up a mechanism for analyzing (not just collecting) the data

The federal government, which funds a significant percentage of homeless programs, has a strong interest in data. Congress has mandated an unduplicated count of homeless people at the community level. The most straightforward method of achieving such a count is through the creation of unique identifiers, usually anonymous. Such identifiers

are also extremely useful for data analysis, but care must be taken to protect the confidentiality of vulnerable groups such as victims of domestic violence, those with HIV/AIDS, etc.

Examples

Philadelphia (Pennsylvania) In 1991 Philadelphia initiated a data system to provide more specific data on shelter use and to improve program design. Data are used to allocate resources, to conduct performance based contracting (and thus to look at client outcomes), and to look at trends in numbers and demographic characteristics. Information is attached. A brief profile of this system is at: www.endhomelessness.org/best/PhillyHMIS.htm

Massachusetts Housing and Shelter Alliance The Massachusetts Housing and Shelter Alliance has organized homeless programs statewide to collect information about where people were living immediately before they became homeless. This has been a powerful tool for planning and advocacy. A brief description is at: www.endhomelessness.org/best/MHSAHMIS.htm

Wisconsin Wisconsin has a statewide HMIS system. Information on history, vision, software selection, agency participation, rollout, staffing, resources for users and lessons learned can be found at the following website (published by HUD): http://www.hud.gov/offices/cpd/homeless/hmis/implementation/models/wi-hmis.cfm

Spokane (Washington) Spokane has a long-standing, citywide HMIS system. Information on developing the system, core features, unique features, and capabilities of the system can be found at the following website (published by HUD): http://www.huduser.org:80/periodicals/fieldworks/1202/fworks3.html

Resources

- *Homelessness Management Information Strategies* (A list of the documents HUD has published on the issue) http://www.hud.gov:80/offices/cpd/homeless/hmis/index.cfm

- *HMIS Consumer Guide: A Review of Available HMIS Solutions* (Prepared under contract to HUD) http://www.mccormack.umb.edu/csp/csp_hmis.jsp

- Dennis Culhane and Steven Metraux, "Where to from Here? A Policy Research Agenda Based on the Analysis of Administrative Data," Fannie Mae Foundation, 1997 (describing the uses of administrative data to illuminate the interaction of homeless people with other systems of care or custody for planning purposes). http://www.knowledgeplex.org/kp/report/report/relfiles/homeless_1997_culhane5.pdf

- *Using HMIS for Effective Planning to End Homelessness.* (The proceedings of an audio-conference call sponsored by the National Alliance to End Homelessness, the US Conference of Mayors, the National League of Cities, the National Council of State Housing Finance Agencies, and the Council of State Community Development

Agencies and featuring Dr. Dennis Culhane from the University of Pennsylvania and Julie Hovden from the Wisconsin Department of Administration, and Jennifer Schwartz of the National Council of State Housing Agencies). http://www.endhomelessness.org/best/summary010903.htm

- Runaway and Homeless Youth Management Information System – Federally funded runaway and homeless youth providers are required to report data to the Family and Youth Services Bureau within the U.S. Department of Health and Human Services. Providers collect data on demographics of youth served, services provided, and youth's status upon exiting programs through the Runaway and Homeless Youth Management Information System (RHYMIS). To view RHYMIS data collecting tools, go to: www.acf.hhs.gov/programs/fysb/rhypage/forms.htm

Best Practice – Data

Philadelphia's HMIS

History
In 1991 Philadelphia initiated a data system to keep track of shelter use, utilizing the City's existing information technology. It initiated the program because it needed much more specific data on shelter use for billing purposes, and because it needed better information to improve program design. Information on homeless people and shelter use has been kept since that time, with periodic improvements in hardware, software and methods of data collection.

Vision
The Philadelphia system covers City-funded[1] programs. The data that is currently collected about homeless clients is used to allocate resources, to conduct performance based contracting (and thus to look at client outcomes), and to look at trends in numbers and demographic characteristics. The City is constantly improving its HMIS system. Currently it is shifting to a system that better integrates data on homeless clients with data on other human service programs via what will be a social services data warehouse. This is in part to implement Mayor Street's vision for a collaborative case management system.

Data Elements and Process
The system is collecting two types of information:

- Client demographic information
- Shelter stay history

Philadelphia's system is based upon centralized intake. Potential users of the City shelter system come to one of two sites (or several off-hour sites). One site is for families and single women, and the other is for men. At these sites an intake is performed, and clients are assigned to a shelter. (The intake centers do not share their intake information with the shelters, so most shelters conduct another intake when the client arrives.) The demographic data, therefore, comes from the intake centers.

The shelter stay history is received from the shelters. The shelters submit a summary report at the end of each month. This provides information on how many nights each individual has stayed at the shelter. This is the basis of billing for the shelter, and of course also provides the City with data.

People in transitional housing are not included in the data system being discussed here. There is another, similar, system that captures data from the City-funded[2] transitional programs. However, many of the clients in the transitional system arrived there via the shelter system, and thus their demographic data is captured by the shelter data system.

With respect to confidentiality for specific groups (HIV/AIDS, domestic violence, etc.), the decision about how to handle the data in such cases is made through a due diligence process to determine an appropriate protocol.

Agency Participation: All of the City-funded shelters participate. It is estimated that the majority of people who become homeless are included in the system.

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[1] Includes Continuum of Care funding.

[2] Includes Continuum of Care funding.

Staffing: Seven full time staff people work in the department that handles the data. The staff's job is to make sure the data comes in and is analyzed, maintain the mainframe, keep track of the hardware (some 300 computers), and ensure that everyone is trained. Staff includes a director, a programmer, a business analyst, and hardware technicians. In addition, there are several hundred people who collect data.

Resources: The City pays for this system with its own funds supplemented by state and federal resources. Anyone who is involved in collecting or working with the data receives training arranged by the Information Technology office.

Analysis and Interaction with Other Systems: The Information Technology office analyzes the data generally. However others, including researchers, also analyze the data. When data is given to researchers, either the clients are asked to sign research protocols, or the City blinds the data (makes it anonymous). When the data is placed in the data warehouse, the City will be able to cross analyze it with other systems within the warehouse. At present this can only be done by cross-referencing identifiers, which is done under the provisions noted above.

Lessons Learned:

- Having data helps with fundraising. Not only is the City able to provide ready data to funding processes such as the Continuum of Care, but grantors like the idea that the City is paying attention to how the money is being used.

- Centralized intake is helpful for data collection and purity, but you have to have good systems in place for security, because you have a larger universe of users.

- When setting up a system, do as much planning as you can. Find out in detail what businesses processes you need, what could be improved by automation, and what could not. Don't look at the software first and then try to fit your needs into it. Decide what your needs are first, and then go shopping for software.

- When dealing with software and hardware vendors, make sure that the roles and responsibilities are clearly delineated (installation, maintenance, etc.) The same is true after the system is up.

- Once the system is in place, make sure the technology people understand how the users are using it. This will ensure that the system is enhanced to meet real needs.

- Recognize that social services data is very fuzzy. Technology people who have not worked in the human services field will find this difficult at first.

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Best Practice – Data

Massachusetts Housing and Shelter Alliance Census

When seeking to prevent homelessness, it is important to know and quantify where homeless people come from. Such data would indicate where prevention efforts could be productive. One important place to look is public systems of care or custody.

The Massachusetts Housing and Shelter Alliance (MHSA), which seeks to end homelessness for single adults in Massachusetts, has collected nightly census data from adult shelters in the state since 1992. Beginning in 1997, it began a Census of Emerging Subpopulations: the collection of shelter-based data on new guests entering from certain specific state systems of care, treatment and custody, and expanding the census to include homeless youth. This data indicates which public systems of care are discharging people into shelter.

MHSA recommends this data collection system as an important tool to address homelessness. It is relatively simple, since shelters already collect the information – MHSA simply collates it statewide. This subpopulation census provides the basis for much of MHSA's work in understanding the routes into homelessness from state systems without adequate or appropriate discharge planning practices, protocols, or residential resources. Below are web addresses for an example of the subpopulation outcomes and a sample data collection tool that can be adapted to local issues and circumstances. Shelters complete a one-page form monthly and forward it to MHSA to be aggregated into monthly and annual reports. Providers receive an annual updated list of facilities and categories so that they can amplify answers self-reported by guests.

For an example of questionnaire used by MHSA, go to
http://www.endhomelessness.org/best/Subpop_form.doc
For am example of the report that can be generated with the data go to
http://www.endhomelessness.org/best/Sample_Subpop.pdf

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ESTABLISHING EMERGENCY PREVENTION PROGRAMS

GOAL: Your community has in place an emergency homelessness prevention program that includes rent/mortgage/utility assistance, case management, landlord/lender intervention, and other strategies to prevent eviction and homelessness.

The most economically efficient way to end homelessness is to prevent its occurrence. Financial assistance to prevent an eviction, mediation to address problems with a landlord or lender, and case management can all prevent individuals and families from becoming homeless. A 1991 study of eviction prevention programs by the U.S. Department of Health and Human Services found that the average cost to prevent family homelessness was one-sixth the average cost of a stay in a shelter. Yet a recent examination of the continuum of care planning process found that few of the communities studied dedicate substantial resources to preventing homelessness.

Among the innovations that are developing in the area of emergency homelessness prevention are:

- Enhancing coordination and information sharing among emergency assistance (including rent/mortgage and utility assistance) providers to ensure all existing prevention dollars are maximized.
- Moving beyond one-time eviction prevention payments to providing time limited housing subsidies until families become financially stable.
- Combining emergency assistance with either time limited or ongoing case management to reduce future risk of homelessness.
- Targeting new homelessness prevention/emergency assistance efforts to the neighborhoods that a disproportionate number of people seeking shelter are exiting.
- Integrating homelessness prevention activities at the intake sites for shelters in an effort to identify if resources/services could be deployed to prevent homelessness.

Examples

Hennepin County Homelessness Prevention Program (Hennepin County, Minnesota) The county contracts with eighteen non-profit agencies to deliver services that include financial assistance, case management and other assistance to eligible families to prevent

the loss of housing. A description can be found on line at: http://www.endhomelessness.org/best/prevention.htm

The Philadelphia Housing Support Center (Philadelphia, Pennsylvania) The Housing Support Center coordinates housing and service resources from various City social service departments through one central gateway. Pulling together diverse resources, the Center serves as a "one-stop shop" to meet housing needs—providing both prevention and re-housing assistance. To complement its prevention services, PHSC participates in the Youth Housing Continuum Task Force to ensure that youth aging out of foster care have safe and adequate housing plans. A description is on line at: http://www.endhomelessness.org/best/SupportCenter.htm

Project SAFE (Everett, Washington) Project Safe intervenes with youth and families to prevent young people from becoming homeless. A description is on line at: http://www.endhomelessness.org/best/ProjectSAFE.htm

Resources

- The U.S. Department of Housing and Urban Development has developed a guidebook on how Emergency Shelter Grants are being utilized to prevent homelessness. The guidebook contains a selection of best practices. *Homelessness Prevention in the Emergency Shelter Grants Program* is available on line at: http://www.hud.gov/offices/cpd/homeless/library/esg/esgprevention2.PDF.

- M. Shinn and J. Baumohl (1999). Rethinking the Prevention of Homelessness. In L. B. Fosburg and D. L. Dennis (ed.) *Practical Lessons: The 1998 National Symposium on Homelessness Research.* Washington, DC: U.S. Department of Housing and Urban Development and the U.S. Department of Health and Human Services. Available on line at: http://aspe.hhs.gov/progsys/homeless/symposium/13-Preven.HTM.

Best Practice – Emergency Prevention

Hennepin County Homelessness Prevention Programs
Hennepin County, Minnesota

With a housing vacancy rate below 1% and very high rental rates, Hennepin County is promoting efforts that will keep families in sustainable housing and preventing them from ever requiring emergency shelter. The county is on the forefront of rapidly re-housing those who become homeless through the Rapid Exit Program, relying primarily on federal funds. The state Family Homelessness Prevention and Assistance Program supplements the Rapid Exit Program and provides the financing for homelessness prevention activities. The county subcontracts with eighteen nonprofit agencies to deliver services that include financial assistance, case management and other assistance to eligible families to prevent the loss of housing.

Target Population

The target population includes all imminently homeless families and single adults.

Eligibility

- No other available public or private resources sufficient to resolve housing crisis including savings, use of public benefits, selling some goods, downsizing vehicle
- Family must be able to sustain housing following receipt of short-term assistance either in existing housing or in a more affordable housing unit
- Impending crisis--written eviction notice, overcrowded housing, condemned building, victim of domestic violence, lost income, hazard in home, mortgage in default, requires temporary housing subsidy to complete an approved family reunification plan.

Services

- Legal services to address eviction cases in court
- Short and long term case management
- Volunteer assistance to help families stabilize housing
- Landlord/tenant mediation and assistance in securing new housing (if housing is lost) without requiring stay in homeless shelter
- Financial assistance.

Source of Funding

The program is funded through the Family Homeless Prevention and Assistance Program (FHPAP) that includes TANF block grant and state general revenue funds.

Available Data

- First year, 1,483 families served (4,712 individuals) with FHPAP funds
- Second year, 1,456 families served (5,063 individuals) with FHPAP funds
- 3-4 percent of families served became homeless in succeeding twelve months
- 9 percent of families served had history of county homeless shelter use in year prior to receiving prevention services
- Over the two-year period $938,898 was used for prevention activities, an average of $331 per family served.

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Best Practice – Emergency Prevention

Housing Support Center
City of Philadelphia, Pennsylvania

The Philadelphia Housing Support Center is the latest innovation in a series of initiatives from a city that has successfully reduced homelessness in recent years. The Center coordinates housing and service resources from various City social service departments through one central gateway. Pulling together resources such as Family Unification Program Vouchers, TANF dollars, and other mainstream and homeless program funds, the Center serves as a "one-stop shop" for housing resources -- providing both prevention and back-door mechanisms to decrease the actual number of people experiencing homelessness while helping to reduce the length of time others have to remain homeless.

Target Population

The Center serves mainly families experiencing or at risk of homelessness. In the last six months of 2002, the Center began serving people leaving emergency shelters, transitional housing programs, recovery houses, behavioral health programs, foster care, and the corrections system. The Center also accommodates people who do not fit neatly into other housing program models, such as those facing barriers to being housed by public housing authorities due to former criminal convictions or substantial debt.

Program Description

The Philadelphia Housing Support Center incorporates five main strategies that underpin the City's Adult Services:

1. Focus on prevention and diversion
2. Shorten the average length of stay in shelter
3. Work on the back door (develop and access more permanent housing)
4. Increase connections to mainstream services
5. Use a housing first approach

The Center began as a joint venture between the Department of Human Services (the county's child welfare agency) and Adult Services to combine efforts and coordinate the activities of two separate housing programs, the Good Neighbors Make Good Neighborhoods (GNMGN) program and the Family Unification Program. GNMGN collaborates with the local housing authority to provide families with Housing Choice Vouchers so that they can move out of shelters and various temporary housing programs into permanent housing. The program promises up to a year of case management as well as other supports to help families transition into their new communities. In the months following its inception, the Philadelphia Housing Support Center attracted resources and staff from other social service systems as well. The increased coordination and management of the various service resources through one central gateway will serve to strengthen the links between the shelter system and permanent housing--most critically by providing access to Housing Choice Vouchers--and increase the capacity for interventions to prevent further homelessness.

Furthermore, by pulling together the different programs, the Center will become better able to address the gaps through which people sometimes fall when they did not fit into any of the available programs. The Emergency Relocation Program was created for just such a purpose. The Center identifies people who did not fit into any of the program models, move them into an apartment, provide them with intensive case management, and help them overcome the barriers that would prevent them from getting into relevant programs.

Source of Funding

For the permanent housing, the Center relies primarily on Housing Choice Vouchers through the local public housing authority. Three factors improve the success of the Center in utilizing these resources:

- The local housing authority has one of the first "Moving-to-Work" designations from HUD.
- The local housing authority has the ability to create priorities through an administrative process.
- Families experiencing homelessness qualify under the definition of the Family Unification Program to receive such Housing Choice Vouchers

For services accompanying permanent housing placement, the Center will utilize a mix of resources, including Supportive Housing Program (SHP) dollars, some Temporary Assistance to Needy Families (TANF) funds, in addition to a variety of other mainstream sources.

Further service resources have been provided by the Department of Public Health. The Center has developed a strong relationship with the department through the creation of a lead paint relocation program, in which home-owning families temporarily move out of their homes while the Health Department abates the lead. This new program has enabled the Health Department to conduct abatements at a rate 3-4 times faster than if the families remained in their units. While the Center focuses on the temporary relocation, it would also provide necessary supportive services to these families before and after they return to their housing in order to ensure the safety and well being of the children.

The Center itself, which consists of approximately 30 staff members, is funded through existing resources allocated by each of the departments that participate in the joint venture.

Outcome Data

In its first year, the Center has reduced the length of shelter stay and provided permanent housing with services for 500-600 families through the Good Neighbors Program and the Family Unification Program as well as for an additional 100-200 families through other programs.

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Best Practice – Emergency Prevention

Project SAFE
Everett, Washington

Project SAFE - Resources for Parents of Teens was initiated in 1999 to prevent teen homelessness in Snohomish County, Washington. Project SAFE offers three services to parents/caretakers of teens: phone consultation, groups and workshops, and a resource library. Parents/caretakers who are concerned about their teen can call and speak with a therapist who provides consultation and links to various resources in the community. They then receive a follow-up phone call, can opt to participate in support and educational workshops, and have access to project SAFE newsletters, "tip sheets" and other resource library materials.

Target Population

Project SAFE serves parents and caretakers of youth who are currently, or may be in the future, at risk of homelessness due to a number of problematic behaviors. Project SAFE also works with parents of younger children to address problematic behaviors early on to curtail teen homelessness. Interventions in every phase of the project are based on research identifying the parental risk factors that often lead to teen homelessness as well as teen substance abuse, violence and criminal acts, mental illness, promiscuity, running away and/or exposure to abuse and neglect.

History

Project SAFE was started as a pilot project of Cocoon House, Snohomish County's only provider of services to runaway and homeless youth. Cocoon House was founded in 1991 as an 8-bed shelter for youth age 13-17. The shelter serves both rural and urban areas and provides short-term housing. When possible, teens are reunified with their families.

When reunification is not possible, and when all other housing options have been exhausted, the teens can move to the Cocoon Complex, a 20 bed transitional housing program that was added in 1994.

In 1998 Cocoon House was chosen by Snohomish County to take over the management of the County's Teen Advocates Program, which aims to provide disconnected youth with linkages to essential services and resources.

During the late 1990s, an increasing number of distressed parents and caretakers whose teens were not currently at Cocoon House were calling seeking advice and referral about their youth. Many were ready to drop their teen off at Cocoon's Shelter because they felt they had no alternative.

Recognizing the growing number of homeless youth and parents seeking assistance, Cocoon House saw the importance of moving upstream to prevent the number of youth showing up at Cocoon House for housing and supportive services. Project SAFE was born to address this critical need.

Services

Phone-line consultation: Parents can call Project SAFE and consult with a Masters-level therapist. Conversations typically last 45 minutes to one hour. Together, the parents and therapist develop an action plan, and decide what resources are needed to carry it out. In addition to parenting strategies, action plans include steps, especially self-care, to help parents deal with their own depression or other issues contributing to their conflict with their teens. A follow-up call is made to parents, usually one week later, to check on their situation, maintain connections, and provide additional referrals if needed.

Groups and Workshops: In addition to consultations, Project SAFE operates support groups and workshops. The groups work on communication, empathy, problem solving, and other cognitive behavioral skills to promote healthier family functioning.

Resource Library: A resource library offers books and video materials to parents and caretakers. Project SAFE staff is developing summaries or "tip sheets" that condense longer books into simple, digestible information. A newsletter is also available describing resources while also providing quick tips for parents.

Presentations: Project SAFE also gives regular presentations both in-house and in the community. Workshop and group materials are developed based on input from Cocoon House staff and teens, and in collaboration with other community players such as guidance counselors, juvenile corrections officials, housing providers, and early intervention programs. The presentations focus on raising awareness of parental risk factors that contribute to teen problematic behaviors and developing multiple protective factors to promote healthier family functioning and to prevent teen homelessness.

Source of Funding

Cocoon House receives funding for their $1.3 million budget through federal and regional government grants, such as HUD McKinney Supportive Housing Program, ACF Runaway and Homeless Youth Transitional Living Program, Community Service and Community Development Block Grants. Key corporate and foundation supporters include The Boeing Company, Medina Foundation, Paul G. Allen Foundation, and Everett Clinic Foundation. Cocoon also receives funding from community organizations and individuals.

Project SAFE is funded by: Boeing, Whitehorse Foundation, Washington Alliance to Prevent Child Abuse and Neglect, Everett Clinic Foundation, and Butler Trust.

Available Data

In FY 2001, Cocoon House provided housing to more than 260 teens. Seventy-eight percent of youth left the shelter program for positive housing situations. Ninety-one percent of Cocoon Complex residents attended school, graduated, or completed a GED and over 90 percent received mental health counseling, drug and alcohol services, and life skills training. The Teen Advocate Program served 350 clients, and reached more than 1,000 individuals through outreach presentations.

In FY 2001, project SAFE served approximately 100 parent/caretakers and 250 community members through presentation, and distributed over 1,000 pieces of literature and materials.

Initial Project SAFE outcome data shows significant positive outcomes in parental/caretaker perception of improved ability to cope with their youth as well as a significant decrease in parental perception of the youth having to leave the home.

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MAKING SYSTEMS CHANGES THAT PREVENT HOMELESSNESS

GOAL: Mainstream programs (mental health, substance abuse, TANF, child welfare, etc.) that provide care and services to low-income people consistently assess and respond to their housing needs.

GOAL: There is placement in stable housing for all people being released from public institutions.

Most people who become homeless are eligible for assistance from mainstream systems of care, and many are or recently have been active clients of one or more of these systems. Studies on where homeless people have lived immediately before becoming homeless show trends that suggest solutions.

Public systems or institutions, such as jails and prisons, hospitals, the child welfare system and mental health facilities, too often "graduate" people directly into the homeless system. One aspect of prevention is to stop these discharges into homelessness, through basic transition planning so that people leaving these institutions have stable housing and some means for maintaining it.

Other people who become homeless still are, or should be, clients of mainstream systems of care. These systems can prevent homelessness by paying attention to the housing stability of the people they assist, particularly those who are at greatest risk of homelessness due to lack of family supports, extremely low incomes, mental illness or other personal difficulties.

Examples

Connecticut Department of Children and Families Housing Continuum. In the past several years, Connecticut revamped the service delivery to adolescents in their care. Youth work their way through a continuum of housing options, moving from highly structured, supervised living arrangements to a transitional phase where support is provided while structure and restriction is decreased. A description of this approach is available at http://www.endhomelessness.org/best/CTyouth.htm

Illinois Department of Children and Families Youth Housing Assistance Program. The Illinois Department of Children and Family Services developed a housing advocacy program to provide youth aging out of foster care with housing assistance. The program helps young people locate housing and provides youth with cash assistance and partial housing subsidies. For additional information on this program, go to http://www.endhomelessness.org/best/ILyouth.htm

Lighthouse Youth Services Housing Continuum. Lighthouse prevents youth in child welfare from becoming homeless by employing a semi-supervised scattered-site apartment model based on the philosophy that young people learn best by "doing" and that youth should have opportunities to live on their own and develop self-sufficiency skills prior to discharge from care. Further information on this program is available at http://www.endhomelessness.org/best/lighthouse.htm

Minnesota Family Homeless Prevention and Assistance Program. Minnesota's TANF system helps to fund FHPAP, which in turn funds local agencies to prevent homelessness. Prevention activities include work with landlords and crisis intervention. A profile of this program, which also addresses other aspects of homelessness, is at http://www.endhomelessness.org/best/fhpap.htm

New Mexico Adolescent Transition Groups. New Mexico has established entities to take responsibility for young people transitioning from out-of-home care into adulthood. A description appears at http://www.endhomelessness.org/best/ATG.htm

Resources

- *Essential Tools for Discharge Planning.* This report documents and extracts lessons from five years of effort by the Massachusetts Housing and Shelter Alliance to successfully encourage good discharge planning practices by inpatient health care facilities. It provides a thorough, detailed guide for those seeking adoption of effective policies and practices at the state or local level. Available on line at: http://www.nhchc.org/discharge

- *Preventing Homelessness Among People with Serious Mental Illness: A Guide for States,* published by the National Resource Center on Homelessness and Mental Illness, describes risk factors for homelessness, and some examples of state mental health systems that have adopted policies to prevent homelessness. Available on line at http://www.nrchmi.com/pdfs/publications/Preventing_Homelessness.pdf

- *Preventing Homelessness: Discharge Planning from Corrections Facilities,* published by the Community Shelter Board of Columbus, OH, presents an overview of the issue and effective ideas at the program and policy levels. A good example of a persuasive background piece used in a local community. Available on line at: http://www.csb.org/What_s_New/FinalReportAug2002/Final%20Report%20August%202002.pdf

- *Family Unification Program.* Through the Family Unification Project (FUP), child welfare agencies and public housing authorities collaborate to provide safe, affordable housing for families who have been separated from their children or at-risk of separation due to homelessness, domestic violence, or inadequate housing, and youth ages 18-21 who are transitioning out of foster care. For more information on FUP, see: http://www.cwla.org/programs/housing/

Best Practice – Systems Changes to Prevent Homelessness

Connecticut Department of Children and Families Housing Continuum

Program Overview

In the past several years, Connecticut revamped the service delivery to adolescents in their care. Youth work their way through a continuum of housing options, moving from highly structured, supervised living arrangements to a transitional phase where support is provided while structure and restriction is decreased. Connecticut contracts approximately 60 Independent Living Providers and is able to expand housing options within the continuum as demand increases.

Target Population

Connecticut's Adolescent Services targets youth 14 and older, whose permanency goal is emancipation.

Referral Process

At age 14, all youth are transferred to caseworkers specializing in independent living services for youth. Youth are then referred to a provider that will serve the individual housing needs of the youth.

Services

Phase I: Preparation for Adult Living Group Homes

- The average length of stay is two years.
- Average age of youth served is 14-16.
- 8-10 youth live in each group home.
- 24-hour supervision is provided.
- Average per diem is $165.

Phase II: Transitional Living Apartment Program

- The average length of stay is 18 months.
- Average per diem is $175.
- Youth generally enter this phase at age 16 or 17.
- Youth live in apartments or homes with other youth.
- The provider agency pays the rent.
- Youth have resident advisor who live on site and provide 24-hour supervision.

Phase III: Community Housing Assistance Program (CHAPS)

- The average length of stay is 2 years.
- Youth generally enter the program around the age of 18.
- The average per diem is $52-70.
- Youth must have completed the Department's life skills program, be employed, and enrolled in an educational or vocational program, and exhibit adequate behavior and social skills.
- Youth receive a subsidy based on market rent and cost of food, utilities, telephone, transportation, and clothing.
- Youth directly receive subsidy and must provide receipts to agency and provider caseworker.
- Youth must contribute 25% of their income to the subsidy total, and must save 40% of their income. CHAP contracts are reviewed every 3 months.
- Five hours of case management is provided at $22 per hour. More can be provided based on individual need.

For more information on Connecticut's Housing Continuum, please contact:

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Best Practice – Systems Changes to Prevent Homelessness

Illinois Department of Children and Families
Youth Housing Assistance Program

Program Overview

In 1999, Congress enacted the Foster Care Independence Act (FCIA), authorizing $140 million for the John H. Chafee Foster Care Independence Program to improve service delivery for foster youth transitioning out of care. FCIA includes a provision allowing states to use 30% of federal independent living dollars on room and board.

With the implementation of the Chafee Foster Care Independence Program, Illinois embarked on developing a Youth Housing Assistance Program, which provides housing advocacy and cash assistance to youth aging out of foster care. The program was modeled on Illinois' Norman housing advocacy program, which provides housing services to families at risk of involvement in child protective services due to the lack of safe and stable housing.

The program was built on research that demonstrates that housing is essential to stabilizing clients and providing services to meet their needs. The Department for Children and Families involved advocates, current and former foster youth, providers, and state agency officials in the development of the program. DCFS chose several housing advocacy agencies that they had existing relationships with and placed 16 Housing Advocates throughout the state to help youth locate affordable housing and access social services for stabilization.

Target Population

Illinois' Youth Housing Assistance Program targets youth at high risk of becoming homeless who are approaching emancipation or who have already emancipated from the foster care system. Housing advocacy is provided for youth between the ages of 17 1/2 and 21 and cash assistance is provided to youth between the ages of 18 and 21.

Referral Process

Caseworkers refer youth to the Youth Housing Assistance Program six months before emancipation if they are in need of housing services. Youth must submit a request for Housing Advocacy and/or Cash Assistance to the Youth Housing Assistance Coordinator. Youth is assigned to a Housing Advocate located in their region for services.

Services

- Housing Advocacy – service to help youth locate housing, receive budget counseling, and gain access to community resources and social services.
- Start-up Grant – Youth can receive up to $800 ($1200 if youth is parenting, pregnant, or disabled) to cover start up costs including deposits, furniture, appliances, etc. The start-up grants assist youth to move in to housing at the time of emancipation.
- Partial Housing Subsidy – If youth's housing cost exceeds 30% of their income, their landlord will receive up to $100 per month for up to 12 months following the youth's emancipation. The monthly subsidy is designed to be large enough to provide a cushion for young people learning to live on their own for the first time, but small enough to discourage youth from becoming dependent on the subsidy.
- Cash assistance- Cash assistance may be used for housing security deposits, rent, partial rental subsidies, furniture, appliances, utilities, and other item required for youth to avoid or manage a crisis. Youth are provided up to $2000 per 12-month period following emancipation to help youth stabilize after a crisis. If any employed youth loses a job and needs to pay rent before another job is secured, youth is eligible for $600 one-time exception. Lifetime limit for all types of cash assistance is $4000.
- Follow-up services for a minimum of three months after the client secures appropriate housing.

Funding Source

Federal Chafee Independent Living Program

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Best Practice – Systems Changes to Prevent Homelessness

Lighthouse Youth Services Housing Continuum
Cincinnati, Ohio

Program Overview

Lighthouse Youth Services prevents youth in child welfare from becoming homeless and prevents young adults in the adult shelter system from remaining homeless through their Independent Living and Transitional Living Programs. In 1981, Lighthouse developed an semi-supervised scattered-site apartment model based on the philosophy that young people learn best by "doing" and that youth should have opportunities to live on their own and develop self-sufficiency skills prior to discharge from care. The agency has served over 1000 youth in its model and averages around 80 youth a day living in their own apartments.

Lighthouse is committed to continuously educating public systems about the importance of giving youth opportunities to live on their own and the need for affordable housing at discharge. Lighthouse was successful in helping to change state codes to mandate Independent Living training for youth and to allow unsupervised living arrangements. County and city child welfare, mental health, and juvenile corrections systems were educated on the funding split between services for foster youth and homeless youth, demonstrating that corrections, mental health, and foster care cannot shift the responsibility of aftercare for their wards to the small and under-funded homeless youth assistance system. After years of advocating for a housing continuum that includes flexible, less restrictive living arrangements, many county and state care providers have bought into the model and subsequently, have provided funding to Lighthouse to serve system youth.

Target Population

The Independent Living Programs targets foster youth and juvenile offenders between the ages of 16 and 19. The Transitional Living Program targets homeless youth between the ages of 18 and 25.

Referral Process

Sources of referral include child welfare, homeless shelters, juvenile courts, and various community-based organizations.

Services

Lighthouse's Housing Continuum includes several housing options for youth: Scattered-Site Apartments, Supervised Apartments, Shared Homes (4-5 youth), Host homes, and boarding homes. Youth can move from more structured living arrangements to less

restrictive living arrangements, depending on the level of support and services needed. Having a number of housing options allows the program to find a living arrangement that meets a youth's particular needs. If a young person does not succeed in living in his or her own in an apartment, they can be moved to other living arrangements until the right option is identified.

The desired outcomes for the Independent Living and Transitional Living Programs at Lighthouse include:

- Youth retain affordable housing at discharge, often taking over the lease of the apartment or accessing low-income housing.
- Youth experience living independently in their own apartment, learning budgeting, money management, and self-sufficiency skills.
- Youth have the opportunity to live in an area that is comfortable or familiar to youth, with easy access to transportation, shopping, and employment.
- Youth make connections with caring adults.
- Youth are connected to adult community resources.

Funding Sources

Independent Living: Children's Services County Levy, per diem from referring agencies

Transitional Living: Federal Runaway and Homeless Youth Program (HHS), state and city grants, HUD, United Way, private donors, and client contribution.

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Best Practice – Systems Changes to Prevent Homelessness

Family Homeless Prevention and Assistance Program
State of Minnesota

Minnesota's Family Homeless Prevention and Assistance Program (FHPAP) is facilitating the end of homelessness by providing state funds, including TANF block grant dollars, that can be used innovatively by counties and community nonprofit organizations to help families remain in their homes, re-house those who become homeless and shorten the length of time families spend in shelters. Last year, the Illinois State Legislature established a Family Homeless Prevention and Assistance Program modeled after the Minnesota legislation.

History and Background

Created in 1993 by the Minnesota State Legislature, the Family Homeless Prevention and Assistance Program is designed to achieve three primary goals:

- Prevent homelessness from occurring
- Shorten lengths of time in homelessness and emergency shelters
- Prevent repeated episodes of homelessness

The program provides grants to local communities to achieve the goals of the legislation. The funds are very flexible and use of funds is determined at the local level by an advisory group. The application process for grant funds is competitive and grantees must reapply every biennium. The program requires grantees report outcome data and future funding decisions are determined based on performance.

The program originated after Hennepin County administrators successfully heightened public awareness that the county's existing emergency shelter system would not be able to meet the demand and, as a result, families would soon be turned away from shelters. The Governor was committed to responding to the need and the Administration developed a policy proposal. Rather than building more shelters to meet the demand they decided to take action to reduce demand--by preventing homelessness, facilitating people's re-entry to and stabilization in housing.

In developing the state policy, a collaborative of private non-profit agencies used focus groups with families who experienced homelessness to shape the legislation. They identified the reasons they became homeless, what might have prevented them from losing their housing and what were the barriers they encountered in becoming re-housed. The Republican Governor's proposal received strong bipartisan support and passed easily. The legislation allows for a great deal of local flexibility in determining the use of funds and stresses tracking outcomes. It has received increased appropriations every year since it was created, with continued bipartisan support.

Program Description

Funding for the program is awarded on a competitive basis to counties or community nonprofit organizations. Grantees are required to establish a local advisory group responsible for the local initiative, including designing the program, developing eligibility criteria, problem solving throughout implementation, identifying sub-contractors and submitting biennial reports. Local advisory groups are advised to meet monthly and are expected to be active in their community's Continuum of Care efforts.

A dedicated staff person in the Minnesota Housing Finance Agency is responsible for reviewing funding applications, program reports and provision of technical assistance. State leadership in developing and promoting the "culture" of the program – to end, not manage homelessness – is viewed as a critical component.

Perhaps contributing to the success of the program and grantees' adherence to meeting the purposes of the legislation is the involvement of the state Interagency Task Force on Homelessness (ITF). Each local advisory group must include a member of the ITF, which consists of representatives from nine other state agencies. Each Interagency Taskforce member is assigned to a grantee advisory group and attends the grantee's meetings as representatives of the ITF. The state ITF also meets monthly as a group and reports on what is occurring at the local level.

Grantees must reapply every biennium. Applications are reviewed by a state advisory committee that makes recommendations on level of funding for applicants based on their performance on outcome measures. Funding is very limited, which forces the advisory committee to target the dollars and limit the amount of assistance to promote the program's effectiveness. Outcomes are stressed not outputs or numbers served. This requires tracking individuals and families served to capture future incidents of homelessness or sustained housing stability. The grant application process and outcome data requirements are viewed as helping direct local activities toward achieving the purposes of the legislation.

Currently there are fourteen grantees representing one half of all the counties in Minnesota. The program relied on state general funds until 2000 when dedicated TANF block grant dollars were added, creating more funding and a new level of complexity with federal reporting and eligibility requirements. $6.5 million has been budgeted for the next biennium, and an additional $4.6 million is being sought by the Minnesota Coalition for the Homeless to expand services to new parts of the state and increase capacity with existing grantees.

Legislation and State Advocacy Efforts

Legislation for the Family Homeless Prevention and Assistance Program can be reviewed online through the Office of Revisor of Statutes, State of Minnesota: http://www.revisor.leg.state.mn.us/stats/462A/204.html

Updates on relevant advocacy activities can be found on the Minnesota Coalition for the Homeless website: http://www.mnhomelesscoalition.org

Impressions of Program Administrators/Advocates

The advisory committees are perceived to be particularly effective in solving problems and opening dialogue around homelessness in the community. Advisory groups are typically comprised of a broad spectrum of the community – including advocates for the homeless, homeless or formally homeless people, housing developers, representatives of the local public housing authority and employers. Local advisory groups have become active on homelessness issues beyond the administration and oversight of the local Family Homelessness Prevention and Assistance Program and have advocated for local policy changes and better utilization of locally controlled resources to respond to the needs of homeless people.

Local flexibility is viewed as a vital component in a large geographically diverse state and diverse counties. It allows for a range of responses appropriate to the particular community and experiments with small "pilot" projects that may prove effective.

Administrators recognize the importance of developing strong relationships with landlords to prevent homelessness and re-house families. Some programs dedicate staff to respond to landlord concerns and work with landlords and tenants to address issues that may threaten housing stability. If necessary, local programs may assist in paying for damages by tenants placed into housing that exceed the security deposit.

Preventing homelessness has become the priority for many administrators. The state's shortage of affordable housing and high rents make re-housing families difficult and they have decided those with affordable, sustainable housing should receive the necessary assistance to retain it through a short-term crisis. Further, the flexibility of the FHPAP funds have facilitated the development of prevention efforts that was reported by some grantees as too difficult to accomplish with HUD funding restrictions.

The program is administered by a dedicated staff person at the Minnesota Housing Finance Agency. The administration of the program is described to be staff intense, particularly in the early stages. There is a need to provide technical assistance that may include helping to develop strong advisory boards and a group culture that will help achieve the purposes of the legislation.

FHPAP is an outcome-based grant program that places the emphasis on results rather than process or numbers served. Numbers served aren't ignored but 'process' is not the emphasis. Grantees have received more funds when they have performed well and some have had funding reduced. This is viewed as an important component carried out both at the state and local level and a key to its success.

Rapid re-housing of families and individuals with greater challenges may require more flexibility in providing follow-up support and case management than can be provided by

the six months of after care that HUD allows for those who can no longer be classified as "homeless." Flexibility to provide follow-up assistance for those rapidly re-housed would remain cheaper than allowing those with significant challenges to remain in transitional housing.

There may be a benefit to increasing federal collaboration between HUD and HHS to better partner housing with services. This would meet both agencies goals as HUD wants to work toward more bricks and mortar yet requires services for some programs and housing is needed for anyone to stabilize sufficiently to benefit from services.

Potential Concerns

Local flexibility -- As program design occurs at the local level, there may be issues around the use of funds and eligibility criteria. For example, some advisory groups have elected not to serve families who have been sanctioned from TANF. The program administrator in one such community reported that they provide assistance to families to help reconcile their sanctions first so they can become eligible for assistance. In this community, the family's resources are enhanced as a result of reconciling the sanction that should increase the likelihood of future housing stability. Without assistance to reconcile sanctions, families in need of assistance might be excluded from this source of assistance. Families who have been sanctioned may experience significant barriers to achieving self-sufficiency, such as mental health and substance abuse disabilities, domestic violence and low educational attainment.

Coordination with Emergency Assistance Funds -- Like many other states, Minnesota has continued to approve Emergency Assistance funds under its state TANF block grant plan. Emergency Assistance funds can be used to provide assistance to families at risk of homelessness and are accessed through the local Division of Human Services. For communities interested in establishing a Family Homelessness Prevention and Assistance Program, coordination at the state and local level with the administrators of the existing Emergency Assistance program will enhance effectiveness. Further care may be required to ensure the creation of a FHPAP program serves to enhance measures to prevent homelessness rather than supplanting them by ensuring both FHPAP and Emergency Assistance funds are maximized.

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Best Practice – Prevention

New Mexico Adolescent Transition Groups

In 1994, the State of New Mexico established Adolescent Transition Groups (ATGs) to support the most vulnerable youth transitioning from out-of-home care into adulthood. Adolescent Transition Groups are comprised of representatives from state and local child welfare, juvenile justice, education, and mental health agencies, as well as youth advocates, attorneys, and other community stakeholders. ATGs exemplify a systems management approach that utilizes the experiences of individuals to identify systemic barriers for youth in transition. The primary goals of ATGs are to help youth access services that they are eligible for as adults, to identify and address barriers to services and service gaps, and to raise awareness and promote dialogue between child and adult systems of care.

Currently, there are five Adolescent Transition Groups throughout New Mexico. ATGs receive no dedicated funding, utilizing existing agency resources to staff each ATG and to provide technical assistance and training to communities interested in forming an ATG. Child welfare and juvenile justice agencies refer their hardest-to-serve youth to ATGs. Typically, the youth referred have dual or multiple diagnoses including a mental health condition with substance abuse and/or developmental disorders. ATGs hold monthly half-day meetings, during which professionals, family members, and youth present information about transition-related issues and problems they encounter. After identifying the youth's needs, the group discusses possible solutions and refers the family, youth, and/or caseworker to untapped resources and services. The groups regularly report to state agencies to increase interagency awareness about the needs of youth transitioning out of care.

For more information, please contact:

New Mexico Department of Health
Behavioral Health Services Division
Homeless and Housing Services Supervision
(505) 827-1630

OUTREACH TO HOMELESS PEOPLE ON THE STREETS

GOAL: Your community has an outreach and engagement system designed to reduce barriers and encourage homeless people so that they enter appropriate housing (including safe havens) linked with appropriate services.

Outreach can play an important role in ending homelessness by engaging people who are living on the streets and getting them into housing. A key ingredient of effective outreach is a rapid link to housing, which necessitates some form of low-demand housing—housing with few rules or requirements. Youth or adults who are living on the streets often have a mental illness or substance addiction. Mandating treatment or sobriety can drive them away. Outreach that provides low-demand housing minimizes the negative effects of street living, which include worsened mental and physical health. When people feels safe and secure, they are more likely to participate in treatment. Housing has this effect.

Safe Havens are one popular form of low-demand housing intended to reach hard-to-serve homeless people with serious mental illness. This HUD program provides housing with supportive services, and is eligible for funding through HUD's Supportive Housing Program.

Examples

Pathways to Housing (New York, New York) Pathways helps people with serious mental illness move from the streets directly into permanent housing. Assertive Community Treatment (ACT) teams meet people on the streets and offer permanent housing with supportive services. Participation in treatment is optional. A criminal history is not a disqualifying factor. A profile of Pathways is at: http://www.endhomelessness.org/best/pathways.htm

Project H.O.M.E. (Philadelphia, Pennsylvania) Project HOME has an extensive outreach program that includes two Safe Havens, one each for men and women. A profile of Project H.O.M.E. is at: http://www.endhomelessness.org/best/projecthome.htm

Resource

- HUD has produced a guide to the development of Safe Havens, which can be found at: http://www.hud.gov/offices/cpd/homeless/library/havens/index.cfm

Best Practice – Outreach

Pathways to Housing, Inc.
New York City, New York

Founded in 1992, Pathways to Housing offers scattered site permanent housing to homeless individuals with psychiatric disabilities and addictions. Despite the challenges this population presents, Pathways is unique in what it does *not* require of its residents: "graduation" from other transitional programs, sobriety, or acceptance of supportive services as a condition of tenancy. The vast majority of clients are moved directly from the streets into permanent, private market housing. The program then uses Assertive Community Treatment (ACT) teams to deliver services to clients in their homes. The ACT teams help clients to meet basic needs, enhance quality of life, increase social skills, and increase employment opportunities. The program currently serves over 400 people

Target Population

Eligibility
Pathways to Housing is designed to end homelessness for people living on the streets with concurrent mental illness and addiction. In order to be eligible for the program, an individual must be homeless, must have a psychiatric disability that compromises their ability to function, and must be willing to meet with a service coordinator twice a month during the first year of tenancy. Priority is given to women and elderly people because they are at greater risk of victimization.

The program provides an alternative to the more common "linear residential treatment programs," which move people through a continuum of services beginning with outreach, some intermediary housing which helps people become "housing ready," and ending with permanent housing. Pathways provides clients with housing first, and then offers services and treatment to people in their homes.

Referrals
Most clients are contacted through the outreach efforts of Pathways staff. Other referrals come from city outreach teams, shelters and drop-in centers. 1999 data showed that 65% of tenants had last lived on the streets, 18% in shelters, 7% in treatment facilities, and the remainder had lived with friends, at the YMCA/YWCA, or in transitional facilities.

Project Description

Housing
Pathways to Housing staff assist clients in locating and selecting private market rental housing. The housing department keeps logs of new vacancies among the over 200 landlords they work with, and works to negotiate leases and complete Section 8 applications. The greatest challenge to the program is finding vacant apartments at fair market rent. Landlords are amenable to renting to Pathways' clients because they get guaranteed rental payments. Tenants pay 30% of their income towards rent, and Pathways pays the remaining amount if the client does not have a Section 8 voucher.

The agency also leases two transitional apartments for use by clients who have been accepted into the program, but have not yet found an apartment of their own. The average length of stay in these units is 15 days.

Services
Pathways to Housing uses Assertive Community Treatment (ACT) teams to deliver services to clients in their homes. The teams are interdisciplinary and are on-call 24 hours a day, seven days a week. However, the tenant determines the type, frequency, and sequence of services. Service requirements are that the tenant meet with a service coordinator twice a month and participate in a money management program. Refusal to participate in sobriety or other treatment programs does not disqualify an individual, nor does a history of violence or prison time.

ACT teams consist of up to ten service coordinators, each with a particular expertise. The team leader is responsible for supervising the work of the team. The primary goals of the ACT teams are to meet basic needs, enhance quality of life, increase social skills, and increase employment opportunities. Each team sees approximately 70 clients. When a team cannot provide the services directly, tenants are referred and accompanied to the relevant programs. After the rent is paid tenants are required to develop a monthly budget with the service coordinator. The goal is for tenants to eventually manage their own money.

Staffing
Pathways to Housing employs 4 staff responsible for housing services, 40 service coordinators, 5 team leaders, 2 psychiatrists, 2 nurses and a vocational specialist. The staff make-up is culturally and racially similar to the population the program serves. Program success is attributed in part to staff composition that includes 50% consumer representation (i.e. people in recovery) that serve as role models.

Source of Funding
Funding for the Pathways program comes in two parts: housing subsidies and services. Around sixty-five tenants have Section 8 vouchers, and the remainder are subsidized by grants from the HUD Shelter Plus Care program and the New York State Office of Mental Health. The latter also provides funding for the ACT teams. Each unit with services costs approximately $20,000 per year.

Service Utilization/Outcome Data
Data from 2000 showed that 88% of the program's tenants remained housed after five years. Furthermore, Pathways staff contends that its residents have greater satisfaction with their housing, and greater psychological well-being because they were given a choice as to where to live, and what activities to engage in.

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Best Practice – Outreach

Project H.O.M.E.
Philadelphia, PA

Project H.O.M.E. is a nonprofit founded by Sister Mary Scullion and Joan Dawson in 1989. The organization provides a full range of services for chronically homeless people with mental illness and/or substance abuse disorders, including street outreach, safe havens, permanent supportive housing and a range of services to supplement housing. This continuum is an important part of Project H.O.M.E.'s success: each person is recognized as an individual with unique needs. Services at each facility are different; some residents are not ready to accept regimented drug or alcohol treatment, while others may be able to live almost independently.

The project profiled below, the facility at 1515 Fairmount Avenue, is notable for a number of reasons: the careful evaluation at admission to the facility to ensure compatibility with the program, the partnership forged with the State Office of Mental Health and its emphasis on fostering personal development and dignity.

The Facility

After a long, and now infamous, legal battle, the permanent housing facility at 1515 Fairmount opened its doors in 1996. 1515 Fairmount is a 48 bed permanent housing facility for homeless mentally ill men and women. The services provided at 1515 Fairmount are not intensive, and the residents are self-sufficient enough to clean their rooms and cook for themselves. There are no curfew or program requirements at 1515. The most common diagnoses are schizophrenia and bipolar disorder. Diagnoses are not what concern staff of this facility, however. More important is the level of independent living skills that potential clients possess, and the appropriateness of an environment that provides stable housing combined with low-level supportive services. Residents live in "clusters," in which 5-7 residents share living, dining and kitchen facilities.

Referrals

Project H.O.M.E. is unique in its method for reaching clients for 1515 Fairmount. All referrals to 1515 Fairmount come through the Office of Mental Health. OMH stays involved with referred clients by continuing to provide one-on-one case management. All clients must have a history of homelessness or have been at risk of imminent homelessness. 1515 Fairmount employs a “team interview” method to identify appropriate residents. A group of people who have been involved in the prospective resident’s treatment, including the city case manager and other programs officers, work with the Project H.O.M.E. team to determine whether 1515 would be a good fit. The notion of "fit" is integral to the program's success; not everyone will benefit from the model of low services administered at 1515.

Services

1515 Fairmount employs two full-time caseworkers and one part-time caseworker from 9-5 Monday-Friday. Also staffed is a 24-hour reception desk. Case management is supplemented greatly by the requirement that each resident have a case manager assigned by the city. 1515 Fairmount does not require a regimen of supportive services, but does ask each resident to be involved in some structured activity - whether it be employment, classes, or other daily activity - for 15 hours per week.

Fifteen of the 48 residents work. Project HOME facilitates employment and community reintegration, by employing residents in two in-house businesses: The Back Home Café, and Our Daily Threads Thrift Store.

Source of Funding

Project H.O.M.E. was awarded a $2 million grant from the Department of Housing and Urban Development in 1996 to rehab the property at 1515 Fairmount Avenue. The units have project-based Section 8 vouchers, which allow residents to pay 30% of their income toward rent. 1515 Fairmount has an annual budget of $182,000, most of which comes from a grant from the Office of Mental Health for all of the supportive services in the project. Additionally, OMH supplies each resident with his/her own case manager. Project H.O.M.E. manages the project, while their limited partner, 1515 Fairmount Limited Partnership, acts as the investor and developer.

1515 Fairmount did not always receive this large amount from the Office of Mental Health. Indeed, only recently the grant was $70,000. According to Sister Mary Scullion, the city became willing to support more of the project after the need for permanent supportive housing was proven, through data collection and analysis. Project H.O.M.E. keeps its private donations as flexible as possible, in order to channel the money to where it is most needed. Private donations that had been used for the facility at 1515 Fairmount are now being used in newer facilities, that are not established enough to receive city support.

Outcomes

According to the project coordinator, Project H.O.M.E.'s most important outcome, and the primary ingredient for its success, is respect for each resident's dignity. While this is a difficult goal to measure, one needs only to visit 1515 Fairmount, or any of Project H.O.M.E.'s sites, to know that they have succeeded. Residents feel a tremendous pride in their homes, and often in their recovery and independent living skills. Of all the residents that have lived at 1515 Fairmount since 1996, close to half still live there. Others have moved on to live independently, and others have cycled back into the homeless assistance system.

Fewer people have relapsed in the later years of the project. Darryl Parker, the program coordinator, believes that this success is due in large part to better client screening. The

unsuccessful residents were largely those who needed more structure than 1515 Fairmount was designed to provide.

For More Information Contact

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An evaluation of the program can be found at:
http://www.projecthome.org/homelessness/phmc_study2001.PDF.

SHORTENING THE TIME PEOPLE SPEND HOMELESS

GOAL: The shelter and transitional housing system in your community is organized to reduce or minimize the length of time people remain homeless, and the number of times they become homeless. Outcome measures will be key to this effort.

Ending homelessness requires an alignment of resources to reduce the duration of each spell of homelessness, and prevent recurrence. A "Housing First" approach is critical to successfully ending homelessness. Housing First involves addressing the immediate barriers to housing so that homeless people can move into permanent housing as quickly as possible. Service needs are addressed through home-based case management, which helps stabilize the family, ensure that they will have sufficient income to sustain their housing, and prevent a recurrence of homelessness. For such a system to be effective, the incentives embedded in the homeless assistance system have to reflect these outcomes. Examples of such incentives include:

- Shelters and other homeless services providers should have access to and incentive to use prevention resources to avert a homeless episode.

- Shelters and transitional housing providers should have incentives to move people out of homelessness and into stable permanent housing as quickly as possible. To the maximum extent possible, a homeless person's service needs should not delay his or her entry into permanent housing.

- Structures should be in place to meet the service needs of re-housed households.

- Homelessness providers should be held accountable for people they have served in the past and should be rewarded to the degree that their former clients continue to be stably housed.

- At the same time, homelessness providers should be encouraged to serve people who have the most barriers to permanent housing and are most likely to be homeless longest. Incentives for quick, sustained rehousing should not sanction "creaming."

- Outcome measures should track the number of people who become homeless, the average length of homeless episodes (not necessarily the average stay in a shelter), and the rate of recidivism.

- Homelessness programs should be discouraged from using time limits, sanctions, or other devices that may reduce shelter use but do not end homelessness.

Examples

Chicago Department of Human Services (Illinois) Chicago is undertaking an ambitious plan to transform its shelter and transitional housing system into one that moves people into housing as quickly as possible. For a description of the plan's approach to shortening homelessness systemwide, see http://www.endhomelessness.org/best/GettingHoused.htm

Community Shelter Board (Columbus, Ohio) The Community Shelter Board (CSB) coordinates the city's response to homelessness. CSB reports semi-annually on each shelter and homeless assistance program, using these outcome measures:

Measures for homeless assistance programs

- Households served
- Successful housing outcomes
- Recidivism

Measures for emergency shelters (CSB funds only a portion of total shelter budget)

- Pass shelter certification
- Decreasing maximum length of stay
- Average stay not increasing
- Improving housing outcomes
- Increasing rates of persons not returning to shelter

To see more information about CSB's approach, see http://www.csb.org.

Resource

Materials on the Housing First approach, prepared by the National Alliance to End Homelessness, are at: http://www.endhomelessness.org/networks/housingfirst/intro.htm

Best Practice – Shortening Homelessness System-wide

Getting Housed, Staying Housed
Chicago, Illinois

The following profile is adapted from "Getting Housed, Staying Housed. A Collaborative Plan To End Homelessness," endorsed by Mayor Richard H. Daley on January 21, 2003

For those families and individuals who are already homeless or for whom homelessness cannot be prevented, the Chicago Continuum of Care is transitioning to a system-wide Housing First strategy. This approach seeks to assist persons to exit homelessness as quickly as possible by placing them in permanent housing and linking them to needed services. This approach assumes that the factors that have contributed to a household's homelessness can best be remedied in permanent housing. It also accepts that for some, lifelong support may be required to prevent the reoccurrence of homelessness. The plan seeks to maximize utilization of mainstream resources.

But for most, the model will promote long-term self sufficiency through a wraparound service philosophy (Wraparound services refer to a comprehensive service provision model that guarantees that any and all services needed by an individual or family are integrated through a cohesive, individualized service plan that guides all service provision. Chicago's Continuum will infuse this service approach across all components of its homeless service delivery system – prevention, interim housing, and permanent housing.)

The system-wide Housing First strategy has required a fundamental shift in the city's shelter strategy, away from its current tiered system of care to an Interim Housing model in which short-term housing is provided for the minimum time needed to access permanent housing, with services focused on an immediate and comprehensive needs assessment, resource acquisition (i.e., public benefits and other forms of assistance), and housing placement.

Over the next five years, Chicago's Continuum plans to undertake three efforts simultaneously in pursuit of its new Housing First approach. It plans to expand the availability of affordable permanent housing; increase its accessibility; and transition the existing tiered shelter system into a Housing First system.

To expand the **availability** of affordable permanent housing, the city will:

- Create new project-based permanent supportive housing units for persons with serious and persistent disabilities.
- Expand permanent supportive housing subsidies for persons with serious and persistent disabilities who can live independently in market rate housing with appropriate supportive services.

- Develop additional engagement housing, such as safe havens and harm reduction programs for those who need permanent housing, but are resistant to traditional service models.
- Expand transitional rent subsidies for households who can be placed in community-based permanent housing with integrated services, in which the tenant holds the lease or assumes the lease over the period of the transitional subsidy.
- Develop and increase the availability of appropriate Housing First models of permanent housing for youth who are homeless.

To increase the **accessibility** of affordable permanent housing, the city will:

- Develop an affordable housing clearinghouse that will be used to link households in interim housing with appropriate market housing.
- Expand and increase coordination of street outreach for persons who are homeless and not requesting services to provide assessment and linkage to engagement housing and permanent supportive housing.

To **transition** the existing shelter system to a Housing First system, the city will:

- Develop standards for Interim Housing and permanent housing models that promote housing placement in the most suitable, least restrictive settings possible.
- Use local public funding to encourage, and eventually mandate, existing shelter programs to convert to the new Housing First model.

As part of the support for the planned activities of each of the initiatives, the city will implement a homeless information management system with information and referral, case management, and benefits screening functionality to collect information about the people who become homeless, improve the effectiveness of service delivery, and understand the relationships between service utilization and client outcomes over time. The affordable housing clearinghouse will also be seamlessly linked with the homeless information management system.

Under the *Getting Housed, Staying Housed* model, current agencies in Chicago's homeless service system will need to redefine how services should be provided and how, as service providers, they will evolve. Some existing shelter providers may choose to shift their shelter program model to the new interim housing model by offering short-term residential care with 'Housing First'-oriented services, such as comprehensive needs and resource assessment, permanent housing placement and community service linkage. Others may move away from residential programs and provide permanent community-based supportive services, and still others may shift their operations to provide permanent supportive housing. This housing and service system shift will be challenging – it will require agency and program-level reorganization, Board and staff training, and deliberate system-level change management. It will also require significant systems integration efforts to coordinate and network services at all levels – client, agency, neighborhood and system.

The complete citywide planning document, "Getting Housed, Staying Housed" is available at: http://www.ci.chi.il.us/HumanServices/pdf/homeless_plan2.pdf

RE-HOUSING PEOPLE RAPIDLY SO THAT THEY DO NOT BECOME HOMELESS

GOAL: Your community has skilled housing search and housing placement services available to rapidly re-house all people losing their housing or who are homeless and who want permanent housing.

One of the primary challenges homeless people face is navigating the housing market. Most communities have a shortage of housing affordable for low-income households. Consequently, landlords can select the most appealing tenants, many of whom have higher incomes, and require a large sum of cash for a deposit and first and last months rent. There is little incentive for landlords to work with potential tenants who have lower incomes, little savings, credit problems, or unstable housing histories.

Housing placement services can address many of the barriers homeless people face. Effective housing search services often include the following elements:

- Skilled housing search staff with knowledge of local housing markets and relationships with landlords
- Marketing and outreach to landlords
- Incentives for landlords to rent to homeless households
- Assurances to landlords that the housing services agency will assist with landlord/tenant problems.
- Access to subsidies, such as vouchers, for households with extremely low incomes
- Coordination with service providers to ensure that a homeless person's service needs are met once he or she is in permanent housing
- Periodic follow-up work to prevent a housing crisis
- Services to address credit problems

The skills necessary to effectively place homeless people in private market housing combine those of a realtor and a caseworker. Locating and developing qualified staff is one of the greatest challenges to having an effective housing search and placement system.

Examples

Beyond Shelter (Los Angeles, California) Since 1988, Beyond Shelter has been assisting homeless families with children move into permanent housing. Housing search staff help families negotiate leases, access move-in funds, and overcome the barriers of poor credit history, prior evictions, and discrimination based on ethnicity, family size and income source. Approximately half of the 400 families served each year are headed by a parent in recovery. For more information, see:
http://www.endhomelessness.org/best/beyondshelter.htm

Philadelphia Housing Support Center (Philadelphia, Pennsylvania) The Center is a one-stop housing resource center that combines services from various state agencies with skilled housing search staff. They partner with the local housing authority to provide housing choice vouchers and family unification vouchers. For more information, see:
http://www.endhomelessness.org/best/SupportCenter.htm

HomeStart (Boston, Massachusetts) HomeStart provides families and individuals with skilled housing search assistance in one of the tightest housing markets in the country. Voluntary stabilizations services help newly housed families and individuals deal with landlord/tenant conflicts. HomeStart also contracts with state agencies to provide housing search services for people involved in various state administered programs. For more information, see: http://www.endhomelessness.org/best/homestart.htm

Rapid Exit (Hennepin County, Minnesota) Rapid Exit provides housing relocation assistance to families with moderate to severe barriers to housing. Within one week of entering a shelter, families are referred for a housing barriers assessment. Rapid Exit caseworkers then help families find permanent housing and coordinate any needed follow-up services. For more information, see:
http://www.endhomelessness.org/best/rapidexit.htm

Resource

"Using HOME Program Funds to Address the Challenges of Homelessness" -- Notice issued by the U.S. Department of Housing and Urban Development in August 2003 to provide guidance to Field Offices, Participating Jurisdictions (PJs) and HOME Investment Partnerships Program Grantees in the use of HOME Program funds to assist individuals and families who are homeless or at risk of homelessness.
http://www.hud.gov/offices/cpd/lawsregs/notices/2003/03-08.pdf

Best Practice – Rapid Re-Housing

Beyond Shelter, Inc.
Housing First Program for Homeless Families
Los Angeles, California

Beyond Shelter was founded in 1988 in response to increasing numbers of homeless families in Los Angeles and the need for a more comprehensive approach to serving them. Today, the mission of Beyond Shelter is to combat chronic poverty, welfare dependency and homelessness among families with children, through the provision of housing and social services and the promotion of systemic change. The agency's programs in Los Angeles County serve as a laboratory for the development of cutting-edge methodologies to help guide the development of both social policy and service delivery mechanisms nationwide. Beyond Shelter, Inc. has been the national leader in the development and promotion of "housing first" strategies to re-house families experiencing homelessness. Beyond Shelter provides technical assistance nationwide for communities interested in adopting a housing first approach, holds annual training conferences, and runs their own housing first program in Los Angeles, California.

Target Population

Beyond Shelter's Housing First program serves homeless families with children and has been set up to serve the emergency shelter/transitional housing continuum of a large, metropolitan city. The Housing First Program methodology relies primarily upon the existing homeless services system in Los Angeles for outreach, crisis intervention and short-term stabilization of homeless families. More than 50 agencies throughout the Los Angeles area -- shelters, transitional housing programs, residential drug treatment programs, domestic violence programs, social service agencies, and homeless access centers -- refer homeless families to Beyond Shelter for the "next step", after they have provided initial emergency or interim services.

The majority of families served each year are families facing multiple challenges that have unstable living patterns and/or histories of homelessness. Approximately 90% of 400 homeless families enrolled each year are headed by a single parent. Approximately 50% of mothers are in recovery and approximately 40% became homeless due to domestic violence. The average age of parents is 30 years old, and the average number of children is 4. Approximately 20% of mothers are pregnant upon enrollment. Approximately 25% of families have histories of child maltreatment and/or neglect. Mothers in recovery have often had children removed to foster care before their mothers sought treatment.

Beyond Shelter requires that an adult family member with a history of substance abuse have at least six months in a recovery program (post-treatment, post-detox) before

moving into permanent housing. Similarly, Beyond Shelter requires that families who have experienced domestic violence have at least four months of separation from their abusive partner.

Program Description

Homeless families are referred to the "Housing First" Program for (1) assistance in moving into permanent, rental housing in residential neighborhoods, and then (2) the provision of home-based case management support for six months after the move, to help them transition to stability. The overriding goal of the program is to return homeless families to permanent housing as rapidly as possible.

Referred families meet with Intake Workers at the Beyond Shelter offices for screening and needs assessments. Upon enrollment, the family and Beyond Shelter staff work together to develop an individualized Family Action Plan. This plan identifies the family's housing and social service needs and the steps necessary to assist the family in moving towards stability in permanent housing.

Beyond Shelter Housing Relocation staff then assists families in relocating to affordable rental housing in residential neighborhoods throughout Los Angeles County, usually within three months of enrollment. Families are assisted in negotiating leases, accessing move-in funds, and overcoming the barriers of poor credit history, prior evictions, and discrimination based on ethnicity, family size, or income source. Through targeted Section 8 programs, approximately 75% are assisted in obtaining a Section 8 subsidy. Beyond Shelter builds and maintains close working relationships with private sector building managers, non-profit affordable housing providers, and local, state and federal housing assistance programs. The fact that there exists a support system for their tenants motivates many private landlords to participate in the program.

Each family is also assigned a case manager, who provides individualized case management support as the family carries out its Family Action Plan. This support begins during the housing relocation phase and continues with home-based case management after the family has moved into their new home. Case management services are time-limited and transitional. The primary function of case management is assessing the needs of the family, developing a plan of action to attain identified objectives, linking families to community resources and advocating on their behalf, and monitoring the progress of families. Families are supported as they reorient to stable living patterns, and are provided assistance with homemaking, nutrition, parenting education, money management, child care, job training, job placement, and job retention. After initial, intensive contact, the focus is on linking families to mainstream programs and resources to meet their on-going and/or special needs.

The "housing first" methodology provides a critical link between the emergency shelter/transitional housing systems and the community-based and governmental services and resources that are often fragmented, difficult to access or simply not available to homeless families trying to attain stability and independence in permanent housing.

The program methodology facilitates the move into permanent housing for homeless families and then engages the newly-housed family in a progressive set of individualized case management activities and interventions for a limited period of time, as they move toward improved social and economic well-being. The "housing first" methodology is premised on the belief that multi-problem and at risk families are often more responsive to interventions and support after they are in their own housing, rather than still living in housing programs that are temporary or transitional.

Source of funding

Original funding for the Housing First program came primarily a demonstration program at the U.S. Department of Health and Human Services (HHS). Primary funding has been provided since 1996 through the Federal Department of Housing and Urban Development (HUD), particularly the Supportive Housing Program (SHP), supplemented by a variety of local, state, and federal contracts and private foundation funding.

Available Data

From 1989-2001, the program enrolled over 2,500 homeless families, with approximately 2,200 relocated to, and stabilized in, permanent housing. The Housing First Program has been tested and refined through several national demonstration projects implemented by Beyond Shelter for the U.S. Department of Health and Human Services (HHS) and the Better Homes Fund. In 1990-1993, Beyond Shelter designed and implemented the Los Angeles Early Intervention Demonstration Project for Recently Homeless and At-Risk Families (in collaboration with Para Los Ninos), with an evaluation by a UCLA researcher. In 1992-1995, the home-visitation model was expanded through the HHS Family Support Center Demonstration Project, conducted over four years for over 250 homeless families.

As part of the Pew Partnership initiative, “Wanted: Solutions for America,” a two-year evaluation of Beyond Shelter's Housing First program has recently been conducted by researchers from the University of Southern California, coordinated by Rutgers University. Data on 185 families were collected from April 1, 2000 to October 1, 2001, based on the Substance Abuse and Mental Health Administration (SAMHSA) Program Logic Model for Homeless Families. More than 90% of the mothers who graduated the program at the end of six months in permanent housing had achieved the short, intermediate, and long-term goals identified in the SAMHSA Logic Model and over 80% of the children's goals were achieved. Over 80% of adults were attached to the labor force through employment, and others were enrolled in job training programs. Only 2.3% of those who entered the program with reported substance abuse problems had relapsed and .4 % of domestic violence survivors had returned to a dangerous relationship.

Recognition for the Housing First Program for Homeless Families includes the following:

- One of "25 US Best Practices," representing the United States at the United Nations Conference, Habitat II, held in Istanbul, Turkey in 1996

- One of "100 International Best Practices," chosen by The United Nations Centre for Human Settlements (Nairobi, Kenya) in 1996 for dissemination worldwide.

- Non-Profit Sector Award, National Alliance to End Homelessness, 1996

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Best Practice – Rapid Re-Housing

Housing Support Center
City of Philadelphia, Pennsylvania

The Philadelphia Housing Support Center is the latest innovation in a series of initiatives from a city that has successfully reduced homelessness in recent years. The Center coordinates housing and service resources from various City social service departments through one central gateway. Pulling together resources such as Family Unification Program Vouchers, TANF dollars, and other mainstream and homeless program funds, the Center serves as a "one-stop shop" for housing resources -- providing both prevention and back-door mechanisms to decrease the actual number of people experiencing homelessness while helping to reduce the length of time others have to remain homeless.

Target Population

The Center serves mainly families experiencing or at risk of homelessness. In the last six months of 2002, the Center began serving people leaving emergency shelters, transitional housing programs, recovery houses, behavioral health programs, foster care, and the corrections system. The Center also accommodates people who do not fit neatly into other housing program models, such as those facing barriers to being housed by public housing authorities due to former criminal convictions or substantial debt.

Program Description

The Philadelphia Housing Support Center incorporates five main strategies that underpin the City's Adult Services:

1. Focus on prevention and diversion
2. Shorten the average length of stay in shelter
3. Work on the back door (develop and access more permanent housing)
4. Increase connections to mainstream services
5. Use a housing first approach

The Center began as a joint venture between the Department of Human Services (the county's child welfare agency) and Adult Services to combine efforts and coordinate the activities of two separate housing programs, the Good Neighbors Make Good Neighborhoods (GNMGN) program and the Family Unification Program. GNMGN collaborates with the local housing authority to provide families with Housing Choice Vouchers so that they can move out of shelters and various temporary housing programs into permanent housing. The program promises up to a year of case management as well as other supports to help families transition into their new communities. In the months following its inception, the Philadelphia Housing Support Center attracted resources and staff from other social service systems as well. The increased coordination and management of the various service resources through one central gateway will serve to strengthen the links between the shelter system and permanent housing--most critically by providing access to Housing Choice Vouchers--and increase the capacity for interventions to prevent further homelessness.

Furthermore, by pulling together the different programs, the Center will become better able to address the gaps through which people sometimes fall when they did not fit into any of the available programs. The Emergency Relocation Program was created for just such a purpose. The Center identifies people who did not fit into any of the program models, move them into an apartment, provide them with intensive case management, and help them overcome the barriers that would prevent them from getting into relevant programs.

Source of Funding

For the permanent housing, the Center relies primarily on Housing Choice Vouchers through the local public housing authority. Three factors improve the success of the Center in utilizing these resources:

- The local housing authority has one of the first "Moving-to-Work" designations from HUD.
- The local housing authority has the ability to create priorities through an administrative process.
- Families experiencing homelessness qualify under the definition of the Family Unification Program to receive such Housing Choice Vouchers

For services accompanying permanent housing placement, the Center will utilize a mix of resources, including Supportive Housing Program (SHP) dollars, some Temporary Assistance to Needy Families (TANF) funds, in addition to a variety of other mainstream sources.

Further service resources have been provided by the Department of Public Health. The Center has developed a strong relationship with the department through the creation of a lead paint relocation program, in which home-owning families temporarily move out of their homes while the Health Department abates the lead. This new program has enabled the Health Department to conduct abatements at a rate 3-4 times faster than if the families remained in their units. While the Center focuses on the temporary relocation, it would also provide necessary supportive services to these families before and after they return to their housing in order to ensure the safety and well being of the children.

The Center itself, which consists of approximately 30 staff members, is funded through existing resources allocated by each of the departments that participate in the joint venture.

Outcome Data

In its first year, the Center has reduced the length of shelter stay and provided permanent housing with services for 500-600 families through the Good Neighbors Program and the Family Unification Program as well as for an additional 100-200 families through other programs.

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Best Practice – Rapid-Re-Housing

HomeStart
Boston, Massachusetts

History and Background

In 1994, the Massachusetts Housing and Shelter Alliance (MHSA) developed a project to meet the housing needs of people experiencing homelessness. MHSA recognized that case managers in homeless service agencies were becoming increasingly specialized to deal with the multiple challenges many of their clients presented. When programs were taxed with high demands and high levels of complex needs, it was the housing search services that were often lost. HomeStart was formed to perform this function. Initially, it relied on one grant that funded three staff positions and was housed under MHSA. By 1999, HomeStart was an independent agency consisting of 22 employees and an annual budget of $1 million. It currently employs 28 people with an annual budget of $1.6 million.

Target Population

HomeStart receives referrals from 50 different agencies in the Greater Boston area. Homeless individuals or families who are referred must have some source of income, such as SSI/SSDI, employment or TANF and must be able to sustain their housing.

Program Overview

HomeStart's focus is to move individuals into housing and provide the stabilization support services necessary to help them retain their homes. Each of the housing search staff work with several referring agencies, allowing for close working relationships. A housing search staff advocate meets with a client while they remain in the shelter to explore the client's housing needs, potential resources and barriers. The housing staff will work with the client to access and maximize existing benefits. If they are denied housing services, an advocate will help them through the appeal process. The housing search staff is responsible for locating appropriate housing options for the clients they work with.

When an individual or family is housed, they are transferred to a stabilization staff person. Stabilization services are usually voluntary and are focused on providing support to help the family or individual sustain their housing. Services may include help accessing programs in the community, such as mental health services, and dealing with life skills issues such as budgeting. Stabilization advocates work with clients to help them deal with any landlord/tenant conflicts that may arise. Staff members support individuals and families by meeting them in their homes as well as in their communities.

To facilitate the successful housing of clients, HomeStart staff members rely on the resources known as their "toolbox." The toolbox includes an array of resources they have

developed or secured including housing subsidies and financial assistance for security deposit and first month's rent.

Source of Funding

The agency has 28 staff and an annual budget of $1.6 million. The majority (80-85%) of their funding is through McKinney-Vento grants. HomeStart also has contracts with state agencies to help house individuals who are exiting state-funded programs, partly because of the state's commitment to improving housing outcomes for those discharged from state-funded programs who are vulnerable to homelessness.

Service Utilization/Data

- Since 1994, the project has moved more than 1,400 people into permanent housing.
- Approximately 65% of the households served by HomeStart are single adults and 35% are families.
- About 35% - 40% of individuals and families that find permanent housing also receive stabilization services.
- 81% of individuals placed into housing through HomeStart are still housed one year later.
- In 2001, 218 individuals moved into housing with HomeStart assistance:
    - 72% moved into subsidized housing;
    - 28% moved into unsubsidized housing;
    - The average length of time to find housing was 6.7 months;
    - 63% received financial assistance such as first or last month's rent or security deposits.

Impressions of Administrators/Advocates

The program is committed to specializing on the "back door" i.e. finding and maintaining housing for those who are homeless. Expanding housing search and stabilization services within existing homeless service centers was considered a less effective approach because staff would inevitably be pulled from housing efforts to meet the daily demands of residential programs. Separate funding streams and dedicated staff essentially produce a "firewall" that allows HomeStart staff to focus solely on re-housing.

The absence of a separate dedicated homeless prevention program has been problematic. HomeStart staff has received a number of inquiries from individuals and families who would more appropriately be served with prevention assistance. This has a demoralizing

effect on the staff, who would like to be able to help people before they become homeless. It also signals a gap in the overall safety net. However, HomeStart has just received private funding to begin a small pilot prevention program.

Stabilization services that are essential to the success of the program include home visiting and budget management. If resources were available, staff members believe that having a mental health specialist or psychiatrist on staff would be beneficial to clients.

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Best Practice – Rapid Re-Housing

Rapid Exit Program
Hennepin County, Minnesota

Hennepin County is a state and national leader in developing new tools to rapidly re-house families and individuals experiencing homelessness. The Rapid Exit Program is an innovative program that facilitates rapid re-housing by relying on early identification and resolution of a family's or individual's "housing barriers" and providing the assistance necessary to facilitate their return to permanent housing. Based on the assessment of a family or individual's housing barriers, a referral is made to a subcontracting agency best able to respond to the client's housing needs. This approach puts "housing" at the front and center of efforts to help people experiencing homelessness, prioritizing the rapid return to housing and providing the assistance necessary to achieve housing stability.

Target Population

The target population of the Rapid Exit Program is those families and individuals who have moderate to severe barriers to obtaining market housing and are currently residing in the county funded shelter.

Program Description

Within one week of entry to the county funded shelter, the family or individual is referred to a Rapid Exit Coordinator for a housing barrier assessment. The assessments incorporate a locally developed scale that reflects client characteristics and challenges that make local landlords reluctant to rent to a family or otherwise make locating housing difficult. To facilitate client disclosure, the Rapid Exit Coordinator services are sub-contracted to a private, non-profit agency with which the client can feel more comfortable sharing information. The Rapid Exit Coordinator also does criminal, credit and housing checks on the clients that are also likely to be done by prospective landlords.

Based on the assessment conducted by the Rapid Exit Coordinator, the individual or family is referred to one of the agencies Hennepin County has contracted with to provide clients with individualized assistance to locate and secure housing or provide transitional housing. Non-contracted agencies will also accept referrals from the Rapid Exit Coordinator.

The contract agencies will provide individualized assistance to locate and secure housing. Such assistance may include:

- Direct financial assistance for application fees, deposits and other household "start up" costs.

- Direct financial assistance to resolve other barriers to housing is provided as part of a pilot project and includes activities such as resolving outstanding debt.

- Legal assistance.

- Case management to resolve personal issues that are, or may become, barriers to achieving housing stability.

- Assistance securing furniture and food.

- Provision of short-term or longer-term transitional housing as indicated by the housing barrier assessment and need to reestablish a stable rental history.

- Provision of follow-up case management and referral to stabilize families in their homes following rapid reentry to permanent housing.

With a metropolitan housing vacancy rate under 1%, the county and contracting agencies are attempting to find innovative ways to seek and retain affordable housing. Such efforts to expand the supply of housing for very low income and homeless people include:

- Intervening to keep housing units affordable when housing developments for low-income people are sold to a new owner.

- Advocacy to promote the "usability" of Section 8 vouchers by reducing landlord disincentives to entering the program.

- Providing dedicated staff time to locating potential housing units and developing an on-going relationship with landlords and responsible landlord association groups in their area.

- Paying double security deposits for those with poor rental history.

- Providing landlords up front Unlawful Detainer/Eviction costs deposits so the landlord will not absorb all of the risk.

- Co-signing leases.

- Paying holding fees, a new fee to keep an apartment available while the landlord considers the application of the "troubled" tenant, sometimes refundable, sometimes not.

- Remaining responsive and committed to provide on-going case management intervention with the client and assist the landlord in resolving issues that places the client's housing in jeopardy.

Source of Funding

Minnesota Family Homeless Prevention and Assistance Program (FHPAP) funds were instrumental in the development of the Rapid Exit Program. It continues to fund the Rapid Exit Coordinator and is used to provide the on-going case management and services that help stabilize individuals and families in homes that are not eligible activities or extend beyond the time limits set by HUD programs. Following the successful implementation of the Rapid Exit Program with state FHPAP funds, administrators sought HUD funding. The program relies on two HUD programs, the Supportive Housing Program (SHP) and Emergency Shelter Grants (ESG). As the HUD funding is typically more restrictive, FHPAP funds are used to complement and extend services.

Available Data

Hennepin County contracts with the Wilder Research Center to maintain a data reporting and outcome system on individuals and families served by the Rapid Exit Program. According to the last biennium report, 2,463 families (8,976 members) were screened and referred by Rapid Exit Coordinator and 1,714 families (6,933 members) were served in Rapid Exit Program.

With a program targeted to those with moderate to severe barriers, the outcome data demonstrates great success. Even though 34% of families served by the Rapid Exit Program had been homeless before, only 9% returned to a shelter after receiving services funded by FHPAP in the following year and 85% did not return within two years. For those families that did return, their average stay in homelessness declined by more than half, from 29.5 days to 10 days.

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PUTTING TOGETHER TREATMENT AND OTHER SERVICES FOR HOMELESS PEOPLE

GOAL: When households are re-housed, they have rapid access to funded services and mainstream programs provide the bulk of these services.

Services can help individuals and families stabilize following a successful housing placement and provide the supports necessary to ensure that they are able to sustain their housing and access other community-based services. For individuals that have been chronically homeless, such supports should be ongoing, readily accessible, and attached to housing. The majority of individuals and families who have experienced homelessness will not require permanent supportive housing, but intensive services should be made available on a transitional basis before and after they move into housing.

For ***individuals that have been chronically homeless***—living on the streets and/or in shelters for years—permanent housing with attached supports are likely to be necessary if they are to sustain their housing. As the majority of people who have been chronically homeless also have a disability, some services can be funded through Medicaid and many individuals will be eligible for services and supports funded through federal mental health and substance abuse block grants.

Individuals and families residing in transitional housing programs often have access to intensive services and supports to help them stabilize and promote individual and family well-being and capacity for self-sufficiency. Shortening the length of time people spend in homelessness does not diminish the need for transitional supportive services. Indeed, the beneficial effects of those services would be increased if they were delivered after a return to permanent housing. Transitional services to individuals and families can be funded through a myriad of different mainstream funding streams—including Temporary Assistance for Needy Families, the Community Services Block Grant, the Social Services Block Grant, and Substance Abuse and Mental Health Services Administration block grant programs. In some instances mainstream funding resources can be mobilized to help deliver tailored assistance to individuals and families that have experienced homelessness—through contracting with existing homeless and transitional housing providers to provide services to newly re-housed people. In other instances, services provided by mainstream providers should be made easily accessible to homeless and formerly homeless individuals and families so that they can receive the resources and supports to help them stabilize in housing and prevent future episodes of homelessness.

Examples

For chronically homeless people:

Pathways to Housing (New York, New York) Pathways provides housing and support services to individuals who are entering permanent housing directly from the shelter system or the streets. The majority of residents have a dual diagnosis of a mental illness and substance abuse disorder. Services are oriented toward helping the individuals sustain housing. For more information, visit: http://www.endhomelessness.org/best/pathways.htm

Anishinabe Wakiagun (Minnesota) This project provides permanent supportive housing to Native American single adults with an active addiction to alcohol. The program uses a harm reduction model—participants are not required to maintain sobriety, although reducing the impact of alcohol on the individuals' health and encouraging reduced consumption are goals. Residents receive case management and health services as desired. Once in the program, participants use hospital emergency rooms and emergency detoxification far less often than before they enroll. For more information visit: http://www.endhomelessness.org/best/anishinabe.htm

Project H.O.M.E. (Philadelphia, Pennsylvania) Project H.O.M.E. provides an array of permanent housing opportunities, including Safe Haven programs, that provide housing with supports for individuals with mental illnesses and/or substance abuse disorders. The low-threshold program at 1515 Fairmount Avenue has few service demands and the supportive services are funded using state mental health resources. For more information visit: http://www.endhomelessness.org/best/projecthome.htm

For newly re-housed individuals and families:

Beyond Shelter, Inc. (Los Angeles, California) Beyond Shelter developed the Housing First model that promotes the rapid return of families to permanent housing and the provision of intensive case management services to help the families stabilize in the housing. For more information visit: http://www.endhomelessness.org/best/beyondshelter.htm

Lutheran Social Services of Minnesota (Minneapolis, Minnesota) Lutheran Social Services has transformed its transitional housing programs to housing first models. They are moving families more rapidly into permanent housing, providing assistance to families to help them locate housing and intensive services as necessary to help them stabilize. For more information visit: http://www.endhomelessness.org/best/rapidexit.htm

Rapid Exit Program (Hennepin County, Minnesota) Rapid Exit is helping families with moderate to severe barriers to access housing by working with families and landlords. Intensive case management is available to help families stabilize following housing placement. The community-wide initiative served 1,714 families with 6,933 members over a two-year period. For more information visit: http://www.endhomelessness.org/best/rapidexit.htm

Resources

The Corporation for Supportive Housing has a wide array of resources designed to help non-profits and government entities interested in developing permanent supportive housing. Those resources can be viewed at: www.csh.org.

Materials on the Housing First approach, prepared by the National Alliance to End Homelessness, are at http://www.endhomelessness.org/networks/housingfirst/intro.htm

Best Practice – Services/Permanent Supportive Housing

Pathways to Housing, Inc.
New York City, New York

Founded in 1992, Pathways to Housing offers scattered-site permanent housing to homeless individuals with psychiatric disabilities and addictions. Despite the challenges this population presents, Pathways is unique in that it does not require of its residents: "graduation" from other transitional programs, sobriety, or acceptance of supportive services. The vast majority of clients are moved directly from the streets into permanent, private market housing. The program then uses Assertive Community Treatment (ACT) teams to deliver services to clients in their homes. The ACT teams help clients meet basic needs, enhance quality of life, increase social skills, and increase employment opportunities. The program currently serves over 400 people.

Target Population

Eligibility
Pathways to Housing is designed to end homelessness for people living on the streets with concurrent mental illness and addiction. In order to be eligible for the program, an individual must be homeless, must have a psychiatric disability that compromises their ability to function, and must be willing to meet with a service coordinator twice a month during the first year of tenancy. Priority is given to women and elderly people because they are at greater risk of victimization.

The program provides an alternative to the more common "linear residential treatment programs," which move people through a continuum of services beginning with outreach, some intermediary housing which helps people become "housing ready," and ending with permanent housing. Pathways provides clients with housing first, and then offers services and treatment to people in their homes.

Referrals
Most clients are contacted through the outreach efforts of Pathways staff. Other referrals come from city outreach teams, shelters and drop-in centers. 1999 data showed that 65% of tenants had last lived on the streets, 18% in shelters, 7% in treatment facilities, and the remainder had lived with friends, at the Y, or in transitional facilities.

Project Description

Housing
Pathways to Housing staff assist clients in locating and selecting private market rental housing. The housing department keeps logs of new vacancies and the over 200 landlords they work with, and works to negotiate leases and complete Section 8 applications. The greatest challenge to the program is finding vacant apartments at fair market rent. Landlords are amenable to renting to Pathways' clients because they get guaranteed rental payments. Tenants pay 30% of their income towards rent, and Pathways pays the remaining amount if the client does not have a section 8 voucher.

The agency also leases two transitional apartments for use by clients who have been accepted into

the program, but have not yet found an apartment of their own. The average length of stay in these units is 15 days.

Services
Pathways to Housing uses Assertive Community Treatment (ACT) teams to deliver services to clients in their homes. The teams are interdisciplinary and are on-call 24 hours a day, seven days a week. However, the tenant determines the type, frequency, and sequence of services. Service requirements are that the tenant meet with a service coordinator twice a month and participate in a money management program. Refusal to participate in sobriety or other treatment programs does not disqualify an individual, nor does a history of violence or prison time.

ACT teams consist of up to ten service coordinators, each with a particular expertise. The team leader is responsible for supervising the work of the team. The primary goals of the ACT teams are to meet basic needs, enhance quality of life, increase social skills, and increase employment opportunities. Each team sees approximately 70 clients. When a team cannot provide the services directly, tenants are referred and accompanied to the relevant programs. After the rent is paid tenants are required to develop a monthly budget with the service coordinator. The goal is for tenants to eventually manage their own money.

Staffing
Pathways to Housing employs 4 staff responsible for housing services, 40 service coordinators, 5 team leaders, 2 psychiatrists, 2 nurses and a vocational specialist. The staff make-up is culturally and racially similar to the population the program serves. Program success is attributed in part to staff composition that includes 50% consumer representation (i.e. people in recovery) that serve as role models.

Source of Funding
Funding for the Pathways program comes in two parts: housing subsidies and services. Around sixty-five tenants have Section 8 vouchers, and the remainder are subsidized by grants from the HUD Shelter Plus Care program and the New York State Office of Mental Health. The latter also provides funding for the ACT teams. Each unit with services costs approximately $20,000 per year.

Service Utilization/Outcome Data
Data from 2000 showed that 88% of the program's tenants remained housed after five years. Furthermore, Pathways staff contends that its residents have greater satisfaction with their housing, and greater psychological well-being because they were given a choice as to where to live, and what activities to engage in.

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Best Practice – Services

Anishinabe Wakiagun
Minneapolis, Minnesota

Anishinabe Wakiagun is notable for two reasons: the population it serves, and the funding sources it uses. The men and women of Anishinabe Wakiagun are among the hardest to serve as they are long-term homeless, and chronically addicted to alcohol. In exposing the problems experienced by this population, advocates were able to secure a funding source from the State, which to many outside of Minnesota may seem expensive but actually saves money for the State and Hennepin County.

Program Overview

Anishinabe Wakiagun provides permanent supportive housing in a wet/dry facility to 40 late stage chronic inebriates. The program is intended to "minimize the negative consequences of the residents' drinking patterns, while providing a stable, culturally appropriate living environment which encourages a reduction in alcohol consumption." The program also intends to reduce the public costs of providing services to their population. It has a staff of 13 people.

Target Population

Anishinabe Wakiagun targets late stage chronic inebriate Native American men and women. The target group has: entered a detoxification center twenty or more times in the last three years, attempted chemical dependency treatment twice or more, deteriorated physically due to alcohol use, experienced homelessness for the majority of the past five years, and proven incapable of self-management due to alcohol use. Residents' average age is 45. Anishinabe Wakiagun accepts referrals from other area service providers, through self-referral, but most often through project staff's relationships and outreach.

Project Description

Anishinabe Wakiagun does not require sobriety of its residents, nor are residents required to "progress" in a clinical sense. The only thing asked of residents is that they do not act violently or damage the facilities, and that they treat other residents and staff with respect. It is expected, however, that residents will be able to overcome some of the debilitating consequences of their alcoholism. The facility provides housing and case management. Each resident has his or her own room, but shares dining and bathroom facilities. Each resident receives case management services, health services (both on- and off-site) and other support services, as desired. Again, residents are not required to follow any rigid curriculum or treatment, and are free to stay as long as they choose to. Average length of stay is 27 months.

Overcoming Barriers

A major barrier to operating this program was its cost - $15,256 per resident per year, for a total annual budget of $650,000. Only 10% of the residents receive SSI payments and the other 90% have no income at the time of intake. Anishinabe Wakiagun is funded by virtue of the fact that it is cheaper than maintaining homelessness for this population. Hennepin County conducted a study on costs of detox and recidivism which found that detox for this population, at over $180 day, in addition to other social services used, was considerably more expensive than providing housing and services. In 1994, three people with chronic alcohol problems cost Hennepin County an average of $85,000 each for continuous revolving door medical assistance.

Anishinabe Wakiagun gets $40,000 from the Hennepin County Office of Chemical Health, $80,000 from HUD, and the rest from the Group Residential Housing Program (GRH), a program set up to respond to the needs of low income people who are placed in a licensed or registered setting. GRH eligibility includes automatic eligibility for medical assistance and pays $1,219.50 per month per resident to Anishinabe Wakiagun. Without GRH, program director Kelby Grovender explained, Anishinabe Wakiagun would not be able to provide the housing and services it does. (More information on GHR is available at www.dhs.state.mn.us)

Program Results

According to cumulative data collected by Anishinabe Wakiagun, the project served 151 residents from 1996-1999. Of these, 8% became totally sober, 60% stayed over one year, 78% over six months. In an analysis conducted by the Hennepin County office of Policy and Planning, researchers examined data on residents' service use before and after entering Anishinabe Wakiagun. Prior to moving into Anishinabe Wakiagun, residents had an average of 18 detox episodes per year, which accounted for 42 days. After entering Anishinabe Wakiagun, this number dropped to 2.5 admissions, or 6.3 days, on average. The number of admissions to the hospital emergency department declined close to 20% for those with emergency room visits within the past year. Further, while 61% of the pre-Wakiagun admissions were noted as alcohol related, only 38% of the post-Wakiagun admissions were noted as alcohol related.

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Best Practice – Services/Permanent Supportive Housing

Project H.O.M.E.
Philadelphia, PA

Project H.O.M.E. is a nonprofit founded by Sister Mary Scullion and Joan Dawson in 1989. The organization provides a full range of services for chronically homeless people with mental illness and/or substance abuse disorders, including street outreach, safe havens, permanent supportive housing and a range of services to supplement housing. This continuum is an important part of Project H.O.M.E.'s success: each person is recognized as an individual with unique needs. Services at each facility are different; some residents are not ready to accept regimented drug or alcohol treatment, while others may be able to live almost independently.

The project profiled below, the facility at 1515 Fairmount Avenue, is notable for a number of reasons: the careful evaluation at admission to the facility to ensure compatibility with the program, the partnership forged with the State Office of Mental Health and its emphasis on fostering personal development and dignity.

The Facility

After a long, and now infamous, legal battle, the permanent housing facility at 1515 Fairmount opened its doors in 1996. 1515 Fairmount is a 48 bed permanent housing facility for homeless mentally ill men and women. The services provided at 1515 Fairmount are not intensive, and the residents are self-sufficient enough to clean their rooms and cook for themselves. There are no curfew or program requirements at 1515. The most common diagnoses are schizophrenia and bipolar disorder. Diagnoses are not what concern staff of this facility, however. More important is the level of independent living skills that potential clients possess, and the appropriateness of an environment that provides stable housing combined with low-level supportive services. Residents live in "clusters," in which 5-7 residents share living, dining and kitchen facilities.

Referrals

Project H.O.M.E. is unique in its method for reaching clients for 1515 Fairmount. All referrals to 1515 Fairmount come through the Office of Mental Health. OMH stays involved with referred clients by continuing to provide one-on-one case management. All clients must have a history of homelessness or have been at risk of imminent homelessness. 1515 Fairmount employs a “team interview” method to identify appropriate residents. A group of people who have been involved in the prospective resident’s treatment, including the city case manager and other programs officers, work with the Project H.O.M.E. team to determine whether 1515 would be a good fit. The notion of "fit" is integral to the program's success; not everyone will benefit from the model of low services administered at 1515.

Services

1515 Fairmount employs two full-time caseworkers and one part-time caseworker from 9-5 Monday-Friday. Also staffed is a 24-hour reception desk. Case management is supplemented greatly by the requirement that each resident have a case manager assigned by the city. 1515 Fairmount does not require a regimen of supportive services, but does ask each resident to be involved in some structured activity - whether it be employment, classes, or other daily activity - for 15 hours per week.

Fifteen of the 48 residents work. Project HOME facilitates employment and community reintegration, by employing residents in two in-house businesses: The Back Home Café, and Our Daily Threads Thrift Store.

Source of Funding

Project H.O.M.E. was awarded a $2 million grant from the Department of Housing and Urban Development in 1996 to rehab the property at 1515 Fairmount Avenue. The units have project-based Section 8 vouchers, which allow residents to pay 30% of their income toward rent. 1515 Fairmount has an annual budget of $182,000, most of which comes from a grant from the Office of Mental Health for all of the supportive services in the project. Additionally, OMH supplies each resident with his/her own case manager. Project H.O.M.E. manages the project, while their limited partner, 1515 Fairmount Limited Partnership, acts as the investor and developer.

1515 Fairmount did not always receive this large amount from the Office of Mental Health. Indeed, only recently the grant was $70,000. According to Sister Mary Scullion, the city became willing to support more of the project after the need for permanent supportive housing was proven, through data collection and analysis. Project H.O.M.E. keeps its private donations as flexible as possible, in order to channel the money to where it is most needed. Private donations that had been used for the facility at 1515 Fairmount are now being used in newer facilities, that are not established enough to receive city support.

Outcomes

According to the project coordinator, Project H.O.M.E.'s most important outcome, and the primary ingredient for its success, is respect for each resident's dignity. While this is a difficult goal to measure, one needs only to visit 1515 Fairmount, or any of Project H.O.M.E.'s sites, to know that they have succeeded. Residents feel a tremendous pride in their homes, and often in their recovery and independent living skills. Of all the residents that have lived at 1515 Fairmount since 1996, close to half still live there. Others have moved on to live independently, and others have cycled back into the homeless assistance system.

Fewer people have relapsed in the later years of the project. Darryl Parker, the program coordinator, believes that this success is due in large part to better client screening. The

unsuccessful residents were largely those who needed more structure than 1515 Fairmount was designed to provide.

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Best Practice – Services for Newly Re-Housed People

Beyond Shelter, Inc.
Housing First Program for Homeless Families
Los Angeles, California

Beyond Shelter was founded in 1988 in response to increasing numbers of homeless families in Los Angeles and the need for a more comprehensive approach to serving them. Today, the mission of Beyond Shelter is to combat chronic poverty, welfare dependency and homelessness among families with children, through the provision of housing and social services and the promotion of systemic change. The agency's programs in Los Angeles County serve as a laboratory for the development of cutting-edge methodologies to help guide the development of both social policy and service delivery mechanisms nationwide. Beyond Shelter, Inc. has been the national leader in the development and promotion of "housing first" strategies to re-house families experiencing homelessness. Beyond Shelter provides technical assistance nationwide for communities interested in adopting a housing first approach, holds annual training conferences, and runs their own housing first program in Los Angeles, California.

Target Population

Beyond Shelter's Housing First program serves homeless families with children and has been set up to serve the emergency shelter/transitional housing continuum of a large, metropolitan city. The Housing First Program methodology relies primarily upon the existing homeless services system in Los Angeles for outreach, crisis intervention and short-term stabilization of homeless families. More than 50 agencies throughout the Los Angeles area -- shelters, transitional housing programs, residential drug treatment programs, domestic violence programs, social service agencies, and homeless access centers -- refer homeless families to Beyond Shelter for the "next step", after they have provided initial emergency or interim services.

The majority of families served each year are families facing multiple challenges that have unstable living patterns and/or histories of homelessness. Approximately 90% of 400 homeless families enrolled each year are headed by a single parent. Approximately 50% of mothers are in recovery and approximately 40% became homeless due to domestic violence. The average age of parents is 30 years old, and the average number of children is 4. Approximately 20% of mothers are pregnant upon enrollment. Approximately 25% of families have histories of child maltreatment and/or neglect. Mothers in recovery have often had children removed to foster care before their mothers sought treatment.

Beyond Shelter requires that an adult family member with a history of substance abuse have at least six months in a recovery program (post-treatment, post-detox) before

moving into permanent housing. Similarly, Beyond Shelter requires that families who have experienced domestic violence have at least four months of separation from their abusive partner.

Program Description

Homeless families are referred to the "Housing First" Program for (1) assistance in moving into permanent, rental housing in residential neighborhoods, and then (2) the provision of home-based case management support for six months after the move, to help them transition to stability. The overriding goal of the program is to return homeless families to permanent housing as rapidly as possible.

Referred families meet with Intake Workers at the Beyond Shelter offices for screening and needs assessments. Upon enrollment, the family and Beyond Shelter staff work together to develop an individualized Family Action Plan. This plan identifies the family's housing and social service needs and the steps necessary to assist the family in moving towards stability in permanent housing.

Beyond Shelter Housing Relocation staff then assists families in relocating to affordable rental housing in residential neighborhoods throughout Los Angeles County, usually within three months of enrollment. Families are assisted in negotiating leases, accessing move-in funds, and overcoming the barriers of poor credit history, prior evictions, and discrimination based on ethnicity, family size, or income source. Through targeted Section 8 programs, approximately 75% are assisted in obtaining a Section 8 subsidy. Beyond Shelter builds and maintains close working relationships with private sector building managers, non-profit affordable housing providers, and local, state and federal housing assistance programs. The fact that there exists a support system for their tenants motivates many private landlords to participate in the program.

Each family is also assigned a case manager, who provides individualized case management support as the family carries out its Family Action Plan. This support begins during the housing relocation phase and continues with home-based case management after the family has moved into their new home. Case management services are time-limited and transitional. The primary function of case management is assessing the needs of the family, developing a plan of action to attain identified objectives, linking families to community resources and advocating on their behalf, and monitoring the progress of families. Families are supported as they reorient to stable living patterns, and are provided assistance with homemaking, nutrition, parenting education, money management, child care, job training, job placement, and job retention. After initial, intensive contact, the focus is on linking families to mainstream programs and resources to meet their on-going and/or special needs.

The "housing first" methodology provides a critical link between the emergency shelter/transitional housing systems and the community-based and governmental services and resources that are often fragmented, difficult to access or simply not available to homeless families trying to attain stability and independence in permanent housing.

The program methodology facilitates the move into permanent housing for homeless families and then engages the newly-housed family in a progressive set of individualized case management activities and interventions for a limited period of time, as they move toward improved social and economic well-being. The "housing first" methodology is premised on the belief that multi-problem and at risk families are often more responsive to interventions and support after they are in their own housing, rather than still living in housing programs that are temporary or transitional.

Source of funding

Original funding for the Housing First program came primarily a demonstration program at the U.S. Department of Health and Human Services (HHS). Primary funding has been provided since 1996 through the Federal Department of Housing and Urban Development (HUD), particularly the Supportive Housing Program (SHP), supplemented by a variety of local, state, and federal contracts and private foundation funding.

Available Data

From 1989-2001, the program enrolled over 2,500 homeless families, with approximately 2,200 relocated to, and stabilized in, permanent housing. The Housing First Program has been tested and refined through several national demonstration projects implemented by Beyond Shelter for the U.S. Department of Health and Human Services (HHS) and the Better Homes Fund. In 1990-1993, Beyond Shelter designed and implemented the Los Angeles Early Intervention Demonstration Project for Recently Homeless and At-Risk Families (in collaboration with Para Los Ninos), with an evaluation by a UCLA researcher. In 1992-1995, the home-visitation model was expanded through the HHS Family Support Center Demonstration Project, conducted over four years for over 250 homeless families.

As part of the Pew Partnership initiative, “Wanted: Solutions for America,” a two-year evaluation of Beyond Shelter's Housing First program has recently been conducted by researchers from the University of Southern California, coordinated by Rutgers University. Data on 185 families were collected from April 1, 2000 to October 1, 2001, based on the Substance Abuse and Mental Health Administration (SAMHSA) Program Logic Model for Homeless Families. More than 90% of the mothers who graduated the program at the end of six months in permanent housing had achieved the short, intermediate, and long-term goals identified in the SAMHSA Logic Model and over 80% of the children's goals were achieved. Over 80% of adults were attached to the labor force through employment, and others were enrolled in job training programs. Only 2.3% of those who entered the program with reported substance abuse problems had relapsed and .4 % of domestic violence survivors had returned to a dangerous relationship.

Recognition for the Housing First Program for Homeless Families includes the following:

- One of "25 US Best Practices," representing the United States at the United Nations Conference, Habitat II, held in Istanbul, Turkey in 1996

- One of "100 International Best Practices," chosen by The United Nations Centre for Human Settlements (Nairobi, Kenya) in 1996 for dissemination worldwide.

- Non-Profit Sector Award, National Alliance to End Homelessness, 1996

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Best Practice – Services for Newly Re-Housed People

Lutheran Social Service of Minnesota
Crow Wing, Morrison, & Todd County, Minnesota

Lutheran Social Service of Minnesota is facilitating the re-housing of homeless youth and families in several rural counties in Minnesota through their Housing Options for Everyone Program. The Family Homelessness Prevention and Assistance Program helped the agency respond to the increasing number of their clients who reported having a housing crisis. Although a grantee and direct provider, Lutheran Social Service of Minnesota benefits from the FHPAP requirement that an advisory group comprised of local community members and organizations develop the program and program goals and assess progress toward measurable outcomes. As an agency, Lutheran Social Service of Minnesota is invested in promoting a "housing first" approach--rapidly returning those who experience a housing crisis to permanent housing and linking them with the available supports to promote future housing stability. Intervention to stabilize families and individuals in housing--including financial assistance, landlord mediation and case management--are similar for those who are re-housed and those whose homelessness was effectively prevented.

Target Population

The target population includes families with dependent children, youth under 22 and single individuals who are homeless or at imminent risk of homelessness.

Referral Process

- Central agency is the initial point of contact. This agency administers an on-site Housing Resource Center, along with several other programs including LIHEAP, credit counseling, financial education. The agency developed the Housing Resource Center as it identified housing needs among clients served.
- Receives referrals from county administered programs, churches and Community Action Programs (CAPs).

Services

- Provides financial assistance for those at risk of losing housing.
- Provides direct assistance in the form of rent deposit, first month rent and mortgage assistance for those who are homeless or facing homelessness.
- Provides assistance in locating housing, case management services and education about tenant rights and responsibilities.
- Conducts a self sufficiency plan with the family, identifies budgeting, housing subsidies and increasing familial financial resources as paramount to preventing future episodes of homelessness.

- Connects family members with resources in the community, builds self-advocacy skills, provides follow up case management weekly during initial stabilization period. May decrease in intensity, but family remains eligible for case management services for 12 months following intervention.

Resource Development

Dedicated housing staff with background in property management develops relationships with landlords, works with housing authority to identify available rental assistance resources and participates in housing membership organizations.

Sources of Funding

- Family Homeless Prevention and Assistance Program (FHPAP) that includes TANF block grant and state general revenue funds
- Small grants and funding through local churches
- Community Action Program (CAP) agencies
- United Way award

Available Data

- Served 212 households from 1999 to 2001
- 94% of total households were in permanent housing twelve months after receiving assistance
- 85% of families who were homeless were in stable housing nine months after receiving assistance
- 90% of families have accessed at least 40% of community resources listed in their self-sufficiency plan

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Best Practice – Services for Newly Re-Housed People

Rapid Exit Program
Hennepin County, Minnesota

Hennepin County is a state and national leader in developing new tools to rapidly re-house families and individuals experiencing homelessness. The Rapid Exit Program is an innovative program that facilitates rapid re-housing by relying on early identification and resolution of a family's or individual's "housing barriers" and providing the assistance necessary to facilitate their return to permanent housing. Based on the assessment of a family or individual's housing barriers, a referral is made to a subcontracting agency best able to respond to the client's housing needs. This approach puts "housing" at the front and center of efforts to help people experiencing homelessness, prioritizing the rapid return to housing and providing the assistance necessary to achieve housing stability.

Target Population

The target population of the Rapid Exit Program is those families and individuals who have moderate to severe barriers to obtaining market housing and are currently residing in the county funded shelter.

Program Description

Within one week of entry to the county funded shelter, the family or individual is referred to a Rapid Exit Coordinator for a housing barrier assessment. The assessments incorporate a locally developed scale that reflects client characteristics and challenges that make local landlords reluctant to rent to a family or otherwise make locating housing difficult. To facilitate client disclosure, the Rapid Exit Coordinator services are sub-contracted to a private, non-profit agency with which the client can feel more comfortable sharing information. The Rapid Exit Coordinator also does criminal, credit and housing checks on the clients that are also likely to be done by prospective landlords.

Based on the assessment conducted by the Rapid Exit Coordinator, the individual or family is referred to one of the agencies Hennepin County has contracted with to provide clients with individualized assistance to locate and secure housing or provide transitional housing. Non-contracted agencies will also accept referrals from the Rapid Exit Coordinator.

The contract agencies will provide individualized assistance to locate and secure housing. Such assistance may include:

- Direct financial assistance for application fees, deposits and other household "start up" costs.

- Direct financial assistance to resolve other barriers to housing is provided as part of a pilot project and includes activities such as resolving outstanding debt.

- Legal assistance.

- Case management to resolve personal issues that are, or may become, barriers to achieving housing stability.

- Assistance securing furniture and food.

- Provision of short-term or longer-term transitional housing as indicated by the housing barrier assessment and need to reestablish a stable rental history.

- Provision of follow-up case management and referral to stabilize families in their homes following rapid reentry to permanent housing.

With a metropolitan housing vacancy rate under 1%, the county and contracting agencies are attempting to find innovative ways to seek and retain affordable housing. Such efforts to expand the supply of housing for very low income and homeless people include:

- Intervening to keep housing units affordable when housing developments for low-income people are sold to a new owner.

- Advocacy to promote the "usability" of Section 8 vouchers by reducing landlord disincentives to entering the program.

- Providing dedicated staff time to locating potential housing units and developing an on-going relationship with landlords and responsible landlord association groups in their area.

- Paying double security deposits for those with poor rental history.

- Providing landlords up front Unlawful Detainer/Eviction costs deposits so the landlord will not absorb all of the risk.

- Co-signing leases.

- Paying holding fees, a new fee to keep an apartment available while the landlord considers the application of the "troubled" tenant, sometimes refundable, sometimes not.

- Remaining responsive and committed to provide on-going case management intervention with the client and assist the landlord in resolving issues that places the client's housing in jeopardy.

Source of Funding

Minnesota Family Homeless Prevention and Assistance Program (FHPAP) funds were instrumental in the development of the Rapid Exit Program. It continues to fund the Rapid Exit Coordinator and is used to provide the on-going case management and services that help stabilize individuals and families in homes that are not eligible activities or extend beyond the time limits set by HUD programs. Following the successful implementation of the Rapid Exit Program with state FHPAP funds, administrators sought HUD funding. The program relies on two HUD programs, the Supportive Housing Program (SHP) and Emergency Shelter Grants (ESG). As the HUD funding is typically more restrictive, FHPAP funds are used to complement and extend services.

Available Data

Hennepin County contracts with the Wilder Research Center to maintain a data reporting and outcome system on individuals and families served by the Rapid Exit Program. According to the last biennium report, 2,463 families (8,976 members) were screened and referred by Rapid Exit Coordinator and 1,714 families (6,933 members) were served in Rapid Exit Program.

With a program targeted to those with moderate to severe barriers, the outcome data demonstrates great success. Even though 34% of families served by the Rapid Exit Program had been homeless before, only 9% returned to a shelter after receiving services funded by FHPAP in the following year and 85% did not return within two years. For those families that did return, their average stay in homelessness declined by more than half, from 29.5 days to 10 days.

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CREATING AN ADEQUATE SUPPLY OF PERMANENT AFFORDABLE HOUSING

GOAL: Your community has a sufficient supply of permanent supportive housing to meet the needs of all chronically homeless people.

GOAL: Your community is implementing a plan to fully address the permanent housing needs of extremely low-income people.

Supportive Housing

The cost of homelessness is high, particularly for those with chronic illnesses, mental health issues and addictions. Because they have no regular place to stay, life on the streets and in the shelter system exacerbates illness and leads to the use of a variety of public systems in an inefficient and costly way. Preventing a homeless episode or ensuring a speedy transition into stable, permanent housing can result in significant cost savings.

A landmark study conducted by researchers from the University of Pennsylvania found that supportive housing – independent housing linked to comprehensive support services – provided major reductions in costs incurred by homeless mentally ill people across different service systems - $16,282 per person in a housing unit year round. When all the costs of supportive housing and public services are considered, it costs the public only $995 more a year to provide supportive housing to a mentally ill individual than it does to allow him or her to remain homeless.

The cost of supportive housing must also be considered in conjunction with the fact that homeless services would be freed up for other homeless individuals and families. The chronically homeless population represents about ten percent of the single homeless population. However, they virtually live in the homeless assistance system and utilize nearly half of its resources.

To effectively end homelessness, supportive housing also needs to provide for individuals who are resistant to treatment and are not in recovery but are still substance abusers.

Affordable Housing

Housing instability for extremely low-income individuals will continue until the supply of affordable housing increases substantially. While federal funding for affordable housing has dramatically declined over the past decade, states and municipalities have

developed a number of strategies to respond to the housing needs of extremely low-income individuals.

The number of state and local housing trust funds has significantly increased since the 1990s, leveraging resources to increase the supply of affordable housing for low-income people. Some counties and cities have developed inclusionary zoning programs, requiring developers to include affordable housing units when building new developments.

Examples

Supportive Housing

Project H.O.M.E. (Philadelphia, Pennsylvania) Project HOME provides a full range of services for chronically homeless people with mental illness and/or substance abuse disorders, including street outreach, safe havens, permanent supportive housing and a range of services to supplement housing. This program is notable for the partnership forged with a mainstream funding source, in this case the State Office of Mental Health, and for its emphasis on fostering personal development and dignity. For more information, see: http://www.endhomelessness.org/best/projecthome.htm

Anishinabe Wakiagun (Minneapolis, Minnesota) This program provides permanent supportive housing to late stage chronic inebriates, targeting the Native American population. The program is intended to "minimize the negative consequences of the residents' drinking patterns, while providing a stable, culturally appropriate living environment which encourages a reduction in alcohol consumption." The program also intends to reduce the public costs of providing services to their population. For more information, see: http://www.endhomelessness.org/best/anishinabe.htm

Pathways to Housing (New York, New York) Pathways offers scattered-site permanent housing to homeless individuals with psychiatric disabilities and addictions. Despite the challenges this population presents, Pathways is unique in that it does not require of its residents: "graduation" from other transitional programs, sobriety, or acceptance of supportive services. Data from 2000 showed that 88% of the program's tenants remained housed after five years. Pathways staff report that its residents have greater satisfaction with their housing, and greater psychological well-being because they were given a choice of where to live, and what activities to engage in. For more information, see: http://www.endhomelessness.org/best/pathways.htm

Affordable Housing

Seattle Housing Levy (Seattle, Washington) In September of 2002, Seattle's voters approved a measure on the city's ballot to establish the Seattle Housing Levy that would provide $86 million for low-income housing. The revenue produced will go to the creation and preservation of over 1,700 low-income apartments, emergency assistance for over 500 renter households at risk of eviction, and subsidies for over 300 first-time buyers. For more information, see http://www.cityofseattle.net/housing/Levy.htm

Los Angeles Affordable Housing Trust Fund (Los Angeles, California) In June of 2000, the Mayor of Los Angeles and the City Council established the Los Angeles Affordable Housing Trust Fund through the city's budget process. The Trust Fund was provided with $5 million to support proposed housing developments that the City hadn't funded. In 2002, the Mayor announced a $100 million multi-year funding plan to help meet the critical housing needs in Los Angeles. See the Los Angeles Housing Department's website for more information: http://www.ci.la.ca.us/lahd/afhsgtrstfd.htm

Inclusionary Zoning (Montgomery County, Maryland) Cities and Counties have used inclusionary zoning policies to help develop affordable housing for low-income families. A discussion of inclusionary zoning policies in the Washington DC area—including one of the longest running and most successful, in Montgomery County, Maryland—can be found at: http://www.brookings.org/dybdocroot/es/urban/publications/inclusionary.pdf.

Resources

- *The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative.* http://intranet.csh.org/publications/NYNYcoststudy.pdf

- *Supportive Housing for Youth: A Background of the Issues in the Design and Development of Supportive Housing for Homeless Youth,* Corporation for Supportive Housing. http://intranet.csh.org/pdfs/supp_hsng_youth.pdf

- *New Financing Opportunity for Services in Supportive Housing for Homeless Families and Young Adults: TANF*, Corporation for Supportive Housing. http://intranet.csh.org/pdfs/TANFReportNov01.pdf

- Corporation for Supportive Housing Web Site http://www.csh.org

- *Housing Trust Fund Progress Report 2002: Local Responses to America's Housing Needs*. Center for Community Change. http://www.communitychange.org/pub-hous-trust.htm

- *Rental Housing for America's Poor Families: Farther Out of Reach Than Ever.* The National Low Income Housing Coalition. http://www.nlihc.org/oor2002/index.htm

Best Practice – Supportive Housing

Project H.O.M.E.
Philadelphia, PA

Project H.O.M.E. is a nonprofit founded by Sister Mary Scullion and Joan Dawson in 1989. The organization provides a full range of services for chronically homeless people with mental illness and/or substance abuse disorders, including street outreach, safe havens, permanent supportive housing and a range of services to supplement housing. This continuum is an important part of Project H.O.M.E.'s success: each person is recognized as an individual with unique needs. Services at each facility are different; some residents are not ready to accept regimented drug or alcohol treatment, while others may be able to live almost independently.

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The Facility

After a long, and now infamous, legal battle, the permanent housing facility at 1515 Fairmount opened its doors in 1996. 1515 Fairmount is a 48 bed permanent housing facility for homeless mentally ill men and women. The services provided at 1515 Fairmount are not intensive, and the residents are self-sufficient enough to clean their rooms and cook for themselves. There are no curfew or program requirements at 1515. The most common diagnoses are schizophrenia and bipolar disorder. Diagnoses are not what concern staff of this facility, however. More important is the level of independent living skills that potential clients possess, and the appropriateness of an environment that provides stable housing combined with low-level supportive services. Residents live in "clusters," in which 5-7 residents share living, dining and kitchen facilities.

Referrals

Project H.O.M.E. is unique in its method for reaching clients for 1515 Fairmount. All referrals to 1515 Fairmount come through the Office of Mental Health. OMH stays involved with referred clients by continuing to provide one-on-one case management. All clients must have a history of homelessness or have been at risk of imminent homelessness. 1515 Fairmount employs a “team interview” method to identify appropriate residents. A group of people who have been involved in the prospective resident’s treatment, including the city case manager and other programs officers, work with the Project H.O.M.E. team to determine whether 1515 would be a good fit. The notion of "fit" is integral to the program's success; not everyone will benefit from the model of low services administered at 1515.

Services

1515 Fairmount employs two full-time caseworkers and one part-time caseworker from 9-5 Monday-Friday. Also staffed is a 24-hour reception desk. Case management is supplemented greatly by the requirement that each resident have a case manager assigned by the city. 1515 Fairmount does not require a regimen of supportive services, but does ask each resident to be involved in some structured activity - whether it be employment, classes, or other daily activity - for 15 hours per week.

Fifteen of the 48 residents work. Project HOME facilitates employment and community reintegration, by employing residents in two in-house businesses: The Back Home Café, and Our Daily Threads Thrift Store.

Source of Funding

Project H.O.M.E. was awarded a $2 million grant from the Department of Housing and Urban Development in 1996 to rehab the property at 1515 Fairmount Avenue. The units have project-based Section 8 vouchers, which allow residents to pay 30% of their income toward rent. 1515 Fairmount has an annual budget of $182,000, most of which comes from a grant from the Office of Mental Health for all of the supportive services in the project. Additionally, OMH supplies each resident with his/her own case manager. Project H.O.M.E. manages the project, while their limited partner, 1515 Fairmount Limited Partnership, acts as the investor and developer.

1515 Fairmount did not always receive this large amount from the Office of Mental Health. Indeed, only recently the grant was $70,000. According to Sister Mary Scullion, the city became willing to support more of the project after the need for permanent supportive housing was proven, through data collection and analysis. Project H.O.M.E. keeps its private donations as flexible as possible, in order to channel the money to where it is most needed. Private donations that had been used for the facility at 1515 Fairmount are now being used in newer facilities, that are not established enough to receive city support.

Outcomes

According to the project coordinator, Project H.O.M.E.'s most important outcome, and the primary ingredient for its success, is respect for each resident's dignity. While this is a difficult goal to measure, one needs only to visit 1515 Fairmount, or any of Project H.O.M.E.'s sites, to know that they have succeeded. Residents feel a tremendous pride in their homes, and often in their recovery and independent living skills. Of all the residents that have lived at 1515 Fairmount since 1996, close to half still live there. Others have moved on to live independently, and others have cycled back into the homeless assistance system.

Fewer people have relapsed in the later years of the project. Darryl Parker, the program coordinator, believes that this success is due in large part to better client screening. The

unsuccessful residents were largely those who needed more structure than 1515 Fairmount was designed to provide.

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Best Practice – Supportive Housing

Anishinabe Wakiagun
Minneapolis, Minnesota

Anishinabe Wakiagun is notable for two reasons: the population it serves, and the funding sources it uses. The men and women of Anishinabe Wakiagun are among the hardest to serve as they are long-term homeless, and chronically addicted to alcohol. In exposing the problems experienced by this population, advocates were able to secure a funding source from the State, which to many outside of Minnesota may seem expensive but actually saves money for the State and Hennepin County.

Program Overview

Anishinabe Wakiagun provides permanent supportive housing in a wet/dry facility to 40 late stage chronic inebriates. The program is intended to "minimize the negative consequences of the residents' drinking patterns, while providing a stable, culturally appropriate living environment which encourages a reduction in alcohol consumption." The program also intends to reduce the public costs of providing services to their population. It has a staff of 13 people.

Target Population

Anishinabe Wakiagun targets late stage chronic inebriate Native American men and women. The target group has: entered a detoxification center twenty or more times in the last three years, attempted chemical dependency treatment twice or more, deteriorated physically due to alcohol use, experienced homelessness for the majority of the past five years, and proven incapable of self-management due to alcohol use. Residents' average age is 45. Anishinabe Wakiagun accepts referrals from other area service providers, through self-referral, but most often through project staff's relationships and outreach.

Project Description

Anishinabe Wakiagun does not require sobriety of its residents, nor are residents required to "progress" in a clinical sense. The only thing asked of residents is that they do not act violently or damage the facilities, and that they treat other residents and staff with respect. It is expected, however, that residents will be able to overcome some of the debilitating consequences of their alcoholism. The facility provides housing and case management. Each resident has his or her own room, but shares dining and bathroom facilities. Each resident receives case management services, health services (both on- and off-site) and other support services, as desired. Again, residents are not required to follow any rigid curriculum or treatment, and are free to stay as long as they choose to. Average length of stay is 27 months.

Overcoming Barriers

A major barrier to operating this program was its cost - $15,256 per resident per year, for a total annual budget of $650,000. Only 10% of the residents receive SSI payments and the other 90% have no income at the time of intake. Anishinabe Wakiagun is funded by virtue of the fact that it is cheaper than maintaining homelessness for this population. Hennepin County conducted a study on costs of detox and recidivism which found that detox for this population, at over $180 day, in addition to other social services used, was considerably more expensive than providing housing and services. In 1994, three people with chronic alcohol problems cost Hennepin County an average of $85,000 each for continuous revolving door medical assistance.

Anishinabe Wakiagun gets $40,000 from the Hennepin County Office of Chemical Health, $80,000 from HUD, and the rest from the Group Residential Housing Program (GRH), a program set up to respond to the needs of low income people who are placed in a licensed or registered setting. GRH eligibility includes automatic eligibility for medical assistance and pays $1,219.50 per month per resident to Anishinabe Wakiagun. Without GRH, program director Kelby Grovender explained, Anishinabe Wakiagun would not be able to provide the housing and services it does. (More information on GHR is available at www.dhs.state.mn.us)

Program Results

According to cumulative data collected by Anishinabe Wakiagun, the project served 151 residents from 1996-1999. Of these, 8% became totally sober, 60% stayed over one year, 78% over six months. In an analysis conducted by the Hennepin County office of Policy and Planning, researchers examined data on residents' service use before and after entering Anishinabe Wakiagun. Prior to moving into Anishinabe Wakiagun, residents had an average of 18 detox episodes per year, which accounted for 42 days. After entering Anishinabe Wakiagun, this number dropped to 2.5 admissions, or 6.3 days, on average. The number of admissions to the hospital emergency department declined close to 20% for those with emergency room visits within the past year. Further, while 61% of the pre-Wakiagun admissions were noted as alcohol related, only 38% of the post-Wakiagun admissions were noted as alcohol related.

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Best Practice – Supportive Housing

Pathways to Housing, Inc.
New York City, New York

Founded in 1992, Pathways to Housing offers scattered-site permanent housing to homeless individuals with psychiatric disabilities and addictions. Despite the challenges this population presents, Pathways is unique in that it does *not* require of its residents: "graduation" from other transitional programs, sobriety, or acceptance of supportive services as a condition of tenancy. The vast majority of clients are moved directly from the streets into permanent, private market housing. The program then uses Assertive Community Treatment (ACT) teams to deliver services to clients in their homes. The ACT teams help clients meet basic needs, enhance quality of life, increase social skills, and increase employment opportunities. The program currently serves over 400 people.

Target Population

Eligibility
Pathways to Housing is designed to end homelessness for people living on the streets with concurrent mental illness and addiction. In order to be eligible for the program, an individual must be homeless, must have a psychiatric disability that compromises their ability to function, and must be willing to meet with a service coordinator twice a month during the first year of tenancy. Priority is given to women and elderly people because they are at greater risk of victimization.

The program provides an alternative to the more common "linear residential treatment programs," which move people through a continuum of services beginning with outreach, some intermediary housing which helps people become "housing ready," and ending with permanent housing. Pathways provides clients with housing first, and then offers services and treatment to people in their homes.

Referrals
Most clients are contacted through the outreach efforts of Pathways staff. Other referrals come from city outreach teams, shelters and drop-in centers. 1999 data showed that 65% of tenants had last lived on the streets, 18% in shelters, 7% in treatment facilities, and the remainder had lived with friends, at the YMCA/YWCA, or in transitional facilities.

Project Description

Housing
Pathways to Housing staff assist clients in locating and selecting private market rental housing. The housing department keeps logs of new vacancies among the over 200 landlords they work with, and works to negotiate leases and complete Section 8 applications. The greatest challenge to the program is finding vacant apartments at fair market rent. Landlords are amenable to renting to Pathways' clients because they get guaranteed rental payments. Tenants pay 30% of their income towards rent, and Pathways pays the remaining amount if the client does not have a Section 8 voucher.

The agency also leases two transitional apartments for use by clients who have been accepted into the program, but have not yet found an apartment of their own. The average length of stay in these units is 15 days.

Services
Pathways to Housing uses Assertive Community Treatment (ACT) teams to deliver services to clients in their homes. The teams are interdisciplinary and are on-call 24 hours a day, seven days a week. However, the tenant determines the type, frequency, and sequence of services. Service requirements are that the tenant meet with a service coordinator twice a month and participate in a money management program. Refusal to participate in sobriety or other treatment programs does not disqualify an individual, nor does a history of violence or prison time.

ACT teams consist of up to ten service coordinators, each with a particular expertise. The team leader is responsible for supervising the work of the team. The primary goals of the ACT teams are to meet basic needs, enhance quality of life, increase social skills, and increase employment opportunities. Each team sees approximately 70 clients. When a team cannot provide the services directly, tenants are referred and accompanied to the relevant programs. After the rent is paid tenants are required to develop a monthly budget with the service coordinator. The goal is for tenants to eventually manage their own money.

Staffing
Pathways to Housing employs 4 staff responsible for housing services, 40 service coordinators, 5 team leaders, 2 psychiatrists, 2 nurses and a vocational specialist. The staff make-up is culturally and racially similar to the population the program serves. Program success is attributed in part to staff composition that includes 50% consumer representation (i.e. people in recovery) that serve as role models.

Source of Funding
Funding for the Pathways program comes in two parts: housing subsidies and services. Around sixty-five tenants have Section 8 vouchers, and the remainder are subsidized by grants from the HUD Shelter Plus Care program and the New York State Office of Mental Health. The latter also provides funding for the ACT teams. Each unit with services costs approximately $20,000 per year.

Service Utilization/Outcome Data
Data from 2000 showed that 88% of the program's tenants remained housed after five years. Furthermore, Pathways staff contends that its residents have greater satisfaction with their housing, and greater psychological well-being because they were given a choice as to where to live, and what activities to engage in.

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ENSURING THAT HOMELESS PEOPLE HAVE INCOMES TO PAY FOR HOUSING

GOAL: When it is necessary in order to obtain housing, your community assists homeless people to secure enough income to afford rent, by rapidly linking them with employment and/or benefits. It also connects them to opportunities for increasing their incomes after housing placement (opportunities provided primarily by mainstream programs).

Most homeless people will reenter housing without the benefit of a deep housing subsidy. For them, rehousing cannot occur without income. The quicker a minimal income is obtained, the sooner a new home is possible.

Many of the employment models explored as part of welfare reform show how people can quickly obtain work, in many instances paying enough to afford a minimal rent. In order to stabilize housing, however, people who have been rehoused must be linked with longer-term, career-based employment services, giving them the tools they need to increase their earnings. In locations with higher rent levels, this will sometimes be necessary even to initially escape from homelessness. Mainstream systems such as those funded by the federal government under the Workforce Investment Act should be used for this purpose.

Many homeless people are unable to work due to a disability, or unable to quickly earn enough to afford rent. They are often eligible for cash assistance from Supplemental Security Income, Temporary Assistance for Needy Families or similar programs. Systems should be in place to work through the eligibility processes in these programs as quickly as possible. This may require exceptions to local TANF procedures, which in some places involve discouraging people from applying for benefits. These exceptions are worthwhile, however, because of the increased self-sufficiency that comes about as a result of more stable housing.

Examples

The Maryland SSI Outreach Project (Baltimore, Maryland) This project assists homeless people with disabilities in establishing their eligibility for Supplemental Security Income benefits. The project helps compile medical records and packages them with an eye to demonstrating compliance with SSI eligibility requirements. A profile is at: http://www.endhomelessness.org/best/mdssioutrch.htm.

STRIVE (New York, New York) Strive provides short-term job readiness training, seeking to help people overcome barriers to employment and obtain a job. STRIVE follows up with its clients after the job begins. A brief description and contact information are at: http://www.endhomelessness.org/best/bpst.htm.

Impact Employment Services (Boston, Massachusetts) Impact Employment Services is a citywide employment service for homeless people. It assists with job searches and placement to help homeless people obtain a job quickly and at the highest pay possible. A description is at: http://www.endhomelessness.org/best/IMPACT.htm

Larkin Street Youth Services' HIRE UP Program. (San Francisco, California) HIRE UP is the workforce development initiative of Larkin Street Youth Services (LSYS), a community-based nonprofit founded in 1984 to divert homeless youth from prostitution, drug-dealing and theft. Tied to LSYS' comprehensive continuum of emergency, transitional, and permanent housing services, HIRE UP was launched in 1998. Together this integrated approach assists youth in addressing the two major barriers to self-sufficiency – homelessness and joblessness. For more information, see: http://www.nyec.org/pepnet/awardees/larkin.htm

Resource

- *Toolkit for Income Growth for Out-of-School Youth.* The New York Association of Training and Employment Professionals recently issued a toolkit for frontline workers targeting out-of-school youth. To access the toolkit, "The Road to Self Sufficiency: An Income Growth Strategy for Out-of-School Youth," refer to: http://www.nyec.aa.psiweb.com/IncomeGrowthStrat.pdf

Best Practice – Income

Maryland SSI Outreach Project
Baltimore, Maryland

The Maryland SSI Outreach Project helps homeless mentally ill people become enrolled in the Supplemental Security Income (SSI) program. It does this by providing services that the Social Security Administration does not: outreach, help with record gathering and application completion, and advocacy on the clients' behalf.

History

The Maryland SSI Outreach project was started in 1993 as a demonstration project in the Social Security Administration (SSA). The outreach demonstration funded staff costs, including salaries for a project director, two counselors, and an administrative assistant. The project was intended to link SSI benefits to homeless people of age 18 and over who have serious and consistent mental illness. The program went through a number of incarnations from 1994-1998, as funding from SSA diminished. Starting in 1998, the Social Security Outreach Project coordinated with the Baltimore continuum of care in order to obtain $190,000 in HUD funding each year.

Target Population

The SSI Outreach Project is geared toward severely mentally ill people who are living on the streets. In addition to the street outreach done by the staff, the SSI Outreach project takes referrals from all over the city -- from the Department of Social Services, transitional housing programs, emergency shelters, and drop-in centers. Clients are usually those who are clearly good candidates for SSI, but by virtue of their disabilities, have been either unable to navigate the application process or simply unaware that they might be eligible for such an entitlement.

Project Description

The SSI Outreach project remains staffed by a project director, two counselors, and an administrative assistant. According to their grant agreement, they must serve at least 100 people a year. The project is set-up to address what Project Director Yvonne Perret sees as the three major obstacles to severely mentally ill people seeking benefits:

- the illness itself, which makes navigating a complicated application process nearly impossible,
- the fact that mental illness is stigmatized to the point that people won't admit to suffering from one, and
- the challenge of paper management, especially while lacking a fixed address.

The SSI Outreach team makes it a point to see each referred client within three days of a phone call. They conduct a twenty-minute screening on-site, complete an information

sheet (largely on income and resources), and have the client sign "appointment of representative" forms, which allow SSA to release the client's information to the Project. Once the appropriate forms have been reviewed by SSA, the counselor receives a determination on whether the client is eligible for the SSI or SSDI programs, or whether an application is already pending, in which case the counselor can only help the client with the paperwork.

The second and more challenging part of the process is preparing the disability report. The counselor collects all information available on the client's treatment records -- where people have been treated, and for what. They conduct a clinical evaluation that takes anywhere from 1-10 hours, extended over a number of meetings. The Project Director then writes a report describing a diagnosis and any functional impairment, and submits it to the Disability Determination Services office. In all, the staff spends an average of 30 hours on each case.

The SSI Outreach Project is also able to provide "presumptive" benefits to people they are certain will join the SSI rolls. This means that for up to six months while waiting for their eligibility determination, clients receive SSI payments. This part of the program is a remaining perk from the original demonstration project, which allowed for presumptive eligibility. After the first year of the demo, all of the 54 people who received their benefits presumptively were eventually enrolled in the SSI program. Those who do not receive presumptive eligibility are less visibly disabled -- either they may not have received treatment for their mental illness, or there is difficulty teasing out the substance addictions from the mental illness.

For some of the severely disabled clients, the Maryland SSI Outreach Project acts as the representative payee, and SSA sends all benefits to the staff, which acts as the clients' money manager.

Source of Funding

The SSI Outreach Project is part of the Baltimore continuum of care, and receives $190,000 per year from HUD. Yvonne Perret believes that the Social Security Administration, which currently does not provide grants for outreach projects, is the more appropriate source of funds.

Available Data

Since 1994, the SSI Outreach Project has deemed between 400-450 people presumptively eligible. Of this number, only two people have been denied SSI.

The benefits of this program do not end with SSI payments. The SSI Outreach project also succeeds in linking people with other county services. Typically the SSI Outreach staff spends between 20 and 40 hours with each person. They serve, as a precondition of their grant, at least 100 people per year.

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Best Practice – Maximizing Income

STRIVE
New York, New York

STRIVE, one of the several privately owned job-training programs in New York City, has a history of securing employment for the hard-to-employ. It consists of a network of 18 job-training sites in four cities including New York, Boston, Chicago, and Pittsburgh and 30 job trainers interacting with about 1,000 employers annually. STRIVE also works with clients after placement to ensure their continued success. Since its inception in 1984 the program has employed a two-step process of helping people find employment and attain self-sufficiency.

Services

- *Technical Job Training Programs* focus on three career fields, including telecommunications, financial services, and environment/automotive technology.
- *Fragile Families Initiative for Men* is a parenting/manhood development course designed to enhance young fathers sense of responsibility.
- *The Rites of Passage Programs* are an attempt to support and promote the safe and positive development of men and women into responsible adulthood.
- *STRIVE Training Academy* is a program designed to train other leaders on STRIVE's program techniques, philosophy, and program design and training techniques.

Source of Funding

STRIVE is supported primarily through private funding, with the exception of several federal grants.

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Best Practice – Maximizing Income

IMPACT Employment Services
Boston, Massachusetts

IMPACT, a program of the *Friends of the Shattuck Shelter*, is Greater Boston's largest employment service for homeless individuals and families. Since 1994, more than 2500 skilled job seekers have successfully obtained employment through the program. IMPACT's professional staff of employment counselors, job developers and educational and training specialists speaks a variety of languages and represents diverse cultural and economic backgrounds.

Target Population

IMPACT Employment Services serves people experiencing homelessness as well as people leaving correctional facilities.

Eligibility

There two ways people enter the IMPACT program. The first of these is through the homeless assistance system. The following are eligibility requirements for entering the program through the homeless assistance system:

- Must comply with HUD definition of homeless
- Must be referred by one of 140 partnering homeless service agencies
- Preferably must have had at least 3 months sobriety if they have had a substance abuse issue in the past

The second way people enter the IMPACT program is through a closed referral process by the Department of Corrections. Those that are referred to the program meet with IMPACT counselors at least 4 times (once a month) while they are in prison before they officially enter the program upon release. Participation in the program after release is on a voluntary basis.

Services

- Outreach to 138 emergency shelters, transitional shelters, recovery programs, battered women's shelters and family shelters
- Individual employment counseling and job search planning
- Information, referrals and assistance to help people find and enroll in educational and job-skills training program throughout greater Boston
- Resources for job searching, including:
    - Resume development
    - Interview skills, including videotaped practice
    - Education and training, including information and referrals to free and low-cost ESL, adult literacy and GED programs

    - Career development
    - Workshops on job search techniques and employment barriers
    - Job leads and employer contacts
    - Referrals for appropriate clothing
    - Internet and e-mail access
    - Current information and resources for community-based programs, institutes and colleges
    - Assistance determining financial aid options
    - Referral and follow-up to housing resources
- *For those entering through the Corrections system,* services also include general case management and community support.

Source of Funding:

- Primary funding for IMPACT comes from HUD McKinney SHP funds.

- Since summer 2001, IMPACT has secured funding from the Massachusetts Department of Corrections for services for people that have entered the program through the Department's closed referral system.

Outcomes:

Under SHP, the program has served over 630 homeless individuals per year, 65 percent of which (or around 410 people per year) have found and maintained employment for 3 months or more, which enhances their ability to become self-sufficient.

According to data tracked from July 2002, out of 33 active clients who are out in the community, the segment of the program linked with the Department of Corrections has placed 18 people into housing and helped 22 successfully obtain jobs.

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THE NATIONAL ALLIANCE TO END HOMELESSNESS, INC.

Housing First:
A New Approach to Ending Homelessness for Families

Many communities are adopting a "Housing First" approach to ending homelessness for families. The approach is based on two very simple principles:

> *1. The best way to end homelessness is to help people move into permanent housing as quickly as possible.*
>
> *2. Once in housing, formerly homeless people may require some level of services to help them stabilize, link them to long-term supports, and prevent a recurrence.*

Of course, Housing First really isn't that new. Some communities have been practicing it for years, with extraordinary results.

- The city of Philadelphia has used a housing first approach to cut the number of people in shelters by half.
- Last year, the Pew Partnership for Civic Change recognized Beyond Shelter, a Housing First program in Los Angeles, as a "Solution for America." They stated:

  "The 'Housing First' program breaks the cycle of homelessness by placing some of the most vulnerable and at-risk homeless families in the nation immediately into permanent housing and then providing them with intensive support services."

Following is a list of questions that are frequently asked about the Housing First approach.

What is a Housing First approach?

A Housing First approach consists of three components:

- **Crisis intervention, emergency services, screening and needs assessment:** Individuals and families who have become homeless have immediate, crisis needs that need to be accommodated, including the provision of emergency shelter.

There should be an early screening of the challenges and resources that will affect a re-housing plan.

- **Permanent housing services:** The provision of services to help families' access and sustain housing includes working with the client to identify affordable units, access housing subsidies, and negotiate leases. Clients may require assistance to overcome barriers, such as poor tenant history, credit history and discrimination based on ethnicity, gender, family make-up and income source. Providers may need to develop a roster of landlords willing to work with the program and engage in strategies to reduce disincentives to participate.

- **Case management services:** The provision of case management occurs (1) to ensure individuals and families have a source of income through employment and/or public benefits, and to identify service needs *before the move into permanent housing*; and (2) to work with families *after the move into permanent housing* to help solve problems that may arise that threaten the clients' tenancy including difficulties sustaining housing or interacting with the landlord and to connect families with community-based services to meet long term support/service needs.

Targeting: Is a Housing First approach appropriate for all people experiencing homelessness?

A Housing First approach that emphasizes a rapid return to permanent, independent housing is not believed to be appropriate for all people experiencing homelessness. Some may require longer stays in transitional housing before re-entering housing to cope with other issues such as domestic violence or substance abuse addiction. There is a small population of chronically homeless people who will require permanent supportive housing to exit homelessness. Finally, many individuals and families have the capacity to exit homelessness rapidly without any additional forms of assistance.

Families with significant barriers to becoming re-housed have been the initial target population for Housing First services. Housing First programs have attempted to target those individuals and families who are most likely to remain in the homeless service system longer without such assistance. Such targeting efforts have resulted in greater emphasis on upfront housing assessments to determine the permanent housing strategy that best meets the individual or family's needs.

Assessment: How do you know a family/individual is "ready" for housing?

All programs assess the individual or family's "readiness" for Housing First services. Obviously, having a source of income, which includes a welfare grant, or access to a housing subsidy is a primary and immediate concern. There must be some assurance the housing is financially affordable to the family or individual over the long term. This, of course, means that housing first providers must be attentive to the availability and parameters (such as time limits) of publicly funded programs -- such as Temporary Assistance to Needy Families (TANF) and Section 8 housing vouchers.

It is important to stress that Housing First providers do not believe housing should come after successful interventions to help an individual or family achieve self-sufficiency. Indeed, some believe it is not until a family is stabilized in their own permanent housing that real progress in meeting other family goals can be made. A Housing First approach incorporates transitional case management services following a placement in permanent housing that helps families stabilize in their housing and links them with the appropriate services in the community to meet their long-term support needs and goals.

In some cases, a family assessment indicates to program providers that stays in transitional housing may be beneficial for the family. For example, some domestic violence providers believe transitional housing can provide vulnerable families the more intensive, on-site support required during the early days and months of separation from an abusive partner. Those with a recent history of drug/alcohol addiction may find stays in transitional housing programs enhance their recovery work. It is important to recognize, however, that for the majority of individuals and families experiencing homelessness, stays in transitional housing are not indicated. It is typically more costly to the community to prolong the period of time in which an individual or family remains homeless. Transitional housing should therefore be used purposively, when indicated by the needs of the family or individual.

Finally, an essential consideration for those adopting a Housing First model is responding to the concerns of landlords. In many communities, it is very difficult to locate housing affordable to very low-income individuals and families. Housing First providers rely on extraordinary efforts to attract and maintain a roster of landlords willing to accept their clients -- particularly those with more "challenging" rental histories. Because housing first providers are so dependent upon their reputation among landlords to build a pool of housing opportunities for their clients, they must have some confidence in the clients' capacity to be good tenants.

Inevitably, Housing First providers will work with individuals or families whose rental histories may indicate a high level of "risk" both to the landlord and the reputation of the Housing First provider. Housing First innovators are responding to this challenge by working cooperatively with area landlords to explore how to reduce or share the risk burden.

Housing Assistance: What kind of housing assistance is recommended and how can you help families find housing when there is NO affordable housing?

Housing assistance typically involves helping the individual/family identify appropriate housing options, negotiate with landlords, and intervening when problems develop following a housing placement that threatens the client's tenancy. Housing assistance may also include providing financial assistance for security deposits, rent guarantees and housing applications.

Developing housing resources has become a necessary component of implementing a housing first approach -- this may involve marketing the program to landlords to develop a base willing to work with the housing first program. Developing housing resources might also include working closely with the local public housing authority to maximize the community's housing resources for clients.

The increasing difficulty in locating affordable housing accessible to very low-income individuals and families does present a significant challenge for housing first providers. It is even more challenging for the many individuals/families who exit homelessness without access to housing first services. There is a need to continue to develop and refine strategies to locate and develop more housing opportunities in the community and through the use and expansion of publicly funded housing resources. Housing first innovators have found that landlords are often motivated to lease an apartment to a homeless individual or family when they know that there is a support system to provide assistance -- or to call if a problem arises.

Case Management: What is the focus of case management work and why should homeless assistance dollars pay for services to families and individuals who are no longer homeless?

Housing First approaches shifts the paradigm of service provision to homeless people. In the prevailing model, individuals and families often remain eligible for case management services and supports only as long as they continue to be homeless. The goal of such case management services is to stabilize the individual or family so they can enter housing.

Housing First models attempt to significantly reduce the length of time people are homeless. Follow-up case management services are required to help the individual or family stabilize after they are housed. Reducing the length of time families are homeless presents great cost-savings to homeless programs, the cost of the follow-up case management a fraction of that required to meet the comprehensive needs of the family who remain homeless for a longer period of time.

Individuals and families will require some immediate short-term case management while still in emergency shelters to resolve immediate, pending crises. The initial case management services that begin in the emergency shelter often focuses on addressing the

barriers that prevent the individual/family from re-entering housing. Utilizing a Housing First approach, however, means not predicating provision of housing on completing case management services.

Follow-up case management services should be provided to the individual or family for at least six months to one year and may vary in intensity depending on the need of the family. Case management is expected to be transitional, therefore, linking individuals and families with on-going need for supports to community-based services is a focus of case management services.

Role of transitional housing: Doesn't the Housing First approach underplay the value of transitional housing to accommodate the shortage of affordable housing and help families achieve real self-sufficiency?

The Alliance believes there is a role for transitional housing for individuals and families experiencing homelessness. The Alliance strongly believes transitional housing funded out of the homeless assistance funds should be used purposefully -- to achieve an end to homelessness. The Alliance is concerned, however, that transitional housing has become a "waiting area" for too many individuals/families whose only real re-housing need is an assurance of affordability. The consequence is that those individuals/families who might benefit from the supports a transitional housing program may provide -- for example, a family fleeing an abusive relationship or an individual working on his/her sobriety -- are diverted from the help they need because of the backlog of people seeking assistance. By providing the housing first assistance to help those who can move rapidly out of homelessness, transitional housing can be utilized to serve those who would derive the greatest benefits from it.

Permanent supportive housing: Many homeless families appear to need on-going support, so shouldn't we just develop more permanent supportive housing programs for families?

While housing with supports attached may benefit a broad spectrum of individuals and families, the Alliance recognizes that sufficient funding is unlikely within the existing federal housing budget and absolutely impossible out of the limited homeless assistance dollars. Instead, the Alliance supports targeting existing Supportive Housing, Shelter Plus Care and SRO permanent supportive housing dollars to those with disabilities and experiencing chronic homelessness, and who without such assistance, would never escape homelessness. This may include some families.

It is true that many of the individuals and families who have experienced homelessness might benefit from on-going supports -- and the goal of the transitional case management work following a housing placement is to put those supports in place. Studies and experience demonstrate that even those with multiple challenges can live independently

in the community when they have access to supportive services delivered by mainstream programs.

Questions: What do we need to consider when developing a Housing First program?

Each community will need to assess its existing resources. A Housing First approach can be adopted by one agency or it can be accomplished through the collaboration of agencies each providing specialized services. The questions that need to be evaluated in each community are:

- Which individuals/families experiencing homelessness should be targeted for Housing First services?
- Who will be responsible for the referral and assessment of individuals/families?
- Who can provide individuals/families with housing assistance, including:
    - Help overcoming barriers to accessing affordable housing including addressing poor credit, eviction histories, lack of move-in funds
    - Locating subsidized or affordable units in the community,
    - Developing greater affordable housing resources by working with landlords, public housing authorities, etc.
    - Serving as a resource to landlords following a housing placement for problems/issues that may develop.
- Who will provide the case management services to the individual/family, including:
    - Time-limited case management immediately after the move,
    - Linking individual/family with needed supports in the community,
    - Helping to resolve crises that may evolve following a housing placement.
- What funding resources are available?
- What outcome data elements should be captured?

For more information, go to the Housing First Network at
http://www.naeh.org/networks/housingfirst/index.htm

THE NATIONAL ALLIANCE TO END HOMELESSNESS

A Plan: Not A Dream

How to End Homelessness in Ten Years
Executive Summary

Twenty-five years ago there was not widespread homelessness in America. Tonight nearly a million people will be homeless, despite a multi-billion dollar a year infrastructure designed to deal with the problem. Can homelessness be ended?

While the seeds of homelessness were planted in the 1960s and 1970s with deinstitutionalization of mentally ill people and loss of affordable housing stock, widespread homelessness did not emerge until the 1980s. Several factors have affected its growth over the last two decades. **Housing** has become scarcer for those with little money. **Earnings** from employment and from benefits have not kept pace with the cost of housing for low income and poor people. **Services** that every family needs for support and stability have become harder for very poor people to afford or find.

In addition to these systemic causes, social changes have exacerbated the personal problems of many poor Americans, leading them to be more vulnerable to homelessness. These social trends have included new kinds of illegal drugs, more single parent and teen-headed households with low earning power, and thinning support networks.

These causes of homelessness must be addressed. People who are homeless must be helped, and the current system does this reasonably well for many of those who become homeless. But the homeless assistance system can neither prevent people from becoming homeless nor change the overall availability of housing, income and services that will truly end homelessness.

Mainstream social programs, on the other hand, do have the ability to prevent and end homelessness. These are programs like welfare, health care, mental health care, substance abuse treatment, veterans assistance and so on. These programs, however, are over-subscribed. Perversely, the very existence of the homeless assistance system encourages these mainstream systems to shift the cost and responsibility for helping the most vulnerable people to the homeless assistance system. This dysfunctional situation is becoming more and more institutionalized. Can nothing be done?

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Ending Homelessness in Ten Years

The Board of Directors of the National Alliance to End Homelessness believes that, in fact, **ending homelessness is well within the nation's grasp**. We can reverse the incentives in mainstream systems so that rather than causing homelessness, they are **preventing** it. And we can make the homeless assistance system more **outcome-driven** by tailoring solution-oriented approaches more directly to the needs of the various sub-populations of the homeless population. In this way, homelessness can be ended within ten years.

To end homelessness in ten years, the following four steps should be taken, simultaneously.

Plan for Outcomes

Today most American communities plan how to manage homelessness – not how to end it. In fact, new data has shown that most localities could prevent homelessness and help homeless people much more effectively by changing the mix of assistance they provide. A first step in accomplishing this is to collect much better **data** at the local level. A second step is to create a **planning process that focuses on the outcome** of ending homelessness – and then brings to the table not just the homeless assistance providers, but the mainstream state and local agencies and organizations whose clients are homeless.

Close the Front Door

The homeless assistance system ends homelessness for thousands of people every day, but others quickly replace them. People who become homeless are almost always clients of public systems of care and assistance. These include the mental health system, the public health system, the welfare system, and the veterans system, as well as the criminal justice and the child protective service systems (including foster care). The more effective the homeless assistance system is in caring for people, the less incentive these other systems have to deal with the most troubled people – and the more incentive they have to shift the cost of serving them to the homeless assistance system.

This situation must be reversed. The flow of **incentives** can favor helping the people with the most complex problems. As in many other social areas, investment in **prevention holds the promise of saving money** on expensive systems of remedial care.

Open the Back Door

Most people who become homeless enter and exit homelessness relatively quickly. Although there is a housing shortage, they accommodate this shortage and find housing. There is a much smaller group of people, which spends more time in the system. The latter group – most of whom are chronically homeless and chronically ill – virtually lives in the shelter system and is a heavy user of other expensive public systems such as hospitals and jails.

People should be helped to exit homelessness as quickly as possible through a **housing first approach**. For the chronically homeless, this means **permanent supportive housing** (housing and services) – a solution that will save money as it reduces the use of other public systems. For families and less disabled single adults it means getting people very quickly into permanent housing and linking them with services. People should **not spend years in homeless systems**, either in shelter or in transitional housing.

Build the Infrastructure

While the systems can be changed to prevent homelessness and shorten the experience of homelessness, ultimately people will continue to be threatened with instability until the supply of affordable **housing** is increased; **incomes** of the poor are adequate to pay for necessities such as food, shelter and health care; and disadvantaged people can receive the **services** they need. Attempts to change the homeless assistance system must take place with the context of larger efforts to help very poor people.

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Taking these steps will change the dynamic of homelessness. While it will not stop people from losing their housing, it *will* alter the way in which housing crises are dealt with. While it will not end poverty, it *will* require that housing stability be a measure of success for those who assist poor people. The National Alliance to End Homelessness believes that these adjustments are necessary to avoid the complete institutionalization of homelessness. If implemented over time, they can lead to an end to homelessness within ten years.

3/03

For the full text of the National Alliance to End Homelessness Ten Year Plan, as well as best practices, state and local plans, etc., go to www.endhomelessness.org.

Council of State Community Development Agencies
National Alliance to End Homelessness
National Council of State Housing Agencies
National League of Cities
and
U.S. Conference of Mayors

join in presenting:

Leadership to End Homelessness Audio Conference Series

a monthly series of national telephone conferences focusing on key solutions and essential strategies that states, local jurisdictions, and nonprofit organizations have employed to end homelessness

Each one-hour call in the series is held at 3 p.m. Eastern Time on the second Thursday of every month and features:

- 15 minutes of presentation highlighting a specific best practice, and
- 45 minutes of Q&A and information sharing among participants.

Past audio conference topics have included:

- **Innovations in Housing Placement Strategies: The Philadelphia Housing Support Center**
- **Using HMIS for Effective Planning to End Homelessness**
- **Coordinating Service Delivery in Supportive Housing**
- **Citywide and Programmatic Approaches to Ending Chronic Homelessness**
- **Strategies to Pay for Housing for Families Exiting Homelessness**
- **Developing Plans to End Homelessness at the State and Local Levels**
- **Preventing and Ending Homelessness Among Youth**
- **Using Project-Based Section 8 for Supportive Housing**

For more information on the series, please visit:
http://www.endhomelessness.org/audio

Want to Talk to Someone About Planning to End Homelessness?

National Alliance to End Homelessness

The National Alliance to End Homelessness has worked with many jurisdictions working on plans to end homelessness. Contact the following staff people:

Nan Roman, President – general planning, housing
Steve Berg, Vice President – veterans, employment
Norm Suchar, Prog./Policy – supportive housing, services, chronic homelessness, outreach
Sharon McDonald, Prog./Policy – families, TANF
Mishaela Duran, Prog./Policy -- youth

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