

**U.S. Department of Housing and Urban Development
Office of Policy Development and Research**



**Evaluation of Continuums of Care
For Homeless People**

Final Report

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Prepared for:
U.S. Department of Housing and Urban Development
Office of Policy Development and Research

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FOREWORD

A Continuum of Care is a local or regional system for helping people who are homeless or at imminent risk of homelessness by providing housing and services appropriate to the whole range of homeless needs in the community, from homeless prevention to emergency shelter to permanent housing. In 1995, the Department of Housing and Urban Development (HUD) implemented the Continuum of Care approach to streamline the existing competitive funding and grant-making process under the McKinney-Vento Homeless Assistance Act and to encourage communities to coordinate more fully the planning and provision of housing and services for homeless people.

In 2000, HUD contracted with the Urban Institute and its subcontractor, ICF Consulting, Inc., to conduct an assessment of the Continuum of Care approach. This study examined 25 Continuums of Care in all regions of the country. At the outset of the study, the Department was unsure whether the Continuum of Care concept had achieved detectable results in fostering a coordinated response to homelessness. For this reason, the study intentionally identified communities to study that appeared to have been successful in implementing a Continuum of Care. Because they had been able to convey a sense of progress in meeting their goals, these communities also happened to receive more than a typical share of funding under HUD's competitive allocation process. Among these high performers, the study sought to ensure that the study communities were broadly representative geographically, but the sites cannot be taken as representative of all of the communities that are operating HUD-assisted homeless programs.

The completed study provides a rich array of information on the activities of high-performing Continuums of Care and documents the extent of progress of the studied communities along many dimensions of a comprehensive approach to homelessness prevention and remediation. On balance, the report concludes that for the high-performing communities studied, HUD's implementation of the Continuum of Care funding process stimulated increased communication within local communities in their response to homelessness. As a result, respondents generally agreed that more people have received more services and participate in more and better coordinated programs than before as a consequence of the Continuum of Care approach. In the most advanced communities, the response has moved beyond planning to obtain HUD funding to the far broader goal of attempting to integrate all available funding and services to try to end homelessness.

The Department is continually refining and reassessing its approaches to program delivery, and homelessness is no exception. HUD's FY 2003 budget request includes a proposal to Congress to consolidate the existing McKinney programs and change the way homeless activities are funded. The Department's proposal would ensure that localities are provided with a predictable source of flexible funds through a streamlined, locally-driven process. It is designed to preserve the achievements documented in this report while providing more flexibility to local communities in addressing homelessness, as well as incentives for communities that have been less successful in implementing the Continuum of Care to improve their planning and program delivery.

This report is a significant addition to our knowledge about homelessness. It provides important insights into local responses to the problem and identifies issues that must be resolved as the nation grapples with the difficult and serious problem of homelessness.

Lawrence L. Thompson,
General Deputy Assistant Secretary for
Policy Development and Research

Table of Contents

EXECUTIVE SUMMARY	IX
Purpose of the Research.....	ix
Who, What, Where, and When?.....	ix
Why This Study Is Important	xi
Key Findings.....	xii
How Communities Organize Themselves to Respond to HUD and to Homelessness	xii
What Local Homeless Assistance Systems Look Like.....	xiii
Navigating the Homeless System	xiv
Involvement of Mainstream Agencies and Services	xv
CoC Planning for and Coordination of Homeless Services.....	xv
How the CoC Application Process Has Shaped Planning and Provision of Services.....	xvii
Implementing Data Systems: A Few CoCs Far Ahead of the Rest.....	xvii
Implications for Research	xviii
Implications for Practice	xix
Implications for Policy.....	xx
CHAPTER 1: INTRODUCTION AND OVERVIEW OF THE STUDY	1
Introduction.....	1
Background	2
The Growth of America’s Shelter Capacity in the 1980s and 1990s.....	2
Growth of the Homeless Population.....	4
The Need for Continuums of Care	5
First Efforts Toward Continuums of Care.....	5
Methods.....	10
The Rest of This Report	14
Caveats	15
A Word on Numbers, or their Absence.....	15
CHAPTER 2: POWER AND PEOPLE—“LEAD” AGENCIES AND LEADERSHIP	17
No Formal Authority.....	17

Public-Private Arrangements	18
Formal Independent Entities.....	22
The Last Community	24
People	24
Beyond “The Community”.....	25
Implications.....	25
CHAPTER 3: LOCAL HOMELESS ASSISTANCE SYSTEMS	29
The Meanings of “Continuum of Care”	29
Limited View.....	30
Geographically-Influenced View.....	30
Components of CoC Systems	32
Prevention	32
Emergency Shelter.....	35
Transitional Housing	41
Permanent Supportive Housing	43
No/Low Demand Shelter and Housing Programs	45
Importance of Supportive Services	47
Permanent Affordable Housing	48
Implications.....	50
CHAPTER 4: NAVIGATING THE SYSTEM	53
System Entry and Flow.....	53
System Entry: Fragmented, No Wrong Door, and Centralized Approaches	53
Reaching Out to the Hard to Serve	55
Movement Within the System: Ensuring that Individuals Obtain Needed Services	60
Locked Out: Homeless Sub-groups That Have Not Fared Well	63
Persons with Mental illnesses, Addictions, or Both	63
Youth.....	66
Families.....	67
Ex-Offenders.....	67
Implications.....	68
CHAPTER 5: INVOLVEMENT OF MAINSTREAM AGENCIES AND SERVICES	71
Introduction.....	71
Strategies for Involving Mainstream Agencies	72

Staff with Systems/Service Integration Responsibilities.....	74
Creating a Local Interagency Coordinating Body.....	76
Having a Centralized Authority.....	78
Co-Locating Services.....	79
Interagency Management Information Systems.....	82
“Reverse” Integration.....	82
Business and Corporate Involvement.....	83
Fort Lauderdale/Broward County, Florida.....	84
Columbus/Franklin County, Ohio.....	84
Implications.....	85
CHAPTER 6: PLANNING FOR AND COORDINATION OF SERVICES TO HELP HOMELESS PEOPLE.....	87
The Gaps Analysis.....	87
Data Sources and Methods Used in the Gaps Analysis.....	88
Limitations and Criticisms of the Gaps Analysis.....	89
Setting Priorities in the Gaps Analysis Process.....	90
Ranking Homeless Proposals.....	92
The Proposal Ranking Process.....	92
Who Is Included in the Proposal Ranking Process?.....	93
Scope of Planning for Homeless Programs and Services.....	96
Scope of Planning: Limited to the HUD-funded Continuum of Care.....	97
Scope of Planning: The Larger Homeless Assistance System.....	97
Scope of Planning: Strategic Multi-Year Planning for the Larger Homeless Assistance System.....	99
Planning for Homeless Programs and Services in Relation to Other Planning Efforts....	101
Stability and Flexibility of the System and the Impact of Renewals.....	103
Background on HUD CoC Funding and Renewals.....	104
Impact of Project Renewals at Sites Visited.....	105
Other Issues and Problems with the Planning Process.....	110
Implications.....	113
CHAPTER 7: THE HISTORY OF THE SYSTEM.....	115
Planning for the First CoC Application: Seamless Transitions.....	117
Effect of the CoC Application.....	118

Planning for the First CoC Application: From Informal/Fragmented to Structured/ Comprehensive	118
Effect of the CoC Application	121
Planning for the First CoC Application: From Nothing to Something	121
Effect of the CoC Application	122
Developments Since the First CoC Application: Shifting Directions	123
Next Steps: The Primary Issues Facing These Systems	124
Changes That Could Pose Difficulties	125
Implications.....	127
CHAPTER 8: DATA SYSTEMS	129
HMISs in the Most Advanced Communities	129
Boston	129
Columbus/Franklin County, Ohio	130
Balance of Cook County, Illinois	130
Memphis/Shelby County, Tennessee	131
Montgomery County, Maryland	132
Rhode Island	132
Shreveport, Louisiana and Nine Surrounding Parishes	133
Washington, DC	134
Status of HMISs in Other Communities	135
Barriers to Development and Implementation	136
Lack of Power to Collect Data	136
Cost.....	137
Time	137
Confidentiality.....	138
Compatibility of Different Data Systems.....	138
Sharing Case Management Information	139
Status of Performance Measurement Systems	139
Boston	139
Columbus/Franklin County, Ohio	140
Washington, DC	140
Other Types of Data Collection and Limits of an HMIS	141
Implications.....	142

Prospects for Functioning Data Systems	142
HMIS Implementation	143
Use of Performance Information in Funding Decisions	143
CHAPTER 9: SUMMARY AND IMPLICATIONS	145
Question 1: Local Homeless Assistance Networks—Programs and Functioning	145
Question 2: Inclusiveness of CoC Planning, Coordination, and Program Support.....	146
Question 3: Integration with Mainstream Programs and Services.....	147
Question 4: Role of Data and Statistics in Planning	147
Question 5: Effects of HUD’s Application Requirements	148
Question 6: Success in Ending or Reducing Homelessness.....	148
Impressions and Implications	148
Lack of Affordable Housing	149
Steps, Stages, or Levels	149
Importance of the Local Environment	150
Importance of Philosophy about Homelessness	152
Evolving Views of Appropriate Programs and Services	152
Effects of CoC Funding Structure on Cooperation and Coordination	153
Community Differences and Need for More Information on Rural CoCs	154
Possible HUD Actions Suggested by Respondents.....	154
REFERENCES	157
ACRONYMS	159
APPENDIX A: MOST COMMON SOURCES OF FUNDING FOR HOMELESS ASSISTANCE PROGRAMS FROM THE U. S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT	161
Emergency Shelter Grant Program (ESG)	161
Supportive Housing Program (SHP).....	162
Shelter Plus Care Program (S+C)	162
APPENDIX B: DESCRIPTIONS OF THE COMMUNITIES VISITED	167
NORTHEAST	167
Delaware	167
Rhode Island	167
Southwestern Pennsylvania	168
Boston	169

Washington, DC	170
Essex County, New Jersey.....	172
Montgomery County, Maryland	172
SOUTH	174
Shreveport, Louisiana and nine surrounding parishes	174
Fort Lauderdale/Broward County, Florida	175
Orlando/Orange County, Florida	176
Memphis/Shelby County, Tennessee.....	177
Winston-Salem/Forsyth County, North Carolina.....	178
MIDWEST	179
Chicago, Illinois	179
Balance of Cook County, Illinois.....	180
Lake County, Illinois	181
Madison/Dane County, Wisconsin.....	182
Washtenaw County/Ann Arbor, Michigan.....	183
Columbus/Franklin County, Ohio.....	183
St. Paul/Ramsey County, Minnesota.....	184
WEST	186
Alameda County, California.....	186
Denver, Colorado and five surrounding counties	187
San Francisco, California	188
Long Beach, California	189
Phoenix/Maricopa County, Arizona	190
Tacoma/Pierce County, Washington	192

EXECUTIVE SUMMARY

Purpose of the Research

The purpose of this project was to examine Continuums of Care for homeless people throughout the United States, to understand their development, their current structure, and their likely future. A Continuum of Care (CoC) is, ideally, a system for helping people who are or have been homeless or who are at imminent risk of homelessness. A full CoC includes prevention, outreach and assessment, emergency shelter, transitional housing, permanent supportive housing, and affordable housing, plus supportive services in all components. HUD has promoted the CoC concept through much of the 1990s, and has structured its competitive funding under the McKinney-Vento Homeless Assistance Act to further CoC development.

This study sought to answer several questions about the ways in which local communities are organized into CoCs to address homelessness:

- What do local homeless assistance networks look like, how do they work, and whom do they serve?
- Are all the important players, or their representatives, included in planning the local CoC and coordinating their programs and services?
- How well are homeless and mainstream services integrated?
- What goals is each jurisdiction trying to accomplish with its CoC—helping homeless people, ending homelessness, or some combination—and how does its concept of its “continuum” further those goals?
- What role does data or statistics about homeless people, services, and program performance play in the planning process and in decisions about what to support?
- How has the HUD requirement for a coordinated community-wide application affected development of CoCs, client access to and receipt of needed programs and services, inclusion of relevant homeless-specific and mainstream players, and data-based decision making?

Who, What, Where, and When?

In 2000, the Department of Housing and Urban Development’s Policy Development and Research Office funded the Urban Institute and its subcontractor, ICF Consulting, Inc., to conduct a study to answer the research questions. This study examined CoCs in all regions of the country. Telephone interviews were first conducted with key informants in each community. Site visits by two-person teams followed, during which researchers interviewed local homeless assistance system planners, providers, case managers, funders, and consumers. Additional documentation included applications for HUD funding, local studies and reports, and local statistics if available.

A sample of 25 of the more than 300 applicants for CoC funding was selected for the study. These applicants could be single jurisdictions or combinations of jurisdictions. Throughout this report we refer to these applicants as “communities.” These communities are distributed throughout the United States, and represent a wide variety of community configurations. They are:

NORTHEAST

1. Delaware
2. Rhode Island
3. Southwestern Pennsylvania
4. Boston
5. Washington, DC
6. Essex County, New Jersey
7. Montgomery County, Maryland

SOUTH

8. Shreveport, Louisiana and 9 surrounding parishes
9. Fort Lauderdale/ Broward County, Florida
10. Orlando/Orange County, Florida
11. Memphis/Shelby County, Tennessee
12. Winston-Salem/Forsyth County, North Carolina

MIDWEST

13. Chicago
14. Balance of Cook County, Illinois
15. Lake County, Illinois
16. Madison/Dane County, Wisconsin
17. Washtenaw County/Ann Arbor, Michigan
18. Columbus/Franklin County, Ohio
19. St. Paul/Ramsey County, Minnesota

WEST

20. Alameda County, California
21. Denver, Colorado and 5 surrounding counties
22. San Francisco
23. Long Beach, California
24. Phoenix/Maricopa County, Arizona
25. Tacoma/Pierce County, Washington

The final sample includes two whole states and four multi-county regional applicants. It also includes one applicant representing an urban county *minus* its largest jurisdiction and one other that were eligible to apply on their own and did so (Cook County minus Chicago and Evanston). Four applicants were counties; two did not have any cities eligible to apply in their own right, and two had four or five such cities that had opted to apply jointly with the county. Lastly, we had five cities on their own and ten city/county jurisdictions. This sample is skewed in several important ways. First, we deliberately selected communities whose CoC applications received high ratings from HUD (22 of the 25 were in the top 10 percent of FY 2000 applicants). Second, many communities were selected specifically because they exemplified something unique and/or potentially interesting that might provide valuable lessons for other CoCs. Third, due to resource constraints, the sample underrepresents both the most and the least populous communities. With the exception of Chicago and Cook County, we did not select the nation’s largest jurisdictions, nor did we have adequate representation of truly rural areas.

Once site visits were completed, the study team summarized and integrated findings for each research issue across the 25 communities, and wrote this report. Where communities are mentioned by name, the text has been reviewed for accuracy by the primary contact we had for that community.

Why This Study Is Important

This study takes the first systematic look at Continuums of Care for homeless people as they have developed in communities across the United States. It examines how development has been affected by the availability of federal funding for homeless assistance programs and HUD's requirement that to get these funds, communities must organize themselves to provide coherent systems of care. Its findings reflect what communities have accomplished and what factors have been most important in stimulating and supporting CoC development. They provide guidance for HUD and for the communities themselves in promoting future development to serve homeless people and to prevent and reduce homelessness.

In 1987, Congress passed the first federal law specifically addressing homelessness. The Stewart B. McKinney Homeless Assistance Act of 1987, later named the McKinney-Vento Homeless Assistance Act, provides federal financial support for a variety of programs to meet many needs of homeless persons. The housing programs it authorizes are administered by HUD's Office of Special Needs Assistance Programs. McKinney-Vento has been a major federal avenue for supporting the development of homeless assistance systems. Funding in recent years has been slightly more than \$1 billion a year.

Emergency Shelter Grant funds support emergency shelter and, to some extent, activities that prevent households at imminent risk from becoming homeless. Emergency Food and Shelter Program funds may also be used for these purposes, as well as for emergency feeding programs. Programs like these were the mainstay of homeless assistance through most of the 1980s.

McKinney-Vento added other program types for which experience with homeless individuals and families during the 1980s had indicated the need. The intention was to offer a federal incentive to local communities to develop comprehensive homeless assistance systems. These systems were envisioned as being able to offer the array of services and skills necessary to address the needs of all types of homeless people—from first-time emergency situations to long-term chronically homeless substance abusers, people with severe and persistent mental illness, people with HIV/AIDS, and other disabling conditions. New program types included transitional housing for families and people with disabilities and permanent supportive housing for people with disabilities through the Supported Housing Program. They also included Shelter Plus Care funds to develop more permanent supportive housing for people with disabilities, and Section 8 Moderate Rehabilitation SRO funding to increase the supply of this type of housing and give homeless individuals priority for its units. In addition, McKinney-Vento monies can be used to fund supportive services either by themselves or attached to the various shelter/housing programs. Also part of the initial premise was that once programs begun with federal funds had proved their merit locally, local governments and other funders would step up and assume funding responsibility for their survival. While McKinney-Vento has stimulated a great deal of local funding as part of its required financial match, most programs begun with these federal funds continue to rely on them, thus creating tensions between the need to continue funding for existing programs and the desire to develop new programs and approaches.

For the first six or seven years of federal funding for homeless assistance programs, HUD did not impose any requirements for *systematic* planning and comprehensiveness at the local level. Emergency Food and Shelter Program funds and Emergency Shelter Grant funds

were and still are distributed on a formula basis to eligible communities. They do not require competitive applications, nor are communities receiving them required to demonstrate how these funds will be used in ways that complement other federal homeless assistance dollars.

Funds from the remaining programs are distributed by the mechanism of national competitions. In 1987 when the first McKinney Act passed, individual programs applied to these national competitions. Only a few communities made serious attempts to plan or structure their homeless programs and services. Most communities could not be described as having “a system,” and providers developed programs for which they saw a need and could find money, without regard to the larger pattern of services in the community.

Just as there was no comprehensive planning or intentional structure to the array of homeless assistance programs and services before the mid-1980s, initial uses of funds under McKinney and later McKinney-Vento increased capacity but were not structured to “complete” a service system. Nor were they structured to assure that homeless people received all the care they needed that the system had to offer. Since 1996, in contrast, the Department of Housing and Urban Development (HUD) has used a competitive application process for the supportive housing programs authorized by McKinney-Vento to promote the development of Continuums of Care (CoCs) for homeless people in communities throughout the nation. The hope has been that by requiring communities to come together to submit a single comprehensive application, HUD could stimulate them to move toward greater structure and a more strategic vision of their programs and services for homeless people. This increased system structure and rationality was expected to improve services for homeless people and increase the chances that their needs would be met.

This study was designed to assess the degree to which these hoped-for changes have taken place.

Key Findings

How Communities Organize Themselves to Respond to HUD and to Homelessness

Trying to categorize, or even characterize, the nature of leadership in the 25 communities we visited stimulates a great appreciation for the truly enormous variety of arrangements that different communities have evolved to plan for and deliver homeless assistance services. Not only are the arrangements many, but in most cases the arrangements seem to be effective in their own setting at achieving the goals the local communities set for themselves. Given the varied organizational patterns and the importance of housing CoC organizing in an enthusiastic entity, federal pre-specification of a CoC planning configuration would run the risk of weakening CoC planning in many communities.

Three general organizational patterns could be identified:

- The CoC leadership in 10 communities has no formal authority. These communities relied on voluntary cooperation, as no entity is really in a position to make anyone else do anything.

- Another 10 communities have public-private arrangements with both a board and at least one government agency playing a strong role. In some of these communities it was reasonably easy to identify which entity was in the lead and which had a support function, but in others it was not.
- In 4 communities, formal independent entities orchestrate homeless planning. These independent entities may or may not be the formal recipient of the HUD CoC dollars and may or may not enjoy support from mainstream agencies.

The final community in our sample cannot be categorized into any of the foregoing groups. Formal control rests with a government agency, which had long handled the CoC application without paying much attention to input from the larger community or the homeless assistance network, although such input was offered. In recent years the process has been opened up and involvement of the larger community is growing.

Several positive results were evident from the CoC process. The CoC process has stimulated significantly increased communication and information-sharing among homeless service providers, and often also among homeless-specific entities and mainstream entities. Information-sharing has, in turn, led to increased coordination of programs and services, both because people know more about the services available from different components of the homeless assistance network and because people who talk together often go on to develop coordinated or joint programming. We found well-functioning year-round larger planning and coordination processes in all configurations, even those with no formal powers.

Other contributors to a CoC's success are worth mentioning. Leadership is essential to effective CoCs, and should be accepted and appreciated wherever it is found. The local environment beyond homeless-specific services plays a key role in determining how well CoC planners and participants will be able to go in fulfilling a vision of a comprehensive CoC or, even better, of ending homelessness. For example, business and corporate interests can be strongly supportive, both conceptually and financially, or indifferent, or resistant.

What Local Homeless Assistance Systems Look Like

The 25 local homeless assistance systems fall into one of three categories:

- Most of the 25 localities view the CoC as a single system covering a locally defined area and including all of the following components—prevention, outreach and assessment, emergency shelter, transitional housing, appropriate supportive services, permanent supportive housing, and permanent housing.
- Eight of the 25 communities have a limited view of a CoC, seeing it mainly in terms of the activities that are eligible for CoC funding from HUD. Their focus is almost entirely on obtaining HUD funding.
- Geographical considerations have led a few communities in this study to have what could be characterized as sub-CoC systems serving different regions within the larger CoC geographical area described in their CoC applications.

In addition to prevention, outreach and assessment, emergency shelter, transitional housing, supportive services, permanent supportive housing, and permanent affordable housing, low/no demand programs play a key role in the provision of homeless services for many communities, and will probably play an even greater part in the future. These alternative approaches complement outreach, emergency shelter, and permanent supportive housing efforts, providing a haven for those whose needs may not be addressed by other CoC components. Finally, respondents consistently said that the principal challenge facing their community in preventing and eradicating homelessness continues to be centered on the lack of permanent affordable housing.

Navigating the Homeless System

Each community uses its own unique approach and method to deliver services to homeless persons. Entry into homeless assistance networks may be broadly classified as:

- **Fragmented**—homeless people may directly approach any provider in the network, may (or may not) gain entry, and may or may not get connected to other programs and services. About three-quarters of our 25 communities would fall into this category, although for four of these only individuals face this fragmentation because family intake is centralized.
- **“No wrong door”**—homeless people gain access by approaching any program, after which program staff augment these first contacts with shared knowledge of what is available and systematic linkages that help clients get to the right programs and services. A few of our communities fall into this category, and a few more would do so if we expanded our concern to include an integrated approach to assessment and service delivery through multi-service centers, in addition to intake.
- **Centralized**—one or a few linked points of entry. According to proponents, centralized entry minimizes prolonged and misdirected searches for emergency shelter and services, and allows for uniform intake and assessment, which helps ensure equity of access to services. Five of our communities have centralized family intake, while one has a centralized intake mechanism in place for everyone.

This summary of intake approaches in these very high scoring CoCs indicates that many communities still have not streamlined homeless people’s access to programs and services. Families are more likely than single individuals to benefit from a centralized or “no wrong door” approach, but even they do not have such access in most of this study’s communities. The most common situation is that both families and single individuals must rely on the case managers at their particular program to help them gain access to the services they need.

Based on access to resources, local philosophies and priorities, and community need, each of the 25 continuums faces challenges in serving certain sub-populations. Each community identified at least one of the following groups as being hard to serve with existing resources—chronically homeless persons with mental illnesses and/or substance abuse problems, youth, large families and/or families with teenage sons, and ex-offenders.

Involvement of Mainstream Agencies and Services

HUD urges communities to take maximum advantage of mainstream services in responding to the needs of homeless people—not just for planning, but for coordination of services, and supportive services to accompany the housing components. Mainstream programs commonly mentioned in this regard include public housing and vouchers programs, food stamps, SSI, SSDI, general assistance, TANF, job training, health care, mental health care, substance abuse treatment, and veteran programs.

Despite recognizing the importance of mainstream services, relatively few of the 25 communities in this study were successful in fully integrating mainstream agencies and systems whose clients include but are not limited to homeless people. On the other hand, a number of the 25 study communities have taken actions to integrate mainstream services and systems into their homeless assistance system. They have used several different strategies, singly or together, which have achieved varying levels of mainstream agency involvement. These strategies, all of which the CoC approach has encouraged and sometimes funded, include:

- Having staff with the responsibility to promote systems/service integration,
- Creating a local interagency coordinating body,
- Having a centralized authority for the homeless assistance system,
- Co-locating mainstream services within homeless-specific agencies and programs, and
- Adopting and using an interagency management information system (MIS).

Communities that recognize that mainstream agencies need to be seriously involved in broader-scale planning and coordination efforts and spared the details of the CoC application process have experienced greater success. Key components to successful integration are strong leadership in the homeless assistance system and a commitment from both mainstream agency leadership and homeless-specific program and service providers to work together.

CoC Planning for and Coordination of Homeless Services

Some communities in this study engaged in extensive planning for and coordination of their homeless assistance programs and services, while others did only what was necessary to get HUD CoC funding.

With respect to the CoC application, HUD requires that communities present a “gaps analysis” showing the gap between “need” and “current inventory” of programs and services to meet that need, and then propose projects for HUD funding that meet at least part of the identified need. The 25 communities in this study usually divided this work into several distinct components. First, a few people did the preliminary work needed to gather the data to determine need and current inventory for the gaps analysis. Second, there was usually broad participation in meetings to accept the gaps analysis statistics and assign high, medium, and low priorities to identified gaps. Finally, agencies developed proposals for submission to HUD

and a committee ranked all proposals for the final HUD application. Participation in this final ranking committee was often less inclusive than participation in the gaps analysis process. Many communities take great care that the ranking process uses clear criteria and is fair to all applicants. To this end many exclude providers with current HUD funding, or those applying for HUD funding, from the ranking process, and also try to include representatives from business, government, and local funders to supply a broad community viewpoint.

The simplest level of planning, pursued by about one-third of the 25 communities studied, focused primarily on the CoC application and the steps necessary to complete it. These communities paid most attention to the types of projects that HUD CoC funds could support (transitional and permanent supportive housing and supportive services), and gave less attention to the larger spectrum of homeless assistance from prevention and outreach to affordable housing. They also tended to concentrate their efforts in the few months leading up to submission of the HUD application, although a few did year-round planning.

Another one-third of the communities in this study operated at a second level of planning, which they pursued year-round planning with a focus on the larger system of homeless programs and services, including the integration of at least some mainstream programs and services. The final group of communities engaged in multi-year, strategic planning for homeless programs and services well-integrated with mainstream services, and usually with a goal of ending homelessness.

One conclusion from this research is that limited planning produces limited results. By focusing on three key areas—broadening the scope of planning, incorporating additional funding sources, and increasing the participation of mainstream agencies—local CoCs will be better able to meet the constantly changing needs of homeless persons and increase their ability to be flexible in the years to come. Planning and coordination of programs and services that is part-year or limited to CoC funding, while meeting HUD's requirements, does not benefit from coordinated funding and long-term planning. Likewise, year-round planning and coordination that only include limited participation by mainstream providers or do not include multi-year planning efforts, do not reap the same rewards as multi-year, comprehensive, strategic planning. Comprehensive, broad-based planning encompassing mainstream services and multiple funding sources benefits from sharing the burden of solving homelessness among many players and relying on having access to a broader array and higher level of resources.

Broader planning is becoming especially important as communities face pressures to develop new programs and services while maintaining what they have. Many of the communities in this study needed their entire allocation of CoC funding just to maintain existing programs. This situation is being referred to as the “renewal burden,” and it is having a profound impact on the flexibility of CoC systems in all communities in this study. HUD could promote additional flexibility with administrative changes related to renewals. For example, HUD could elect to hold CoCs harmless for generating mainstream support for services. That is, any amounts of HUD funding currently going for services (as opposed to housing) that a community could replace with local resources would stay in the community and be available for alternative uses within the CoC. This would both allow communities to broaden their base of financial support for planning, coordination, and service delivery, as well as increase the role of mainstream providers.

How the CoC Application Process Has Shaped Planning and Provision of Services

When HUD introduced the idea of the continuum of care in several stages from 1993 through 1995, the new requirements were imposed on existing local relationships and power dynamics. The relationships, planning structures, and coordination linkages that existed before the CoC funding approach, or the lack of them, have had a major impact on current homeless systems as well as on the applications to HUD.

We identified three categories to describe the transitions in the 25 communities:

- Seamless transitions—7 communities had already established a formal, system-wide planning process for homelessness, and therefore experienced few changes in the way they plan for homeless programs and services as a consequence of CoC requirements.
- From informal/fragmented to structured/comprehensive—10 CoCs had done at least some system-wide planning for homelessness before the HUD CoC requirements took effect.
- From nothing to something—the CoC application process has had the greatest impact on 8 communities that previously had little or no system-wide planning process in place for homeless programs and services. For the first time, these communities brought together providers, advocates, representatives from local government, and other community members who had previously been working on the issue independently, or with minimal collaboration.

As expected, the level of planning that existed before HUD introduced the current CoC funding process has had a great deal to do with subsequent planning for homelessness as well as the application to HUD. Specifically, communities that did significant, system-wide planning for homelessness prior to the HUD CoC requirements have not only had an easier time meeting those requirements, but also tend to have more comprehensive homeless programs and services, more stable planning structures, and more participants satisfied with the planning process and its outcomes. Furthermore, those jurisdictions with stable leadership and firmly entrenched planning structures tend to be more successful in establishing comprehensive, system-wide planning for the application and in providing a reasonably well-coordinated and full continuum of programs and services.

Implementing Data Systems: A Few CoCs Far Ahead of the Rest

Ideally, every community receiving CoC funding would have in place a system that routinely collected data about homeless people and services on an ongoing basis. While the majority of communities have individual providers collecting data, they have not progressed very far toward developing and implementing a comprehensive Homeless Management Information System (HMIS). At this stage in the ongoing development of CoC data systems, there is a long way to go before most communities reach this ideal. This is not due to lack of recognition of the potential benefits of HMIS, but is due to significant barriers including:

- Lack of power to enforce data gathering in cases where the lead agency for the CoC application does not control CoC funds and does not enter into contracts with homeless providers;
- Cost of implementing and operating an HMIS, such as software and hardware purchase and installation, initial training of current homeless provider staff, the salary of a data systems manager, software and hardware upgrades and installation, subsequent training of new homeless provider staff, and ongoing technical assistance as problems arise or specific accommodations are needed;
- Lack of paid or volunteer staff time to spend on implementing and running an HMIS system;
- Concerns about confidentiality of client data;
- Compatibility of different data systems within the homeless service provider network and among mainstream providers; and
- Sharing case management information electronically is a concern for time, confidentiality, and adequacy reasons.

While several of the CoCs we visited have overcome these barriers, stakeholders in many other communities insist that they are insurmountable. Information sharing among different communities at different stages of implementing HMIS may provide the most convincing argument for those communities facing the most barriers to HMIS development.

Of the 8 communities with the most advanced data systems, 5 have a CoC lead agency that not only is charged with developing the CoC application, but also becomes the grantee, receiving CoC funding directly from HUD. This allows the lead agency to enforce data collection through the contracts it writes with homeless providers.

We also found little evidence of well-developed performance measurement systems among the 25 communities visited, with the exception of three communities that were also well advanced in the systematic collection of other information.

Implications for Research

This study was not able to give sufficient attention to issues in truly rural communities (those beyond easy access to a major metropolitan area). Nor did it examine approaches used by *states* to promote CoCs throughout their boundaries. Issues that would be of interest in states that have developed regional or statewide CoCs include their strategies for identifying appropriate geographical boundaries for regions, strategies for organizing regions, and what happens when regional and state levels of government are added to the CoC development and HUD application process. Some states have been very active in creating, motivating, and supporting regional applicants with technical and other assistance, but we do not know much about how they do it, the decisions they face, and the ways they resolve them. These issues would make a good focus for a follow-up research project similar to the present one.

In addition, many questions focus on who needs transitional housing, in what form, and for how long? Likewise, for whom is transitional housing a disservice and placement in permanent units with supportive services to be favored? Research should be undertaken to address these issues.

Finally, it would be good to learn much more about the characteristics of permanent supportive housing programs that work as safe haven/low barrier approaches, and to identify program characteristics that may need to be different for substance abusers, people with severe mental illnesses, and dually- and triply-diagnosed people.

Implications for Practice

- Based on our impressions of the 25 CoCs visited for this study, several steps, stages, or levels, some more sophisticated than others, describe the various stages in which communities may find themselves in developing CoCs and in addressing the ultimate goal of ending or reducing homelessness:

Step 1: Community planning, and perhaps also coordination, activities cover only the homeless-specific programs and services that HUD will fund through the CoC application. Little if any participation occurs from non-homeless programs, or even from emergency shelter and prevention providers.

Step 2: Community planning and coordination extends to all homeless-specific programs and services, including emergency shelter, outreach, and prevention, incorporating planning for Emergency Shelter Grant monies and perhaps also Emergency Food and Shelter Program funds in the same process.

Step 3: Significant involvement of mainstream agencies for service delivery to people involved with homeless-specific programs and services. These mainstream representatives may include agencies with responsibilities for services related to alcohol, drug, and mental health problems; public health; employment and training; public schools; welfare and cash benefits; public housing; and Veteran Affairs. They may be public or private nonprofit agencies, but usually are public, or at least publicly funded.

Step 4: Once communities achieve Step 3, which is no small feat, and experience its benefits for several years, they may realize that just as many people are coming into the system as ever. They may then rethink their approach. When they do so, the results are usually an even greater involvement of mainstream agencies, this time geared to prevention and expanding the availability of affordable housing. The prevention aspect usually focuses on mental health, substance abuse, and even corrections agencies doing a better job of assuring that people released from their facilities have stable housing and any supportive services that are needed to prevent them from ending up homeless. In addition, resources to avert eviction, pay rent or utility arrearages, do some financial counseling, and otherwise handle situations of imminent homelessness, usually for families, often play a significant role on the prevention side. The affordable housing aspect means doing something serious about the often impossibly tight, and expensive,

housing market facing homeless and other very poor people, and requires a very long-term vision and commitment.

- Communities will not be likely to progress much beyond Steps 1 and 2 without the support of mainstream agencies, local (and sometimes state) governments, and the local business community and other power brokers.
- Local, state, and regional attitudes toward public responsibilities also make a huge difference, as does the basic level of resources. Our 25 communities are located in states that (1) have many resources and are committed to use them, (2) have (or could have) reasonable levels of resources but are opposed to both taxation and public action, and (3) have few resources but are willing to use whatever they have. It should be clear that communities in states of the second sort will get no help from outside, while those in states of the first and even the third sort have distinct advantages.
- Even with strong mainstream agency support and the local power structure on board, it makes a huge difference what one is trying to do. A few of our communities are very well organized and have strong local support, but focus their energies primarily on helping people who are already homeless. A few others have spent a number of years in that situation and have now begun to move toward stopping the flow into homelessness, creating permanent supportive housing for the chronically homeless people in their community, and addressing the desperate need to create more permanent affordable housing for all very poor people.
- The ability of no/low barrier permanent supportive housing programs to create stable housing environments for chronically homeless people taken right off the streets suggests that policymakers and practitioners should be paying more attention to learning how this works where it succeeds, and worry less about strict adherence to theories of rehabilitation and recovery that may have the effect of excluding significant numbers of homeless people from programs and services.

Implications for Policy

- In every community we visited, respondents cited the severe lack of affordable housing as affecting both the level of homelessness and the ability of programs to move people from shelter back into permanent housing. Problems cited included rental vacancy rates of 1 percent or less, average rents 15 to 25 percent above Fair Market Rents, a lack of apartments accepting Section 8 vouchers, zoning and other legal restrictions on SRO and other low-income housing developments, and destruction of public housing units. Respondents were near-unanimous in feeling that their community will not be successful in ending homelessness until it can produce more housing and make it affordable to very poor people, including single people with disabilities.
- Whatever research ultimately shows about the utility of transitional housing, respondents brought up many issues with regard to the inconsistencies in the length of services allowable for people in different configurations of transitional housing. These could be anywhere from 30 months at the most to less than 12 months, depending on how long

clients live in a transitional housing facility before leaving. It was suggested that, to eliminate current inequities, HUD might allow programs to offer clients up to 24 months of transitional supportive services, regardless of where they live.

- Effects of the CoC funding structure and implications for policy.
 - There was little question among respondents in most of the communities in this study that HUD's CoC funding structure has moved them toward significantly greater planning. Further, that planning has come over the years to encompass a broader scope, and in many communities to involve more players. Where community respondents felt the CoC structure had not made much difference, they were already very well organized before 1996 and tried to cover the range of homeless assistance from prevention to permanent supportive housing.
 - In addition to planning, the CoC process has resulted in significantly higher levels of shared knowledge about what is available in the community, more program and service coordination, better referral networks, and development of new joint projects. It has also produced a good deal of cross-jurisdiction cooperation that never happened before, or never happened with respect to homelessness. Eligible geographical areas such as smaller cities and counties have been drawn into larger planning and service systems, and are not either "going it alone" or doing nothing about homelessness.
 - We conclude that HUD's adoption in 1996 of a community-wide approach to distributing its competitive homeless assistance dollars has moved communities further in the direction of broad planning and program development than would have happened without the CoC approach. The ensuing networks of programs and services have been able to offer more support to homeless people, with more cohesion, than would otherwise have been possible. Of course there are never enough programs and services to meet all needs, but the communities in this study come closer to doing so in part as a result of the CoC approach. The mechanism that has brought communities together to accomplish this result should be maintained and strengthened.

CHAPTER 1: INTRODUCTION AND OVERVIEW OF THE STUDY

Introduction

This project was designed to examine the success of a strategy for creating functioning continuums of care for homeless people. Many federal agencies have spent years “suggesting” a collaborative approach to communities and programs. But even when federal program managers have clear ideas about what service structures they think would best serve the clients of their programs, they often do not have the authority to make these happen at the local level. Federal funding mechanisms such as block grants, formula grants, or single-focus competitive funding streams frequently leave federal officials without the leverage to require service components and service structures that have been shown to work. State officials managing similar programs often labor under equivalent restrictions.

HUD’s current funding strategy for homeless assistance programs took advantage of HUD’s control of several funding streams for homeless assistance programs authorized by the McKinney-Vento Homeless Assistance Act. The McKinney-Vento Act authorizes Emergency Shelter Grants (ESG) and several programs to fund transitional and permanent supportive housing, including the Supported Housing Program (SHP), Shelter Plus Care (S+C), and the Single Room Occupancy Program (SRO). ESG funding is distributed by formula to eligible jurisdictions, but all other HUD McKinney Act programs are funded through a competitive grants process. From 1988 through 1993, HUD held national competitions for its homeless assistance program funds every year, for which individual agencies throughout the country wrote applications. Starting with the 1994 funding cycle, HUD changed the nature of this competition with the intent of stimulating more community-wide planning and coordination of programs for homeless people. Under the new approach, HUD required whole communities to come together to submit a consolidated application rather than allowing applications from individual providers. This new competitive structure created an enormous federal “carrot” of combined funding for homeless assistance that was only available if communities “got it together.” This carrot was supported by a structured application process, which we will call the “Continuum of Care (CoC)” application, and ultimately backed up by the “stick” of communities receiving no money if an application did not demonstrate sufficient adherence to the concept of a continuum of care.

Understanding how this approach worked “on the ground” in many localities was the purpose of the present research. Findings can provide valuable insights to help guide the structures of both federal funding and local continuums in the future. The project examined CoCs from several perspectives:

- The array of programs and services available in a community;
- The extent of involvement of homeless and nonhomeless programs and services in the network;
- The extent of program and service coordination and integration; and

- The extent to which clients needing particular programs, services, or benefits could get them.

The project was able to address a final, very important issue with respect to CoCs based on the impressions of key informants—whether a complete and well-functioning CoC is more effective at reducing or ending homelessness than an incomplete and/or less integrated one. However, it was not able to substantiate these impressions with actual performance data. Very few communities currently have the data that would be necessary to assess system performance of this type, so no definitive examination of this issue is possible. The project did, however, explore people’s perceptions of whether their CoC served homeless people better than the previous arrangements, as well as the progress being made in various communities to develop and use performance data.

Background

The Growth of America’s Shelter Capacity in the 1980s and 1990s

Organized systems of programs serving homeless people have been a long time coming in the United States. Many safety net and antipoverty programs to address the needs of the country were instituted during the New Deal in the 1930s and the War on Poverty in the 1960s. It was not until the mid-1980s that homeless-specific programs and services were seen in more than a handful of major U.S. cities, while in rural areas the New Deal and War on Poverty programs, which are not homeless-specific, offered the primary assistance to any rural poor who experienced homelessness, and are still the backbone of rural homeless assistance today.

During the early 1980s and before, urban homeless assistance was provided primarily by missions and soup kitchens operating with a religious or charitable motivation. Located almost exclusively in old “skid row” areas of the nation’s cities, these programs usually received no government funding and offered the bare minimum of meals or overnight shelter. They did not form a coherent system of care, did not assess local need for service and try to fill gaps, and were focused primarily on serving a single male homeless and near-homeless clientele.

During the recession of 1981-1982 emergency shelter and meal services experienced a significant increase in demand. The recession aggravated circumstances that had been developing and converging during the previous decade, and which continued to worsen throughout the 1980s. These included changed incentives for landlords to provide rental housing, destruction of SRO housing, dwindling supplies of housing affordable to poor people, less adequate supports for people with severe mental illness, and changing labor markets for people with less than a high school education. In the early 1980s, for the first time, single women, women with children, and two-parent families added substantial numbers to the single males who had until that time comprised most of the people seeking help from shelters and food programs.

The sheer volume of demand coupled with the shifting nature of the population caused the country to focus on homelessness as a serious national issue for the first time since the Great Depression of the 1930s. In 1983, Congress took the first step to involve federal resources in providing services to homeless and hungry people through the Emergency Food

and Shelter Program, operating out of the Federal Emergency Management Agency. In addition, HUD made the first federal attempt to describe the scope of the shelter system nationwide and estimate the size of the homeless population using systematic sampling techniques (HUD, 1984). That study estimated that nationwide in 1984 there were about 100,000 shelter beds, found in approximately 1,900 shelters.

By the late 1980s, several additional estimates of the country's growing shelter capacity had been developed. HUD's second national survey of shelter supply, conducted in the summer of 1988, estimated that the national availability of shelter beds had grown to 275,000 in 5,400 shelters (HUD, 1989). Not only was this almost three times the number of beds and shelters estimated for 1984, but funding sources had also shifted dramatically. HUD found that about two-thirds of 1988 shelter funding came from government sources. This doubled the proportion of shelter funding from government sources in 1984, from one-third to two-thirds. It also increased the actual amount of funding tenfold, from about \$100 million in 1984 to about \$1 billion in 1989 (HUD, 1989, pp. 17-18). HUD also found that approximately 40 percent of shelter occupancy was accounted for by women and children in family groups (up from 21 percent in the 1984 survey). Both constituted profound shifts from earlier decades. In a few cities (New York, Philadelphia, and Washington, DC), right-to-shelter laws added significantly to these numbers, but virtually all of those assisted received emergency shelter (including hotel/motel) accommodations with few or no attendant services.

Two additional studies that produced estimates of shelter capacity focused exclusively on the nation's largest cities (those with 100,000 or more population). The Urban Institute's 1987 study (Burt and Cohen, 1989), conducted for the USDA's Food and Nutrition Service, estimated the number of shelter beds in these cities in March 1987 at about 120,000. Burt (1992) also was able to track the growth of shelter capacity from 1981 through 1989 in the cities she studied. She found that about one-third of the growth of shelter capacity in these years occurred in the last three years of the period, during 1987, 1988 and 1989. This growth spurt coincided with the first availability, in 1987, of significant federal funding for shelter programs through the McKinney Act.

The McKinney Act provided, for the first time, a source of federal support for new types of shelter for which service providers and advocates were identifying the need. These included transitional housing to help homeless families and single persons with disabilities acquire the skills to maintain themselves in conventional housing, and permanent housing for homeless persons with handicapping conditions serious enough to preclude their achieving and/or maintaining independent and secure housing. The McKinney Act also included support for other elements of what would come to be known as a continuum of care. These included the Emergency Shelter Grant Program, and outreach to street homeless persons and some prevention efforts through the Emergency Food and Shelter Program (which the McKinney Act finally authorized as a permanent program after six waves of emergency funding).

The latest information about homeless assistance system capacity comes from the National Survey of Homeless Assistance Providers and Clients (NSHAPC), conducted by the U.S. Bureau of the Census in 1996 for 12 federal agencies on the Interagency Council on the Homeless (Burt et al., 1999). Burt and her colleagues (Burt, Aron, and Lee, 2001) estimate that, by 1996, emergency shelter capacity (including distribution of vouchers for emergency accommodation) had increased by about 12 percent since 1988, from about 275,000 (HUD, 1989) to about 307,000. However, expected use of transitional and permanent housing

programs for homeless and formerly homeless people totaled an estimated 275,000 beds per night (160,000 transitional and 115,000 permanent housing beds), equal to the total of emergency shelter accommodations in 1988. Further, this capacity for extended and/or permanent housing within a homeless assistance network essentially did not exist at all in 1988 or earlier. No one disputes the role played by McKinney Act funding in the development of this part of the service network. And there was a great need for more assistance to homeless people, as use of the resulting system attests.

Level of need also was evidenced by growth in the number of prepared meals offered by soup kitchens and similar programs. Reliance on meal programs for food has increased greatly between 1987 and 1996, more than threefold in central cities, the only type of jurisdiction for which data from the 1980s exist for comparison (Burt, Aron, and Lee, 2001). This growth occurred with far less federal support than was available for shelter/housing programs, although in many rural communities it would not have happened without funding from the Emergency Food and Shelter Program and U.S. Department of Agriculture grants targeted to emergency food providers.

Growth of the Homeless Population

Obtaining estimates of the size of the homeless population during periods corresponding to this growth in homeless assistance program capacity is a great deal harder, and correspondingly less satisfactory, than estimating changes in the program capacity itself. A bed today is the same bed tomorrow—what one can count on any given day is likely to be the same as what one counts on any other day unless system capacity has increased significantly, and that too can be known with some precision. But a person counted as homeless tomorrow may be someone who was not homeless today. Incidence, the number of people homeless today, is not the same as prevalence—the number of people homeless over a specified length of time such as a year. Data from some cities can supply the latter, but to date and for the foreseeable future, the only type of information available for national statistics relates to incidence.

Basically, there are only three sources or original data on which to base estimates of incidence (the number of people homeless on a single day) for the nation as a whole—HUD's 1984 effort (HUD, 1984), the Urban Institute's 1987 study (Burt and Cohen, 1989), and the 1996 National Survey of Homeless Providers and Clients (Burt, Aron, and Lee, 2001). Any national estimates offered by anyone for any years other than 1984, 1987, and 1996 are projections or manipulations of one of these three data sources, and include assumptions of population change or growth that are not grounded in data. HUD's 1984 study was based on a survey of providers, who supplied their best guesses as to the size of the homeless population in their cities. Only the 1987 and 1996 studies are based on statistically reliable samples of homeless people using homeless assistance programs. Using these three data sources, the number of people homeless at any one time appears to have grown substantially from the mid-1980s until the mid-1990s—from 250,000-350,000 in 1984 (HUD's "most reliable range") to 500,000-600,000 in 1987, to 640,000-840,000 in 1996. Best guesses or projections of the number of people homeless during the course of a year come from various different sources (Burt, Aron, and Lee, 2001; Culhane et al., 1994; Link et al., 1994, 1995) (there are no truly reliable national data). These estimates, using very different approaches, nevertheless converge on figures that between 2.5 and 3.5 million people (including children) experience at least one night of homelessness within a given year.

The Need for Continuums of Care

Just as there was little comprehensive planning or organization to the array of homeless assistance services before the mid-1980s, neither were initial uses of funds under the McKinney-Vento Act increased capacity structured to “complete” a service system. Nor were they structured to assure that homeless people received all the care they needed that the system had to offer. Emergency shelter grants were (and still are) awarded to government agencies in the largest 300 or so communities eligible for Community Development Block Grant (CDBG) funding. Award levels are determined on a formula basis, using the (CDBG) allocation formula. Funding for specialized housing and service programs such as transitional and permanent housing was awarded through statutorily-required national competitions every year. The availability of these federal funds spurred a dramatic growth in shelters appropriate for families, and in transitional and permanent housing programs for people attempting to leave homelessness. Further, local governments and private sources increased their financial support for these services in part because a local match was required to access the federal dollars.

Applicants for McKinney-Vento Act support to create transitional and permanent supportive housing programs could be, and usually were, individual shelter or housing programs. Applicants were not required to document local planning or service coordination, and usually little such coordination existed locally. Applications had to justify that a need existed for the services they proposed to offer, but did not have to show where those services fit into the entirety of services available in their community, or that theirs was the best use of the next homeless assistance dollar.

It was the norm during this period that government agencies had a hard time keeping track of what services were available, what was being applied for, and what was on the drawing boards. They had formal sign-off authority, meaning they could block an application, but since they could not require that the same amount of money be redirected toward activities that had been shown to be of greater need, they rarely did so. Indeed, they often had little way to determine what the greatest needs were, as few had established any methodical approach to collecting data about service levels or demand for services. In some jurisdictions, the responsible government agency chafed at these constraints, but in many others government agencies wanted little to do with homeless services, and signed off with little attempt at oversight. The lack of care systems and the difficulty of creating them was amply documented in HUD’s intensive investigation of homeless assistance services in five cities, done at the same time as its 1988 shelter survey (Division of Policy Studies, 1989).

First Efforts Toward Continuums of Care

During the late 1980s and early 1990s, some communities responded to the relative disorganization of homeless assistance services by trying to introduce some control and structure. Boston and Columbus/Franklin County, Ohio were among the earliest to do so, with Columbus/Franklin County instituting a shelter tracking database to document need and help make resource allocations, and Boston inaugurating regular surveys (first in 1983, and then annually from 1986) to assess needs. Both communities placed responsibility for planning and resource allocation in the hands of a single shelter board, which also strove to control all public (and much private) funds going into homeless shelter and housing programs. In New York City, the New York City Commission on the Homeless (1992) devoted considerable thought to what

an excellent system of care might look like and produced one of the first articulations of a continuum of care.

To make continuums of care the norm rather than the exception, a strong incentive is essential. HUD introduced the idea of a continuum of care as part of homeless service planning as early as 1994 (Interagency Council on the Homeless, 1995). HUD provided the financial incentive through its reorganization of the way it distributed McKinney-Vento funds. During the FY 1995 funding cycle, HUD gave additional points in its rating of applications that showed evidence of coordination with other services. The biggest step came in FY 1996, when HUD made three major changes. First, HUD required applications to come from whole communities rather than from individual programs. Eligible entities were any county, every city that was designated as having an entitlement to a block grant under the Community Development Block Grant (CDBG), and states or substate regions covering the balance of a state. Second, HUD combined the different competitive funding streams and allowed communities to determine the best uses of HUD homeless dollars. Third, HUD developed a formula that produced a preliminary estimate of how much money a community could expect to get if it wrote a good proposal. HUD published these preliminary estimates in the Notice of Funds Availability and in the Federal Register to give communities a reasonable idea of the amount of money they could plan for. Publication had the additional advantage of allowing people in communities without CoC funding to see what they could get if they only submitted an adequate application. The “carrot” of money motivated quite a number of communities to get organized and apply.

To emphasize that an application should represent the whole community, HUD structured its rating of applications to encourage each community to submit a formal application from a single entity, and allowed any entity that could organize a community-wide process to be that applicant. Applications from individual programs that did not go through a large consolidated or coordinated CoC application were at a severe disadvantage under the new rating approach, and seldom received funding. The same disadvantages applied to communities submitting competing applications covering the same geography. However, eligible jurisdictions were encouraged to combine into broader CoCs if they wished to do so and could organize themselves locally.

An essential requirement for these applications was and still is community-wide cooperation among providers, relevant government agencies, and other community interests. Every provider wanting HUD’s competitive homeless assistance dollars had to work together to develop a coherent plan and submit a joint application. The application had to document the existing stock of different kinds of shelter and housing for homeless and formerly homeless people, and the level of need as indicated by homeless population size and characteristics. It had to use this information to identify gaps in services, and to request funding to fill the gaps following a locally-developed ranking of projects against greatest need.

As the years went on, HUD imposed increasing requirements for local data about services and homeless populations to document the gaps identified and justify the priorities placed on filling them. During funding reviews, applications were rated against a set of criteria for how well need was documented and how well-justified were the rankings for new projects. “Continuum of care” thinking became an essential criterion against which applications were judged. Under the competitive structure with the new CoC criteria, some jurisdictions received no CoC funding because their applications did not reflect a sufficiently thoughtful approach or involvement of the necessary players. Other jurisdictions, in contrast, ultimately received more

(sometimes two or three times more) than their preliminary formula allocation because their plans were so well developed.

As defined by HUD, a full CoC includes seven components—prevention, outreach and assessment, emergency shelter, transitional housing, permanent supportive housing, permanent affordable housing, and supportive services. Figure 1.1 depicts the first six of these components in ovals, arrayed in a circle to indicate that there is no required direction or set of steps that every homeless person is expected to pass through. The solid arrows in the figure reinforce this lack of linearity, showing that people may pass from outreach to any one of the housing components, or from emergency shelter directly to transitional, permanent supportive, or affordable housing. The supportive services component is shown at the bottom of the figure, with broken arrows leading to each of the other six components. Supportive services of many varieties are essential to the successful fulfillment of every component in the continuum.

CoC funding from HUD can only be used for two elements of a full CoC—transitional and permanent supportive housing and associated services. Over the years the incentive of federal funding has brought more and more jurisdictions along toward having an operational continuum of care. The CoC approach appears to have changed the name of the game, and how the game is played. The question of how much this is true has been the key question of this research. Four key concepts and their associated research questions guided this project:

- **What do local homeless assistance networks look like? How do they work? How well are programs and services coordinated? For whom? Do they serve all/most/only some homeless people? Can homeless people get the programs and services they need?** After documenting the continuum of services itself, chief among our concerns has been to observe, from as many points of view as possible, how people get into the system of care; how services are marshaled to help them address barriers to leaving homelessness; and variations related to particular subgroups among the homeless. We looked at the degree to which the actual services available to homeless people, either supported by HUD or not, homeless-specific or available to all, provide a real continuum including the types of service needed by homeless people in the community. Equally important, we observed the degree to which homeless people actually receive the various services, either at their point of entry into the system or throughout their tenure in it. Likewise, we documented the mechanisms being used (case management, team meetings, referrals, co-location, etc.) to assure that homeless people receive services that are appropriate to their needs, in a timely and respectful fashion. Finally, we examined how service delivery has changed over time, and what it took to create the changes.

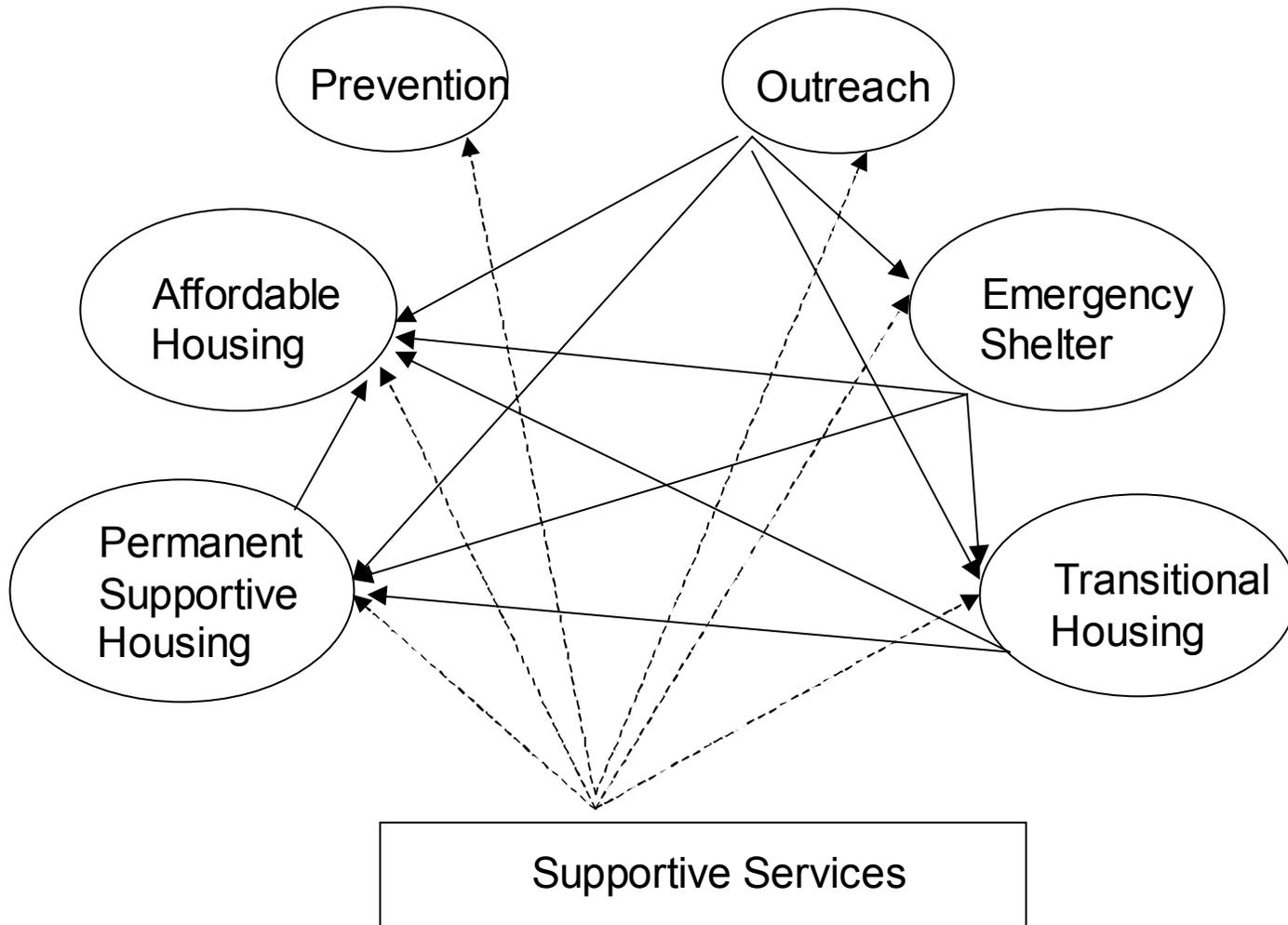


Figure 1.1: Model of a CoC

- **Are all the important players, or their representatives, included in planning the local CoC? In receiving funding to offer programs and services? In coordinating with each other?** We examined the degree to which the CoC planning and service strategizing process, including the work to develop HUD CoC applications, involves all sectors of local communities with a stake in homeless services. Groups of interest included homeless people themselves and people who could reflect on particular services (including both homeless-specific and mainstream—i.e., not homeless-specific—services) and the linkages necessary to provide appropriate services. We looked at whether each player’s level of involvement was significant and powerful, and how and why inclusiveness has changed over time. We also looked at how programs and services are coordinated, and how the planning effort has influenced this coordination.
- **Where do HUD-funded programs and services, and homeless-specific programs and services in general, fit in the context of other systems and services in the community—that is, mainstream services? How well are homeless and mainstream services integrated? What goals is this jurisdiction trying to accomplish with its CoC, and how does it define “continuum” as part of those goals?** We examined where the homeless assistance system fits in the context of mainstream housing, emergency response, health, welfare, alcohol, drug, and mental health, employment and training, and other services in each community, with respect to planning, funding, service structure, and service delivery. We ascertained how jurisdictions conceive of a “continuum of care,” including which clients it serves, how it serves them, where it locates services, and how it connects people to services. To the extent that concepts (and realities) of continuums vary, we examined the major types of continuums and tried to understand how they work. We also developed an understanding of homeless outreach and prevention (and aftercare) services as part of an extended network of services, whether delivered by homeless-specific or mainstream agencies.
- **What role do explicit data or statistics play in the planning process? Where do the data come from? How helpful are they? What types of information are needed and what steps are being taken to get it?** We examined the degree to which jurisdictions have in place one or more systems or mechanisms for generating information about the demands on the service system (numbers of clients and flow into and move around in the system), needs of homeless people, availability of services, actual consumption of services by homeless people, and/or success of the service system in meeting the needs of users. We asked how the availability and use of data has changed over time, and why. In addition, we asked how the jurisdiction thinks about measures of performance; what it might be using as performance measures; whether their present practice helps them make policy decisions and if so, in what ways; what respondents would like, ideally, to have as performance indicators; and where they are going with performance measurement. Part of the issue here was whether the communities are trying to measure outcomes for homeless people, and whether respondents are satisfied with what they are doing or are trying to do more.
- **How has the HUD requirement for a coordinated community-wide application affected development of CoCs, client access to and receipt of needed**

programs and services, inclusion of relevant homeless-specific and mainstream players, and data-based decision making?

As already noted, because the relevant local data do not exist, we were not able to address the question of how successful CoCs have been at ending or reducing homelessness. As communities focus more on performance data and begin making decisions related to such performance, future work will perhaps be able to address this question more successfully than could be done for this project.

Methods

The basic approach to this evaluation was to focus on 25 applicants for CoC funding. Applicants could be single jurisdictions or combinations of jurisdictions. Throughout this report we refer to these applicants as “communities.” The goal was to select a sample of communities that would represent the full range of applicant types, from single cities to whole states. The first criterion for selection was that the community had received a rating of its CoC application of at least 80 from the Office of Special Needs Assistance Programs (SNAPS), the HUD office that processes the CoC applications. A rating of 80 or higher puts the communities we were to visit into the top 50 percent of CoCs in the FY 2000 competition. In fact, 22 of the 25 were in the top 10 percent, with 11 in the top 5 percent. We also tried to select communities that had made some progress in developing homeless data collection, up to and including having a homeless management information system (HMIS). Beyond these two criteria, we tried to maximize variation on type of lead agency, region of the country, and type of community.

Discussions with SNAPS staff brought to light interesting aspects of particular jurisdictions that made them attractive to visit. These included forward-looking planning activities (e.g., multi-year strategic planning), boundary issues (e.g., being a single-city applicant surrounded by a separate county CoC; being an urban fringe county and/or a county at a state border), and a pattern of subCoCs based on geography within a larger geographical area (e.g., each county within a multi-county regional applicant, cities within a whole-county applicant). Ultimately, communities were selected to include some in which we could examine these patterns and practices.

The results of the site selection process are presented in table 1.1. They gave us two whole states, four regional applicants, one “balance-of-county” applicant, four counties without a major single population focus, five cities, and nine city/county jurisdictions. This was two more regional, one less city, and one less city/county applicant than we thought at the time of selection, as Denver, Colorado and five surrounding counties cooperate in one combined application, and Orlando/Orange County, Florida now applies with two adjacent counties. The communities selected gave us good geographical balance around the country.

Columns 4, 5, and 6 of table 1.1 provide additional information about the communities we visited. Column 4 shows the number of CoC geographical areas that make up each community. CoC geographical areas are those listed on the first page of the CoC application’s Exhibit 1, and include all cities and urban counties entitled to receive Community Development Block Grants, all other counties, and any state. The range is 1 to 14, with 19 applications including 5 or fewer. Column 5 indicates the number of counties, cities and “minor civil jurisdictions” of 10,000 or more inhabitants, and the state for Delaware and Rhode Island, within

Site	Location	Type of Community	Number CoC Geographical Areas	Number Counties, Cities and Towns¹	CoC Convener Agency Type²	Special Characteristics
Delaware	Northeast	State	5	7	P+	Sub-CoCs, major changes
Rhode Island	Northeast	State	2	29	P+	
Southwestern Pennsylvania	Northeast	Regional	5	13	P+	Sub-CoCs
Boston	Northeast	City	1	1	P+	
Washington, DC	Northeast	City	1	1	I	Original "CoC" city, with DC Initiative in 1994
Essex County, New Jersey	Northeast	County	5	16	P+	
Montgomery County, Maryland	Northeast	County	1	4	P+	Urban/suburban county
Shreveport, Louisiana and 9 surrounding parishes	South	Regional	11	13	P+	Site where Bowman data system developed
Ft. Lauderdale/Broward County, Florida	South	City/County	14	30*	G	Full-service points of entry
Orlando/Orange County, Florida ³	South	City/County	4	15	P	
Memphis/Shelby County, Tennessee	South	City/County	2	4	P+	Dual committees
Winston-Salem/Forsyth County, North Carolina	South	City/County	2	2	P+	
Chicago	Midwest	City	1	1	G	Part of 3-jurisdiction focus; strategic planning; major changes
Balance of Cook County, Illinois	Midwest	Balance of County	12	125*	P+	Part of 3-jurisdiction focus
Lake County, Illinois	Midwest	County	3	13	G	Part of 3-jurisdiction focus; state border
Madison/Dane County, Wisconsin	Midwest	City/County	2	5	P+	
Washtenaw County/Ann Arbor, Michigan	Midwest	City/County	2	28*	G	
Columbus/Franklin County, Ohio	Midwest	City/County	2	26*	I	Strategic planning, long- standing data system, mainstream investment
St. Paul/Ramsey County, Minnesota	Midwest	City/County	2	10	G	
Alameda County, California	West	County	10	16	G	Sub-CoCs
Denver and 5 surrounding counties, Colorado	West	Regional	12	34*	P+	

TABLE 1.1: DESCRIPTION OF SITES INCLUDED IN THE STUDY

Site	Location	Type of Community	Number CoC Geographical Areas	Number Counties, Cities and Towns ¹	CoC Convener Agency Type ²	Special Characteristics
San Francisco	West	City	1	1	G	
Long Beach, CA	West	City	1	1	G	City separate from huge LA County system
Phoenix/Maricopa County, Arizona	West	City/County	9	24*	I	
Tacoma/Pierce County, Washington	West	City/County	3	4	G	

¹Entries marked by an * were supplied by the community's own 2001 CoC application or by convener in response to UI inquiry. Remaining entries are the number of incorporated cities and civil jurisdictions of 10,000 or more (based on 1996 projections from 1990 data) as listed in Gaquin, Deirdre A. and Dodge, Richard W. (eds.), *Places, Towns, and Townships, 1998*, 2nd Edition, Table A, Lanham, MD: Bernan Press, 1998.

²G = government agency; P = entity made up mostly/entirely of providers; P+ = council or board with providers and significant representation of other entities; I = independent entity that is neither provider nor government. The designation reflects the affiliation of the person named as convener on the application summary page

³ Applicant community also includes Oseola and Seminole Counties.

the geographical boundaries of the applicant community. Here the range is considerably greater, with only the five city applicants remaining at one jurisdiction and 14 communities containing 10 or more such civil jurisdictions. The rather large number of civil jurisdictions in many CoC communities attests to the ways that the CoC process has stimulated cooperation and development of coherent program and service networks across jurisdictional boundaries.

Column 6 reveals the four types of entity that serve as the formal CoC applicant for their community. The two most common types are a broadly-based board or council that includes providers, government representatives, advocates, and other interested parties (12) and a government agency (9 communities). In three communities the applicant agency is an independent nonprofit entity that is neither government nor provider, nor dominated by providers. In a final community the applicant agency is a board on which homeless assistance providers predominate. These are only the formal "conveners" of the application process. As discussed at length in chapter 2, actual decision making arrangements are highly variable across communities, and are not adequately reflected by a simple knowledge of which entity formally "convened" or orchestrated the CoC application process.

The final sample is skewed in that it underrepresents both the most and the least populous communities. With the exception of Chicago and Cook County, the nation's largest jurisdictions were not selected because we thought they would be too hard to cover in the short time we would have on site (Chicago proved that assumption to be correct). We also did not have adequate representation of truly rural areas. The two states we included (Delaware and Rhode Island) are both small and function more like large counties. The one regional CoC we included (southwestern Pennsylvania) allowed us to glimpse but not pursue the complications introduced with the involvement of multiple levels of government (adding the state to regional and local decision making bodies). Further, this regional CoC surrounds Pittsburgh and its

county, giving its residents meaningful access to a major urban area and its programs and services and making it different from many truly remote rural areas.

What could not be known beforehand, but became clear in the course of site visits, is that applicant communities faced very different conditions that affected their ability to create and maintain continuums of care, and to serve all the homeless people who might need help. Some of these conditions, whose influence will appear in various places throughout this report, include different levels of local investment, different relationships to surrounding jurisdictions and institutions, and a “hometown” versus an “absentee” attitude of people and institutions with significant resources. Chapter 9 discusses these and other differences among CoCs.

After reading application and other background materials, teams of two researchers from the Urban Institute or ICF Consulting visited each community for two or three days of interviews and observations. We were particularly interested in obtaining a variety of perspectives on the homeless assistance networks in communities visited, including the views of people who might be dissatisfied with them as well as people who were pivotal in creating them. We also wanted to know how the “system” felt to those who had to try to make it work for them—case managers and clients. To this end, interviews were held with people representing all aspects of homeless planning, programming, service delivery, and advocacy in the communities. We met with representatives of the lead CoC agency or agencies; the CoC planning board or committee; provider groups; mainstream agencies; and advocates. We deliberately held interviews with people who might have some criticisms of the CoC process and its results, or who might be somewhat outside of it. To learn about data availability, we interviewed people responsible for any data systems that existed, or were about to exist. To learn about access to and use of programs and services, we interviewed case managers for homeless single men, single women, and families. Finally, we held focus groups with homeless clients in about half the jurisdictions, to get their perspectives on system accessibility and appropriateness to their needs. The teams also collected extensive written materials.

The Rest of This Report

Chapter 2 briefly examines the things that seem to make or break a CoC—power and people—by presenting the variety of mechanisms through which communities orchestrate their homeless assistance systems, and the ways that the dedication and talents of particular individuals make a difference. Chapter 3 summarizes the basic structures of CoCs in the 25 communities we visited. Chapter 4 describes how homeless people gain access to CoC programs, and how they move about in the CoC with the ultimate aim of leaving homelessness. Chapter 5 focuses on the ability of the different communities to involve mainstream agencies in their planning and service delivery—that is, to move beyond strictly homeless-specific services toward a full continuum from prevention to affordable permanent housing. Chapter 6 describes the planning process for homeless services, including its scope, the nature and activities of the CoC lead agency and affiliated structures, the ways in which different stakeholders are involved in different parts of the planning process, issues related to renewals and flexibility, and multi-year strategic planning. Chapter 7 summarizes the history of homeless service planning and coordination in the 25 communities and the way it has affected the present planning efforts. Chapter 8 examines issues related to data on homeless people and services, and the growth, or lack of development, of homeless data systems. Chapter 9 offers a summary and draws out implications of our findings.

Caveats

We visited only 25 CoCs, and they were not randomly selected. We make no pretense that they are a representative sample—in many ways they were selected specifically because they exemplified something unique and/or potentially interesting that might provide valuable lessons for other CoCs. In addition, completely rural CoCs beyond the proximity of a major population center are not adequately represented.

The applications from the CoCs in the study received quite high ratings from HUD, which again means they are not “average.” We expect that most CoCs in the United States struggle with the same issues as these 25, and that many of them have not, or not yet, done as well as our sampled communities in resolving them. Some of the communities we visited are relatively new to the CoC process, as HUD has pushed in recent years to extend the CoC concept to rural regions and whole states. Even among the 25 communities selected, therefore, the reader will encounter considerable differences in the scope of their planning, service development and coordination, and wider community commitment to developing a full CoC. For these reasons, we have tried to refrain from presenting findings in terms of percentages or proportions, to avoid any impression of over-precision or urge to over-generalize. Any time a community is mentioned by name, the information is either taken from public documents (as in the case of current inventory of beds from the CoC application’s gaps analysis chart) or the description has been reviewed for accuracy by representatives of the community and accepted as accurate or corrected as necessary.

A Word on Numbers, or their Absence

Some issues addressed in this report, lend themselves to relatively precise analysis and others do not. For a few issues, such as the nature of the CoC applicant agency or the configuration of leadership responsibilities, we have made a special effort to categorize the 25 sampled communities as accurately as possible, even when reality may be much less precise than desired. For these issues we report actual numbers of communities in each category, as in chapters 2, 7, and 8. Even with these categorizations, there is room for slippage in definitions, such as what constitutes an “independent” agency or even a ‘government” agency, or a “more” rather than “less” developed data system.

The difficulties of accurate characterization and classification are magnified when one is trying to summarize the behavior of programs in systems that have many programs and even more inter-program interactions. We have not tried to create mutually exclusive and exhaustive categories for every issue we address in this report. Instead, we often speak about “most,” “many,” “some,” or “a few” communities that do a particular thing or have a particular arrangement. To give the reader a rough idea of frequencies, we give rough numerical approximations to these terms, none of which should be interpreted as absolute: “a few” is less than five, “some” is more than five but less than half, “about half” is 11 to 14, “many” is more than half but less than 21, and “most” is 21 or more.

CHAPTER 2: POWER AND PEOPLE—“LEAD” AGENCIES AND LEADERSHIP

Trying to categorize, or even characterize, the nature of leadership in the 25 communities we visited is an extremely daunting task. As the attempt had to be made, however, we would like to report that it has left us with a great appreciation for the truly enormous variety of arrangements that different communities have evolved to plan for and deliver homeless assistance services, and beyond this to try to end homelessness. Not only are the arrangements many, but many arrangements seem to be effective in their own setting at achieving the goals the local communities set for themselves. It is extremely difficult to identify a “bottom line” that must be present for success, although we can suggest some things whose presence usually seems to characterize approaches that feel quite strong in their context.

To understand how communities organize themselves with respect to homelessness, it is important to distinguish the various things they may be trying to do, as it frequently happens that they use different mechanisms for different homeless-related activities. Communities may engage in any or all of (1) responding to the HUD request for CoC applications; (2) addressing the larger issue of planning a service system to help currently homeless people; (3) doing the basic chores of contract writing, standard setting, performance monitoring, and similar activities with respect to funded programs; and (4) ultimately planning and developing approaches to prevent and/or eliminate homelessness. The same entity may do all of these, different entities may do each of them, some may be combined, and some may not be done at all. Every variation on these combinations exists just within the 25 communities we visited, which impressed us greatly considering that these are among the strongest CoCs in the country—or at least those whose applications earn high marks from HUD. One can reasonably expect that the remaining hundreds of communities with HUD CoC funding are equally diverse, and equally resistant to simple categorization.

Leadership may be strong because a strong personality devotes him- or herself to leading. It may also be strong because a “lead agency” has organizational power through its control of money and its ability to require compliance with standards as part of contracts. The lead entity, whether a government entity, an incorporated nonprofit agency, or an informal board, may also have legitimacy, in that it has the agreement and support of the community to fulfill its mission. A lead entity may also derive influence because it has financial resources and thus cooperation with it is in the interest of service providers, because the community sustains a strong collaborative culture, or for any combination of these reasons. Finally, local leadership may have to deal with regional and state-level decision making over which it has no control, either as to timing or content. Local leadership may chafe at these influences, accommodate them, work to make them allies and supporters, or be stimulated, guided, and supported by them. Again, all combinations were present in the communities we visited.

No Formal Authority

Although there is some risk in making the following generalization, we would classify 10 of the communities we visited as having a planning and coordination process with either weak or nonexistent formal powers.

- Several (5) of these 10 could be characterized as consortia, in which some to many civil jurisdictions have joined forces in a board, task force, council, coordinating committee, or coalition (referred to hereafter as "board" for simplicity's sake) to focus on homeless issues. The key in these communities is voluntary cooperation, as no entity is really in a position to make anyone else do anything.
- Other communities in this group of 10 are limited to only one county. In some of these, the county government itself plays a central official role but HUD CoC program dollars flow directly to the programs, the county conceives of its role as facilitator to the HUD CoC application process, and little more. In others, the lead entity is a board or council with broad provider representation as well as representation from government and other agencies and interests. Public agencies may be more or less supportive, and HUD funding goes directly to programs.

In most of the communities of this group of 10, whether encompassing single or multiple jurisdictions, the board has responsibility for HUD CoC planning, and to the extent it happens any other homeless system planning. These boards have a mixed membership (some government, some providers, some others). This entity may be "official" (i.e., appointed by the mayor or county board of commissioners) or "unofficial" (i.e., a group of interested people who have constituted themselves a committee or council). In this group of communities these boards tend not to be incorporated nonprofit entities, although in other communities groups that started out as informal have moved to incorporate as their duties expanded and they were able to add paid staff. HUD money flows directly to providers in these communities, not through a formal entity.

Most of the planning in the 10 communities of this group is focused on the CoC application, with little attention to other planning, development, integration of homeless assistance programs, or the broader issue of ending homelessness. Thus one might be tempted to characterize this entire group of communities as low investment, low power, and with an interest in planning for and coordinating services for homeless people limited only to doing what is necessary to get HUD dollars. This would be a mistake, however. Two among these communities nevertheless engage in serious year-round planning that goes well beyond what HUD will fund, work strenuously on program and service coordination, sustain significant involvement of mainstream agencies, and do it all in a spirit of cooperation. Neither of these two has any paid staff to support its HUD CoC application process, nor does any government or private funder pay even for a consultant to help write the application itself. Volunteers, mostly providers, do it all, and satisfaction with the overall process of planning for homeless services is high in these two communities.

Public-Private Arrangements

Another 10 communities in this study have both a board and at least one government agency playing a strong role. In some of these communities it was reasonably easy to identify which entity was in the lead and which had a support function, but in others it was not. Sometimes the board was a formally constituted subpart of the government entity. Sometimes it was appointed by political figures (e.g., the mayor, city council members), and a local government agency played a strong collaborative role as well as offering technical support. Sometimes it either was the local homeless coalition or was a committee of such a coalition but

with greatly expanded and broadened membership (i.e., many entities besides homeless service providers were included). Sometimes a local government agency had the official lead but contracted with one or more broadly representative organizations to carry out most planning and system development, including preparation of the HUD application.

Those interested in homeless services in these 10 communities all engaged in planning and system development activities going well beyond what was required to apply for HUD funding, and all operated on a year-round basis. In addition, most had significant involvement of at least one mainstream public agency, and often more than one public agency participated in both planning and program and service development and coordination.

Two characteristics of these communities are probably important to their ability to draw mainstream agencies into working on local homeless assistance systems. The first of these is the broader-than-HUD-funding nature of the charge to the boards in these communities. Some part of the work they do is legitimately within the purview of mainstream agencies, and they need mainstream agencies to participate if they are going to fulfill their goals with respect to prevention and permanent housing, as well as with respect to supportive services within homeless-specific programs. Thus they are able to involve representatives of mainstream agencies—and often business, religious, and other civic leaders as well—in planning for and developing parts of the continuum that are not appropriate for HUD CoC funding. This relieves the nonhomeless-provider group from being subjected to the details of the HUD CoC application process. A second possible influence on broadened mainstream agency participation is the presence of at least one mainstream agency taking the role of lead or staff support to a board. The enthusiastic participation of one civil servant in one agency can have a major impact on all agencies with which that person interacts.

Based on the situations in these 10 communities, it would be difficult to predict which government agency will fulfill the government component of these arrangements. Government agencies playing the lead or strong supporting role vary, and include health, human services, housing and community development, and planning agencies. Among multi-jurisdiction applicants that include both cities and counties eligible on their own for HUD CoC dollars, the agency could be a city or county agency, or even a formal association of local jurisdictions. Its only essential characteristics are that its representative(s) be enthusiastic participants, and that its procedures be perceived as fair and even-handed. Nor does this government agency have to be the agency that controls HUD money and writes contracts with providers—in fact, in several of these communities, either all or most HUD dollars flow directly to providers.

Several lessons may be drawn from this diversity in public agencies playing the lead/support role. First is that communities have dealt with homelessness from a variety of perspectives, with human services and housing/community development appearing with about equal frequency as the most invested local agency. The most important thing about a government agency serving in the capacity that occurs in these 10 communities is that the agency be interested in and committed to the process, and supportive of coordinated service delivery. Different types of government agencies filled this role in different communities. Further, even within an agency that in general is supportive of developing homeless programming and working for good coordination among programs and services, the enthusiasm of the main contact person, in combination with his or her political and social skills, can make all the difference in the world. Without this person "leading the charge," a lot less would be happening in some of the communities in this study.

In these dual-leadership communities where a board and a public agency are partners, it is often true that neither entity has any real power, if power means the ability to coerce people to comply (e.g., with standards of care, or performance levels, or even getting their applications in on time). Nevertheless, a complex interplay of self-interests usually results in cooperation on a number of fronts, from participating in planning and data collection to adhering to some agreed-upon standards of care and program operations. Pat Morgan, Executive Director of Partners for the Homeless, which coordinates the Memphis/Shelby County, Tennessee CoC application process, gave the following explanation of that interplay, describing how "carrots" can help to gain more compliance, or at least more willing compliance, than "sticks":

You know, of course, that no matter how good the projects are, or how well the project applications are written, unless we as a community do a good job of collaborating on the planning, a good job with our data collection and gaps analysis, a good job in designing and implementing a fair and equitable process for determining our priorities—and a good job of describing all of this—none of the agencies gets any money.

The applications come to the Steering Committee for review, rating, and ranking. Partners for the Homeless then puts the consolidated application together (all project applications plus Exhibit One, which describes the planning process, gaps analysis, etc.) and submits it to HUD.

We don't, through the CoC application process, require that agencies participate in either quality standards or the planning process. We encourage participation by offering bonus points for participation, and we consider participation and scores of agencies [that adhere to standards] when assessing capacity. Since most of the agencies applying for CoC money are also getting, or trying to get, other HUD or city dollars from the city, the city requires them to participate in the standards as a condition of getting these dollars. Keep in mind that last year was our first year for implementing standards, but so far, almost all the agencies that have gotten CoC money in the past (if they are still operating homeless assistance programs) are participating. We probably need to consider how we can require agencies to participate if they receive, or are applying to receive, CoC dollars. But we must be careful not to institute any requirements that would be seen as stifling competition for the funds by HUD. For example, one agency submitted a new project in this year's competition. To my knowledge, it does not yet receive any other HUD or local government funding so there is no "hammer" as yet to make them do it. We try to convince them that it is in their best interest to do it since it makes their applications for funding from public and private funding sources stronger. We do provide foundations, government, and potential funders with the information on the status of participation and encourage the funding sources to consider requiring the agencies to participate in the event they apply for funding from these sources.

Memphis/Shelby County, Tennessee: Standards of Care

One underlying purpose of coming together as a CoC is that services and service structures ultimately meet a certain “standard of care.” However, only a handful of the sites’ planning bodies currently maintain a degree of power throughout their local Continuum community to be able to enforce or encourage a “standards of care.” The Continuum of Care in Memphis, Tennessee, is one such site which has now incorporated a “Standards of Care” process into its CoC application. The objective of the Standards is to help all agencies meet or exceed the minimum requirements for services, facilities, and fiscal accountability. To date, more than 20 local programs targeted to homeless people have met or exceeded the Standards.

The Memphis/Shelby County continuum is based on a partnership-planning model, which ensures some sort of balance and legitimacy of power within the Continuum community. This model includes the city of Memphis as the lead agency, which in turn contracts out many of the CoC leadership responsibilities to two local organizations. The first—a public-private partnership with city, county, foundation, and corporate funding—relies on data and is responsible for the CoC application and development of the local gaps analysis chart, among other tasks. The second is a city-funded organization, primarily consisting of service providers, charged with ensuring inclusive and on-going planning participation from the Continuum community year-round. Together, these lead agencies have developed two means for encouraging participation in the Standards of Care process.

Any Continuum member agency receiving city funds is contractually required to participate in the Standards process and even in the Continuum planning process to some degree. An incentive method has been set up via the ranking of applications as “bonus points” are given for participation in the Standards and planning processes as a way of encouraging participation. Furthermore, participation in the Standards process and scores of the participating agency are considered in assessing an agency’s capacity, an additional factor in funding decisions.

The Standards of Care process was, in part, begun by the service provider community—with both city and private-sector support. The city contracts with a local expert to assist in providing technical assistance and training to help agencies meet minimum quality standards for services, facilities and fiscal practices. Then, private sector funds support the implementation of the monitoring-evaluation phase of the Standards by a contractor retained by the public-private partnership using private funds. A self-evaluation tool is mailed to agencies to let them self-identify areas that might not meet the standards so as to take corrective action and/or ask for technical assistance. As requested, the contractor then works with the agency individually or collectively to help address any deficiencies prior to the on-site monitoring-evaluation. Examples of changes for some providers include additional questions for clients during intake, such as questions about less-obvious disabilities as well as inquiries about Veteran status. Status reports and scores of participating agencies are then made available to public and private grant-makers and other potential funding sources.

While city dollars provide a “carrot” for service providers to comply with the established standards, it is the extensive level of local “buy-in” to the Continuum planning and application process by providers as well as private and public funders and planners that makes the foundation for the success of this “Standards of Care” process.

Formal Independent Entities

In four communities in this study, independent entities orchestrate homeless planning. Even among these four we encountered unique configurations:

- Three of the four have an approach to homelessness that is broadly conceived and broadly supported.
- Three of the four are the formal recipient of all or most of the HUD CoC dollars, which they in turn contract out to providers.
- Two of the four have fairly broad mainstream support, and from mainstream agencies that have and are investing significant resources into the CoC to support parts of the comprehensive homeless response system that HUD CoC dollars cannot fund.
- Two of the four have invested in data collection approaches and are pushing performance standards, adoption of which is facilitated by the independent entities' strong position with regard to funding and contracting.

Columbus/Franklin County, Ohio: Long-term Strategic Planning

Columbus/Franklin County's lead agency, the Community Shelter Board (CSB), began with strong community backing and the goal of establishing an objective process for creating and operating a well-planned and goal-directed system of homeless services. CSB's status as an independent entity, not government and not a service provider, was seen as key to accomplishing this goal. Very early on, CSB required all agencies receiving its funding to contribute to a rudimentary shelter tracking data system. The data it provided quelled disputes about whether a problem existed, how big it was, and who was involved. Energy was then directed to deciding what to do about it. CSB's structure and charge gave it the authority to collect information, analyze performance, ask whether the system was fulfilling expectations, and, when necessary, redirect the system once having built consensus about which direction to go.

In 1998, CSB presided over a major change in emphasis and direction. Many factors contributed to development of new goals. Five to six years ago, the emphasis was on increasing services within shelter. Now the overarching system goal is to eliminate homelessness within Franklin County. The three approaches to doing this are (1) increasing resources for prevention; (2) for those who do become literally homeless, developing the capacity to resolve their homelessness quickly at the emergency point by increasing access to housing and jobs; and (3) developing permanent supportive housing for those who cannot live independently.

The first two emphases are best reflected in Columbus’ approach to family homelessness. A crisis in families seeking shelter during the summer of 1998 led, with CSB facilitation, to a planning process for the next year that brought together family service providers to share information about vacancies and serve families better. In 2000, CSB revised its contracting to give the YWCA coordinator/facilitator responsibility for family intake. The Y has resources for prevention, and also makes decisions about the level of emergency shelter a family needs and where it will be able to obtain it. CSB was able to use its shelter tracking data to identify the major causes of family overflow and suggest appropriate solutions. In addition to better intake, assessment, and system management, CSB also recommended changes in staffing practice to assure that family case managers would be on hand during the summer period of peak demand from families.

The third goal of Columbus’ long-range planning is being accomplished through an initiative called “Rebuilding Lives.” Desire to redevelop riverfront land on which many chronically homeless people stayed prompted an in-depth study of this homeless population and its needs. Once the results were published, community discussions about solutions followed. Identification of need led to an impressive commitment of resources to develop 800 new units of permanent supportive housing targeted toward ending homelessness for this large component of Columbus’ homeless population. More than 175 units are already functioning or about to be so. The number of applications from chronic “street” homeless people for these units are impressive, as are the 12-month retention rates for people who have already taken up residence.

This is the extent to which one can generalize about these four, as each has a unique configuration of responsibilities and alliances. These four characteristics all describe the lead agency in one community; one lead agency shares three characteristics but not strong mainstream support, one shares two characteristics but not financial control or strong investment in data collection, and one has dollar control but none of the other three characteristics.

In two of these communities, a formal nonprofit agency has responsibility for homeless planning, information sharing, and coordination, widely defined to include everything from prevention to permanent affordable housing. That same agency is the recipient of HUD funding, including ESG dollars transferred from their public recipient and sometimes some CDBG dollars, and writes contracts with providers in both communities. At the same time, some providers in each community have arrangements with HUD that pre-date the consolidated CoC application and keep their particular grants coming directly to them rather than going through the planning entity. Each lead agency has pushed data collection, performance standards, and performance monitoring. Both work with many mainstream agencies, although their relationships to local government are somewhat different. These two agencies are in a very strong position in their communities and appear to share a good many characteristics and behaviors. But even with these strengths, their relationships to their communities leave them in very different positions with respect to power and leadership.

A third community among these four has a dual leadership configuration. An independent agency does some of the homeless planning, including the HUD-specific planning. It does not control the HUD dollars but enjoys amicable and cooperative relationships with the government agencies and providers who do get the money and help with planning and service coordination. The final community in this group is the anomaly, in that it does control HUD dollars and is thus strong within that small framework. But its larger community, including mainstream agencies, has little interest in homelessness and devotes few resources to it, so there is only so much that the planning entity can do within the limits of its resources.

The Last Community

The final community in our sample cannot be categorized into any of the foregoing groups. Formal control rests with a government agency, which had long handled the CoC application without paying much attention to input from the larger community or the homeless assistance network, although such input was offered. In recent years the process has been opened up, and involvement of the larger community in decision making is growing.

People

It is not easy to describe the extremely important role that individual personality and devotion play in the development of homeless assistance systems in the communities we visited without becoming too explicit. However, the fact remains that in most of these communities, a few people have been such essential players that it would be hard to imagine that without them the system would be what it is today. They have not all played the same roles. Some have been the idealistic inspirations who brought public and private resources to focus on the issue of homelessness and stick with it, although their role in the actual organization of services might have been slight. Some have been the organizational masterminds who knew what it would take to get an aggregation of programs and personalities to become a system, and had the social and political skills to make it happen. Some occupied vitally important positions in government agencies and persisted over many years in bringing those agencies to the table, keeping them there, and seeing that agency resources were applied to homeless issues. And some have been instrumental in bringing about a significant meeting of minds because they eschew ego and insist on cooperation, using the approach of "I can't do it all, I need your help/ideas/contributions/support."

These "system inspirations" build, of course, on people with similar talents who apply them to their own organizations, and dedicated staff work from any number of people. Systems are not built by inspiration alone. But it is hard to overestimate the importance of people who really care, and who have the ability to translate that caring into structures of cooperating individuals, programs, and agencies. Without them the homeless assistance systems in their communities would look far different.

People are also important in the sheer mass of work that needs to be done to obtain HUD CoC dollars. Only four of the communities in this study complete their HUD applications without any paid staff, and in two of these, some government agency provides a modicum of support to hire a consultant to do the actual writing. All of the other communities rely on people in paid positions to orchestrate the planning process and write the application. In most

communities, that reliance is on someone in a government agency who has been assigned staff responsibilities for the CoC, at a minimum. In about one-fourth of study communities the CoC preparation is about all these staff people do. In the remainder they work on homeless and housing system issues year-round, along with the various boards and other agencies involved in the same issues. Finally, in the communities with independent entities in leadership positions, paid staff make it possible for them to accomplish a great deal of long-range planning, system coordination, and technical support to programs. Technical support includes holding "best practice" seminars, helping with data problems, formalizing project assessment and rating procedures, and many other activities. In communities without an independent lead entity but with a sufficiently committed public agency supplying CoC staffing, that agency has made sure that these same benefits are available.

Beyond "The Community"

This project included two statewide CoCs, but the states chosen were small in size. We also visited several regional CoCs, but the state played a significant role in only one. We thus were not able to examine in any depth some major issues that make it more difficult to organize a statewide than a local CoC. Size is a real issue, which we observed and appreciated in the Chicago and Cook County CoCs but did not have the opportunity to explore on the scale of a Montana or an Alaska, or even a Kentucky or Minnesota. Kentucky, for instance, must organize 118 counties with distances of up to six hours for statewide meetings. The larger and more diverse the geographical area to be organized, the less chance that everyone has the same priorities and structure, and therefore the more attenuated the idea of a CoC may become unless there is serious investment in program development. Therefore, before statewide policy development can begin, strategies must be developed to regionalize and then find similarities. Without assistance from state-level agencies this is not likely to happen. We saw the role of the state at work in the southwestern Pennsylvania CoC, and realize that it was crucial to getting that and other regional CoCs in that state organized and functioning. But the state-level power structure is usually more remote both because its members do not see the issue of homelessness across the state and are not involved in their local communities. It takes additional effort and a second level of planning and coordination to develop a truly effective statewide CoC under these circumstances. We return to these issues in chapter 9.

Implications

Several implications follow from the analysis presented in this chapter. The very difficulty of doing the analysis and placing communities into clear and convincing categories is itself significant. The variety of arrangements developed for producing an annual CoC application, at a minimum, and ultimately for developing a broad and coherent system of programs and services to prevent and end homelessness, is highly individualistic to each community, and could not have been predicted or anticipated in advance. We draw the following implications from the information presented in this chapter:

- Federal pre-specification that the CoC planning function be lodged in a particular type of agency would run the risk of weakening CoC planning in many communities. The people who care about comprehensive homeless planning are often in different places in different communities. One advantage of the CoC system is that it has

- enough flexibility to accommodate this variation and allow people who care – whatever their formal function – to run the planning process. It is important to retain this flexibility.
- Within communities, the CoC process has stimulated significantly increased communication and information-sharing among homeless service providers, and often also among homeless-specific entities and mainstream entities. Information-sharing has, in turn, led to increased coordination of programs and services, both because people know more about the services available from different components of the homeless assistance network and because people who talk together often go on to develop coordinated or joint programming. The stress in CoC guidance on the importance of grassroots involvement of everyone in the system has led to all types of collaborative programming designs to address the needs of those who are homeless.
 - Mechanisms for year-round planning, service coordination, and integration with mainstream agencies are not absolutely necessary to get HUD CoC dollars. But they ARE necessary if one wants a complete CoC, and absolutely essential if one wants to pursue the larger goals of ending current and preventing future homelessness. We found well-functioning year-round larger planning and coordination processes in all configurations, even those with no formal powers. But it does seem clear that in larger communities, formalization is probably necessary just because the amount of work involved in coordinating all of the actors is formidable. Since there are advantages to homeless service systems in being larger, more comprehensive, and better coordinated, it might be worth thinking about how to encourage communities to establish paid coordinator positions.
 - Leadership is essential to effective CoCs, and should be “taken” and appreciated wherever it is found. Whoever or whatever seems to be able to exercise effective leadership should be given as much clout as is organizationally possible, and as is compatible with the spirit of the community of planners and service systems.
 - The local environment beyond homeless-specific services plays a key role in determining how well CoC planners and participants will be able to go in fulfilling a vision of a comprehensive CoC or even better, of ending homelessness. Business and corporate interests can be strongly supportive, both conceptually and financially, or indifferent or resistant. Local government entities may be highly effective and also willing to coordinate within a CoC and provide needed resources, or they may be ineffective, in debt, or resistant. Nonhomeless resources such as rental assistance programs may be plentiful or nonexistent. Even homeless-specific services may be rare, as in many rural communities where community action agencies are the main avenues of assistance for poor people whether homeless or housed. State-level agencies may be willing to help organize regional or statewide CoCs, may have the skills and resources to do so, or may not. All of these factors are beyond the control of the people developing HUD CoC applications and a CoC in general, but all affect the likelihood that an essentially similar planning process may have very different outcomes for homeless people.

- The CoC process has also been successful in stimulating the development of cross-jurisdictional planning and service structures. Movement, when it occurred in these communities, seemed definitely to be in the direction of greater inclusion, and expansion beyond core urban boundaries into surrounding jurisdictions. The funding structure developed by HUD supports this type of merging and coordination, as jurisdictions incur no penalties for working together and many jurisdictions that themselves might not have written applications or been eligible to do so are able to be included in systems greater than themselves. They benefit from such inclusion because they can learn from participants in the larger system and are not "starting from scratch" in developing local programs and services. Any changes contemplated in the CoC application process or eligibility for CoC funding should not jeopardize these incentives.

CHAPTER 3: LOCAL HOMELESS ASSISTANCE SYSTEMS

This chapter summarizes the results of site visits and other information about local homeless assistance systems in the 25 communities of this study. It covers one of the study's major research questions—what do these CoC systems look like? Chapter 4 then examines how these CoCs work for the people who need to use them, and chapter 5 looks at ways in which mainstream agencies and services have been brought into CoCs to address issues of prevention, permanent affordable housing, and case management and supportive services.

We begin with a brief description of the several meanings that “CoC system” takes on in these communities. Thereafter, we describe the CoC components, including the degree to which the 25 communities offer homelessness prevention programs and services, emergency shelter, transitional housing approaches, and the range of permanent supportive housing options available in the communities in this study. Another element of the continuum, outreach and assessment activities, will be described in the next chapter, as it is an essential part of the story of how people access homeless services and how they move among the components of the CoC and get the supports they need.

In this and all other chapters of this report, we try to give examples of services, structures, and processes we observed in the communities included in this study. When examples are given, we limited ourselves to two or three in the interest of brevity, although others could have been selected as well. It is also important to remember, when reading the examples in this and other chapters, that the communities we visited are among those with the highest-scoring CoC applications, chosen deliberately to provide the opportunity to observe CoCs that appear from their applications to be working well. They are not, and were not intended to be, representative of the entire range of the more than 300 CoCs in place around the country.

The Meanings of “Continuum of Care”

Among the 25 communities visited during the study, the term “CoC system” is interpreted in at least three ways. Most of these localities view the CoC as a single system covering a locally defined area and including all of the following components—prevention, outreach and assessment, emergency shelter, transitional housing, appropriate supportive services, permanent supportive housing, and permanent housing. These communities view homeless issues broadly, including in their purview homeless prevention and tapping mainstream housing and service resources. This interpretation reflects HUD's description of the CoC system. However, some communities without a great deal of direct contact with HUD may not fully understand that HUD wants a collaboration that includes the powerful mainstream agencies in a community, not just a collaboration of the service providers and local leaders directly involved in homeless assistance, plus homeless citizens. At least one of the other two interpretations of a CoC varies from HUD's description in ways that suggest this possibility. Both are described below, one as the “Limited View” and the other as the “Geographically Influenced” view.

Limited View

Eight of the communities visited have a limited view of a CoC, seeing it mainly in terms of the activities that are eligible for CoC funding from HUD. Their focus is almost entirely on obtaining HUD funding. Because homeless prevention, most emergency shelter, permanent supportive housing for homeless persons without disabilities, and most permanent affordable housing are not eligible for CoC funding from HUD, planning efforts give them short shrift or do not attend to them at all. Rather, the homeless planning processes in these localities tend to be driven by the requirements of the CoC competition, as opposed to homelessness issues more generally. One CoC coordinator said, when asked about homeless assistance system planning, “HUD doesn’t allow the CoC to do significant long-term planning to confront homelessness because only certain elements of the continuum are funded (emphasis added).”

Clearly, communities with this attitude did not understand, and certainly were not acting on, HUD’s intent for the full scope of the CoC planning process and the CoC itself. HUD has been promoting an inclusive process that brings together a variety of resources, including both homeless-specific resources and mainstream housing and service programs, to address homelessness comprehensively. HUD did not want homeless assistance planning and actions to focus only on what could be funded by HUD’s CoC resources, knowing that these resources had statutory limits on their use. Some communities may feel, however, that they need to disregard HUD’s larger intentions because they do not have mainstream agencies that are willing to invest in the other parts of the system. In such cases one would have expected to see significant effort to interest those agencies in participation. But that does not always happen, nor does it always succeed even when the effort is made.

Geographically-Influenced View

Due to reasons of geography, several communities in this study have what could be characterized as sub-CoC systems serving different regions within the CoC geographical area described in their CoC applications. Two examples are the Southwestern Pennsylvania and Cook County, Illinois CoCs. The Denver area, on the other hand, has expanded its continuum to incorporate surrounding counties. (See box below.)

Denver, Colorado and five surrounding counties: Regionalism

Dramatically different levels of poverty and urban living mark the 6 counties and 28 municipalities in the *Metropolitan Denver Continuum of Care*. The consortium ranges from suburban Douglas County, home to 175,000 people with a poverty rate of less than 2 percent, to urban Jefferson County with over half a million people and a poverty rate over 16 percent. By joining together to plan and implement an integrated homeless initiative, the Metro Denver CoC developed a regional approach to the complex issue of homelessness. Discussions among service providers identified areas outside of downtown Denver with a need for homeless services. The CoC’s integrated approach to service planning resulted in shelter provision extending beyond the central city to serve residents of outlying areas in their own communities.

Moreover, jurisdictions within the CoC have different degrees of familiarity with homeless needs and services. By joining together, places with more experience have helped educate citizens and government leaders in areas where homelessness may be characterized as “hidden,” with families doubling-up rather than living on the street. Local stakeholders feel that, by working together, Metro Denver has a better chance of raising awareness in local communities and increasing local resources to expand much-needed homeless services and of addressing the region’s growing affordable housing shortage.

Southwestern Pennsylvania. The most striking example of the influence of geography among the 25 communities in this study was found in the CoC in Southwestern Pennsylvania. This CoC consists of five counties, three of which are not contiguous to the other two. Butler, Armstrong, and Indiana Counties are located to the north of urban Allegheny (including Pittsburgh) and several other counties (Beaver, Washington, and Westmoreland), while Greene and Fayette Counties are located to the south of them. This is the smallest of four regional CoCs in Pennsylvania. The five counties are all rural, with communities separated not only by distance but also by Allegheny Mountain topography. There is little or no public transportation connecting the counties to each other, or places within each county to each other.

The five counties do not aspire to be a single, integrated continuum. Instead, they are five separate county continuums that share information and attempt to ensure that at least an adequate level of service is provided in the homeless CoC of each county. CoC members believe this to be a rational strategy for a geographically large region that has little or no public transportation. In addition to geographic and transportation barriers, attitudinal barriers also generally mean that efforts to get people to cross jurisdictional boundaries to attend programs or obtain services have failed.

Balance of Cook County, Illinois. Another example of the influence of geography is found in the Balance of Cook County CoC. Cook County is the second largest urban county in the nation. It covers 709 square miles and includes 125 units of general local government, 28 unincorporated townships, 800 government-taxing bodies, 134 nonprofit homeless assistance providers, and scores of food pantries and charitable organizations. Excluding Chicago and Evanston, which have organized their own CoCs and write their own HUD applications, Balance of Cook County is still home to almost 2.2 million people. Its population size, geography, highway system, and mass transit network configuration led it to develop a decentralized support system divided into North, West, and South community-based regions. These function as service management areas for coordinating homeless services for persons within each area.

Balance of Cook County and its Task Force on Homelessness constitute a single continuum in relation to HUD funding, but see themselves more as a decentralized federation of providers, focused on bringing services to the sub-areas in which the various providers are located. They see this as necessarily following from the enormous size, diversity, and geography of the county. Their experience is also that homeless persons usually do not wish to travel from one part of the county to a distant or less familiar part to receive services, even if they were able to do so. Therefore, planning to establish and coordinate the range of services, and service coordination itself, has occurred more within than across these regions.

In each of these communities, and others that incorporate some aspects of sub-CoCs within the larger continuum, HUD's CoC funding has stimulated a greater degree of organization and systematization of services. Gaps have been filled and services developed to improve access within particular geographic areas. So there has definitely been an effect, but decisionmakers have chosen to work with rather than against people's identification with and comfort in particular geographically-defined areas. Planning for these smaller areas within the HUD-defined CoC probably would not have happened, or would not be as advanced, without the larger planning process involving the entire county or region. Nor would specific localities have the benefits of sharing concerns, ideas, and solutions with people in other communities. So, as is becoming a theme in our findings, the benefits of allowing "a CoC" to be a locally-defined, emergent reality are very great. One size definitely does not fit all, either for homeless people needing services or for communities developing and maintaining a system to help homeless people and reduce homelessness.

Components of CoC Systems

The rest of this chapter describes the various components of CoCs, and the extent to which they can be found within the communities of this study.

Prevention

An integral part of homeless assistance systems is prevention for families and individuals at imminent risk of becoming homeless. Intended to serve all populations, prevention programs are designed according to community need, priority, and availability of resources. Consequently, homelessness prevention programs tend to be structured in various ways, as was evident throughout the 25 communities visited for this study. Although HUD does not fund prevention activities directly through the CoC application process, all sites recognized its importance and conducted at least some prevention activities. However, only a few communities had significant resources to devote to prevention efforts. Many communities use Emergency Shelter Grant resources for prevention activities as well as connections with mainstream agencies; however, the extent of these resources varies by community. Mainstream agencies, such as alcohol and drug, mental health, prisons and jails, and foster care agencies, while critical components in good prevention, vary in regard to discharge planning efforts and coordination. Without adequate discharge planning, including provision of housing resources and the supportive services to keep people in housing, these agencies often become feeder agencies for homeless programs, rather than being a line of defense against homelessness for their clients. Other mainstream agencies may affect the likelihood of homelessness by affecting a household's total level of resources. For example, by making Medicaid available to pay a household's excessive medical costs, the mainstream Medicaid agency might reduce the household's risk of becoming homeless. How well they do this for homeless people depends greatly on the integration of mainstream services with the local homeless assistance system (discussed further in chapter 5).

Winston-Salem/Forsyth County, North Carolina: Prevention

Winston-Salem has been able to leverage significant resources for emergency assistance (EA). Four local agencies—Crisis Control Ministries, Sunnyside Moravian Ministry, the Salvation Army, and Forsyth County Department of Social Services (DSS) — provide emergency financial assistance to individuals and families to help prevent events that could lead to homelessness. The local United Way recently received a grant from the local Kate B. Reynolds foundation to establish an internet-based network that allows the agencies to share information on EA clients.

Funding can be used for such things as rent, utility bills, automobile repairs, and healthcare bills. Assistance averages between \$300-\$350 and is limited to once in a six month period. For individuals or families to receive emergency assistance, they must demonstrate how the money will solve their problem by developing a plan for paying bills in the future. Financial counseling is offered to help them with the financial planning.

Although assistance averages \$300-350, providers have begun to notice a more insidious problem in the community: homeless clients owing large sums of back rent to the local housing authority or a private landlord. The money owed becomes a significant barrier to housing placement. To address this problem, the EA agencies used federal TANF dollars granted by the state for housing assistance. Each of the EA providers collaborated with the local DSS, and DSS co-located a staff member at the largest provider of EA funds. The TANF funds helped significantly, but the program was not renewed.

In 2000, the Winston-Salem EA system provided \$1.95 million to assist 9,263 cases. Just over half of the funds, 54 percent, came from local or private sources (including foundations, corporations, and churches), while federal funding (TANF and Crisis Intervention dollars) comprised the remaining 46 percent.

Depending on the funding resources available, prevention programs range from one-time emergency payment assistance to more comprehensive prevention services including mortgage and rental assistance, utility payments, legal assistance, and financial counseling to handle housing crises. Winston-Salem/Forsyth County, North Carolina; Columbus/Franklin County, Ohio; Montgomery County, Maryland; San Francisco; and Phoenix/Maricopa County, Arizona have been able to leverage funds to establish a coordinated homeless prevention system. Seeing the economic efficiencies implicit in providing prevention services to help individuals maintain housing, as opposed to crisis management after individuals become homeless, these communities have committed municipal, local business, foundation, and/or mainstream agency funding to provide substantial levels of prevention assistance. The leadership functions described in chapter 2 have been central to the ability of these communities to focus mainstream resources on preventing homelessness in these ways. Mainstream agencies are the major source of other aspects of prevention as well, such as fulfilling institutional discharge responsibilities in ways that include housing resources.

Winston-Salem/Forsyth County, for example, devotes significant resources to Emergency Assistance (see box, above). When asked if they thought the EA program was truly helping prevent homelessness as opposed to just delaying the inevitable, providers said they

felt that it was helping. They cited as evidence that in years past, it was not uncommon to see the same individual every six months. Today, however, approximately 85 percent of EA clients are first-time clients. Providers attribute this change to the financial counseling program.

Some communities have also formed partnerships with businesses and foundations to obtain additional funding for prevention activities. A recently established fund dedicated to prevention services in Washington, DC (the DC Emergency Assistance Fund) receives its resources from the District government, local businesses, and foundations. In 2000, this program served 500 households with emergency assistance, some of which prevented homelessness. The Community Partnership for the Prevention of Homelessness (TCP), Washington, DC's lead CoC agency, had established two Family Investment Centers to serve many formerly homeless families who were placed in permanent units in 16 public housing projects. The Centers offered crisis management and employment services to families to help maintain their housing and financial stability, thus preventing re-entry into homelessness. Loss of support from the public housing authority has resulted in closing these centers, however.

Community Action Programs (CAPs) also play a significant role in terms of prevention. In Phoenix/Maricopa County, for example, the county provides almost \$1.5 million annually through CAPs for rental, mortgage, and utility assistance, to which the cities of Phoenix, Mesa, and Tempe contribute an additional \$2.5 million for utility assistance and eviction prevention. Rhode Island's continuum also collaborates with CAPs, as do providers in the Southwestern Pennsylvania CoC. In Rhode Island, the CAPs have family development programs that aim to prevent homelessness by providing case management and other crisis services. A large component of the prevention program is emergency mortgage and rental assistance to prevent evictions, as well as first month's rent to persons moving into permanent housing. Rhode Island has also developed a statewide computerized housing locator system. As part of this collaborative, the Rhode Island Coalition for the Homeless has established a Tenant Education program that helps people learn the basics of being a good tenant, to ensure that homeless people's re-entry into housing is successful. The planning by Rhode Island to integrate prevention into the larger housing system with the local CAP agencies is key to making prevention effective in the state.

Finally, in areas such as Columbus/Franklin County, Ohio and Montgomery County, Maryland, the creation of a central intake system (for families in Columbus/Franklin County and for everyone in Montgomery County) has been a key mechanism in efforts to prevent homelessness. In Columbus/Franklin County, for example, families enter the system through a central intake telephone line at the YWCA, where a triage approach is used to help families avoid homelessness first and foremost. Through this program, over 400 of the 1000 families served in 2000 had their housing crisis resolved without having to enter shelter, thereby avoiding homelessness.

Similarly, Montgomery County's point of entry for families is often through prevention services. Montgomery County has been able to obtain funding from a variety of sources to implement a comprehensive prevention plan. Three regional Montgomery County Department of Health and Human Services (DHHS) Crisis Intervention Units that administer state and county rental assistance programs are located throughout the county. In addition, Montgomery County has 20 eviction prevention programs offering a wide range of emergency assistance and orchestrated through the Emergency Assistance Coalition. The program is supported with

county funds, Federal Emergency Management Agency funds, state homeless assistance grants, and donations from local congregations.

In some communities, investing more resources in prevention could ultimately create a more efficient response to homelessness than bringing people into shelter, as the amount of money required to prevent a family from becoming homeless is far less than providing it with services after it becomes homeless. Yet prevention can absorb vast resources quickly, if it is broadly defined, which is a major reason why many authorities have been reluctant to pay for it with homeless service dollars. Several communities in this study have committed themselves to supporting prevention, but do so through programs that target only those at imminent risk. Imminent risk is defined in practice as individuals or families who approach the homeless assistance system for help. Given limited resources, communities continue to struggle with the need to balance long-term solutions (prevention and affordable housing), with short-term crisis management through emergency shelter and related services.

Integrating institutional prevention efforts (through discharge practices) into the prevention efforts of homeless-specific agencies is a developing policy in several of the communities in this study. Public mental health agencies in Madison/Dane County, Wisconsin, Tacoma/Pierce County, Washington, Winston-Salem/Forsyth County, North Carolina, Boston, and Columbus/Franklin County/ Ohio have committed considerable resources to housing options for their clients upon discharge, as well as supplying case management and other supportive services to individuals who arrive in housing through the efforts of the homeless assistance system.

Emergency Shelter

Responding to the increasing number of homeless people on the streets in the 1980s, emergency shelters became critical resources for communities working with homeless people. Today, emergency shelters are the point of entry into the homeless assistance system for many, assisting those confronted with an immediate loss of housing or those who are already homeless. Most emergency shelters are congregate buildings, but can also include hotel or motel vouchers and short-stay apartments. Emergency shelters generally have an official length of stay ranging from 1 to 90 days, depending on the individual program. However, it is also true that many chronically homeless people manage to live in the emergency shelter environment for years. At the very least, communities typically dedicate separate shelters to singles and families, or to single men and women with or without children, unless the community is very small. In addition, more specialized shelters also existed among the communities we visited, providing emergency assistance to veterans, victims of domestic abuse, teen parents, chronic substance abusers, and runaway youth.

Ann Arbor/Washtenaw County, Michigan: New Shelter System

The new emergency shelter for singles to be built next year in Ann Arbor, MI, will be open 24 hours a day, seven days a week. It will include a host of supportive services, a community kitchen, and it will offer consumers laundry, storage, telephone, mail, and bathing facilities. Another shelter for families has already been established. It is smaller than previous shelters in the area, designed for fewer families to stay for shorter periods of time than in the

past. It is intended as the first step for families who enter the homeless system, a brief stopover on their way toward the next component of the continuum, or back to independent living.

But more important than the features of these new facilities are the details of the process leading to their establishment. In 1996 advocates, providers and Washtenaw County government all recognized the deficiencies of the previous shelter system, and knew changes were necessary. They also recognized the opportunity they had to rethink and restructure the entire homeless system, beginning with the shelter system. To do this the county established two task forces, one for individuals and the other for families. The two task forces brought together a broad spectrum of the community, from the business community to university faculty to residents of smaller cities within Washtenaw County. These were elements of the community that were reluctant to commit themselves to the detailed and involved process of planning for the CoC funding, but that were eager to come together to focus on one component of the system.

What they found, however, was that, in order to discuss the shelter system, they had to step back and look at homelessness as a whole. In doing this, they decided that emergency shelter should be used only as a gateway to transitional or permanent housing, and, in order for the shelters to serve this purpose, they needed to include services that would allow people to stabilize themselves, to find jobs, to move on. They came up with principles of service delivery that are still guiding the Continuum of Care process. They submitted findings and recommendations to a Steering Committee on Homelessness, and a coalition of provider agencies was formed to work with local government to direct the projects. There were bumps and revisions and disagreements along the way, but the plans for the new facilities take significant steps toward implementing the vision that was harnessed over the course of these two years.

The plans for the new system started with the recognition that there existed significant gaps and deficiencies in the previous shelter system. The results do not represent a comprehensive solution, but it is the manner in which the homeless community responded that is noteworthy. The new facilities are directly attributable to a comprehensive, system-wide planning effort that successfully incorporated all elements of the homeless community. Moreover, they represent a coherent, long-term vision of homeless services in Washtenaw County that was developed and refined through this process.

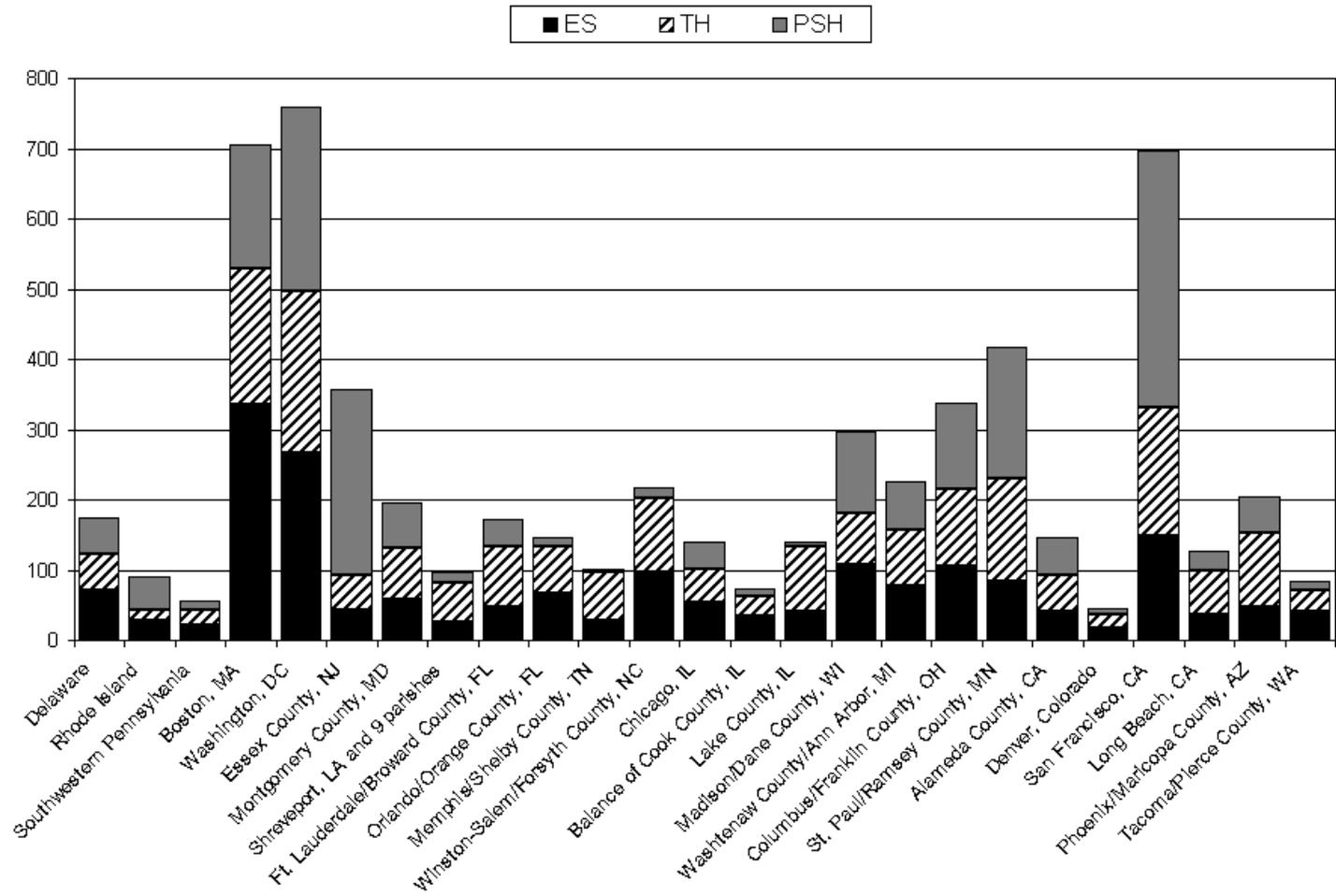
Various types of organizations offer emergency shelter and services, including government agencies, secular and religious nonprofit organizations, and housing authorities. Different communities may have very different configurations of services. For example, in Rhode Island the emergency shelter system, as well as the entire homeless system, is run entirely by nonprofit organizations. In contrast, the Broward Partnership for the Homeless, Inc., a nonprofit itself, includes many types of organizations. It plays a significant role in the provision of emergency shelter and services in Ft. Lauderdale/Broward County, Florida. In Lake County, Illinois, local churches and congregations bear the brunt of providing the majority of emergency shelter in the winter months, through a rotating shelter bed system.

Table 3.1: Emergency Shelter, Transitional Housing, and Permanent Supportive Housing Beds per 10,000 Poor People, 2001

	COMMUNITY	BEDS			BEDS PER 10,000 POOR PEOPLE		
		Emergency Shelter	Transitional Housing	Permanent Supportive Housing	Emergency Shelter	Transitional Housing	Permanent Supportive Housing
Northwest	Delaware	742	526	545	71	50	52
	Rhode Island	330	175	565	28	15	48
	Southwestern Pennsylvania	158	161	83	22	22	11
	Boston, MA	3706	2117	1942	336	192	176
	Washington, DC	2954	2523	2903	268	229	263
	Essex County, NJ	580	685	3630	42	50	264
	Montgomery County, MD	281	365	307	57	75	63
South	Shreveport, LA and 9 parishes	256	577	166	25	56	16
	Ft. Lauderdale/Broward County, FL	917	1629	720	48	86	38
	Orlando/Orange County, FL	1179	1195	252	66	67	14
	Memphis/Shelby County, TN	424	991	70	29	68	5
	Winston-Salem/Forsyth County, NC	318	347	50	96	105	15
Midwest	Chicago, IL	3217	2784	2236	54	47	38
	Balance of Cook County, IL	461	369	120	35	28	9
	Lake County, IL	156	354	19	41	93	5
	Madison/Dane County, WI	327	230	353	106	75	115
	Washtenaw County/Ann Arbor, MI	219	219	197	78	78	70
	Columbus/Franklin County, OH	1244	1310	1444	105	110	122
	St. Paul/Ramsey County, MN	499	859	1093	85	146	186
West	Alameda County, CA	683	898	924	40	53	54
	Denver, Colorado	1817	2092	1013	17	19	9
	San Francisco, CA	1443	1790	3577	147	183	365
	Long Beach, CA	256	457	203	35	63	28
	Phoenix/Maricopa County, AZ	1823	4163	2008	47	107	51
	Tacoma/Pierce County, WA	317	237	92	41	31	12

Source: Urban Institute calculations based on 2001 CoC application gaps analysis chart and Census poverty figures.

Figure 3.1: Emergency Shelter (ES), Transitional Housing (TH), and Permanent Supportive Housing (PSH) Beds per 10,000 Poverty Population, 2001



Source: Urban Institute calculations based on 2001 CoC application gaps analysis chart and Census poverty figures.

Overall, the style and intensity of emergency services provided by communities varies greatly. Washington DC, Boston, and San Francisco, three communities that have devoted quite extensive resources to their homeless assistance systems, provide higher levels of emergency shelter beds than the other 22 communities in this study. As table 3.1 and figure 3.1 illustrate, Washington, DC maintains 268 emergency shelter beds per 10,000 people living in the jurisdiction with incomes below the federal poverty level; Boston offers 336, and San Francisco offers 147 such beds. At the other end of the spectrum, Denver, Colorado and five surrounding counties provide approximately 17 emergency shelter beds per 10,000 poor people, Southwestern Pennsylvania has 22, and Shreveport and its surrounding parishes 25. While this wide variation among communities cannot be attributed to any single factor, differing philosophies, high vs. low levels of homeownership among those living below the poverty level, and availability of resources are clearly key reasons.

As emergency shelters have evolved over the past twenty years, the mission of shelter providers and their place in the continuum have evolved as well. Once the basis of homeless services, emergency shelters now typically serve as entry points into much larger homeless assistance systems. In the majority of communities visited, shelters were not merely a bed and warm meals, but an avenue to myriad housing and supportive services.

Providers tended to view emergency shelters as offering the first step toward eventual departure from homelessness, in which clients can stabilize and prepare for linkage to other phases of the CoC, mainstream services, and permanent housing. Many of the communities visited reflect this approach by offering service-rich shelters and comprehensive programs. Yet other communities have questioned whether service-rich shelters are appropriate settings for people who are experiencing first- and possibly only-time homelessness that will most likely last only a short time.

At many of the shelters we visited, providers sought to help clients address barriers to maintaining housing and build social networks, so that when they do re-enter mainstream society their chances of cycling back into homelessness are reduced. The type and intensity of services vary by program. Services may be located on site or administered through partnering agencies. They may include case management, drug and alcohol abuse treatment services, mental health services, education and job training, child care, and health services. In Alameda County, California, for example, the East Oakland Community Project, an emergency shelter with 100 beds, provides case management, transportation, education classes, and counseling for residents. Three case managers at the shelter refer people to services, which mostly are available through community networks. In contrast, the Tri-City Homeless Coalition in Alameda County provides most services on site, including an in-house drug and alcohol abuse counselor, education classes, and housing counseling. Clients also must work with case managers to develop long-term goals and save part of their income for use upon exiting the shelter.

Some communities are moving toward full-service or one-stop models to assist individuals in moving out of the emergency shelter phase more easily. In Broward County, for example, the bulk of emergency shelter beds are provided at two full-service regional emergency shelters known as Homeless Assistance Centers (HACs). The HACs are open year-round, 24 hours a day, and provide the majority of services on site. Individuals can stay up to 60 days at a HAC.

In contrast to the service-enriched emergency shelter model, some communities in this study were moving away from emergency shelter toward an emphasis on prevention and permanent housing. These communities typically viewed emergency shelter as a short-term “Band-Aid,” when what is needed is a long-term solution. Columbus/Franklin County, Ohio, for example, actually expects to cut back on emergency shelter capacity as it makes progress in developing permanent supportive housing. As more permanent supportive housing has been developed, this community has seen less demand for emergency shelter services. Columbus/Franklin County’s shift in emphasis came about as the result of an intensive study of the local chronically homeless population, motivated by an interest in developing the waterfront area where many of them stayed. The study led to a long-term strategy for “rebuilding lives” (the name by which the study and its report are known), rather than providing short-term crisis management.

Washtenaw County/Ann Arbor, Michigan planners and providers have also held recurring conversations about moving away from emergency shelter and focusing on permanent housing. To this point, this community has concentrated more of its resources on emergency shelter than on any other component of its CoC. However, the need to do something about the community’s seriously dilapidated largest emergency shelter prompted a review of options. The result of a community-wide process is a plan for a restructured emergency shelter system that de-emphasizes emergency services in the community. The new shelters being constructed or developed in Washtenaw County are designed to accommodate people for shorter periods of time, with the intention of moving persons out of emergency shelter and into transitional or permanent housing much more quickly. Likewise, the emphasis in Madison/Dane County, Wisconsin has been on reducing the need for emergency services. Respondents reported their perception that providers held a long-standing belief that homeless people should not be “warehoused.” Instead, they focus on moving clients quickly from emergency services to transitional housing.

While some communities are making a conscious choice to move away from emergency shelter, other jurisdictions have been forced into the decision due to a lack of resources. Administrators and providers in several jurisdictions, for example, described having an emergency shelter “crisis” due simply to lack of resources. Yet because HUD does not fund emergency shelter through the CoC application, these communities are apprehensive about ranking projects to supply it as a high priority. In one of the study communities, limited space due to high housing costs and zoning restrictions, as well as insufficient funding, have all limited the city’s provision of emergency services. As a result, this community must refer persons to shelters in the nearby metropolis or provide crisis services through prevention funding. Similar problems are evident in at least four other communities in this study.

Many shelter providers also noted their perception that increasing numbers of homeless people with significant workforce engagement are becoming clients at their emergency shelters. One shelter in San Francisco noted that over half of all persons receiving emergency shelter and services were currently employed at least part-time. Similarly, a provider in St. Paul/Ramsey County, Minnesota said that one-quarter of shelter users were working full time, while 40 percent were working at least part time. Providers said they are also seeing a significant increase in persons unable to obtain cash assistance benefits such as welfare or SSI because of strict eligibility requirements including income limits and/or time limits.

Overall, providers and administrators agreed that resources invested in emergency shelter were necessary for most communities. For some communities, however, whether due to changing philosophies or a lack of resources, emergency shelter is playing a lesser role in their CoCs.

Transitional Housing

As communities have developed their homeless service systems, transitional housing has become a part of many communities' response to homelessness. Its role in CoCs has evolved, with some communities having second thoughts on the importance and role of transitional housing in their community, as well as about which types of clients to serve. They are trying to reduce their reliance on transitional housing facilities for many homeless households, while maintaining a commitment to transitional supportive services for households placed in permanent housing. Yet other communities continue to develop and provide transitional housing facilities and view them as a key component in their CoC. These differing views are part of the larger process of defining and redefining what types of programs and services work best for whom, and under what circumstances. Communities are shifting and blurring the lines between CoC components as they try to design programs that meet the needs of their homeless populations, as we discuss at greater length below.

Designed to provide persons with housing and services for a pre-determined period of time, transitional housing provides interim placement for persons who are not ready for or do not have access to permanent housing. Residents have access to intensive services, often provided on site or through community partners. These range from alcohol and drug abuse treatment to financial counseling and employment services. As residents become stabilized, providers are expected to help them find permanent housing.

All communities included in the study were providing some form of transitional housing and services for homeless persons moving out of emergency shelter. However, the number of transitional housing options differed considerably throughout the 25 communities. For example, the total number of transitional housing beds provided per 10,000 poor people ranged from 19 or fewer in Denver, Colorado and five surrounding counties and Rhode Island to more than 180 in San Francisco, Boston, and Washington, DC. The amount of transitional housing a community provides was mainly influenced by factors such as funding, need, and community priorities and philosophies.

Although respondents in all communities seem to recognize the importance of transitional housing for providing clients with more time and assistance with stabilization, some jurisdictions are moving away from transitional housing and toward permanent housing with transitional services. Administrators in Montgomery County, Maryland, for example, reported their belief that the transitional housing phase is disruptive, particularly to families. County officials believe that instead of altering the housing situation at an artificial point in time, families need to be in stable housing and to have service packages that can be modified over time, with more intense case management provided in the early stages of intervention. Therefore, the county plans to begin placing people from the emergency shelter system directly into permanent housing while providing them with transitional services. Because of this shift in philosophy, respondents said they would also like to see more service-intensive emergency shelters, i.e.,

longer-term shelter so more intensive assessment and stabilization could occur before placement in permanent housing.

Columbus/Franklin County, Ohio is also reducing its investment in transitional housing due to shifting community priorities, success with diversion efforts, and construction of permanent housing (a shift that could not occur without significant investment of mainstream resources). Providers in Columbus/Franklin County reported their experiences that diversion programs combined with a more rapid movement into permanent housing is effective in stabilizing many clients. Yet some providers in this community still consider transitional housing essential for those needing more time and assistance in stabilization. People in recovery from substance abuse were most frequently named as needing the transitional environment, at a minimum to keep them from returning to neighborhoods and acquaintances where they would have trouble avoiding drugs and alcohol. The needs of families for supportive services to stabilize their situation are increasingly being handled through placement in permanent housing units coupled with supportive services until the family is out of crisis.

In contrast, respondents in other communities reported an increased reliance on transitional housing because permanent housing units at affordable rents are difficult to acquire. Every respondent in every community in this study, including homeless people themselves in focus groups, described the impossibility of finding housing at affordable rents. Vacancy rates in these communities were reported to be less than 2 and often less than 1 percent, and were often accompanied by rents significantly higher than the Fair Market Rents that housing subsidies will support. For some communities, respondents reported that the high cost and scarcity of permanent housing options were the most significant factors in their increased demand for transitional housing. Other communities, however, were trying to expand their transitional housing supply because they perceive that clients need increased time for stabilization. These providers continue to view transitional housing as a solution, especially for those clients who need significant time to address the barriers and/or gain the skills needed to leave homelessness permanently. (Still other communities, recognizing that the problem was insufficient housing, period, were developing or had developed a commitment to build more permanent affordable housing, if that is what it was going to take.)

In Rhode Island, for example, transitional housing projects continue to receive priority in the ranking process. Most providers stated that clients arrive with increasingly complex problems and need services and a stable living environment for at least two years. Additionally, the lack of available permanent housing has forced providers to focus on transitional housing until the market breaks or resources become available to develop more permanent solutions. Rhode Island's housing vacancy rate is at less than 1 percent statewide. Increasing numbers of persons moving to Rhode Island but continuing to work in higher wage markets out of state, a large student population, and summer vacation rental market allow landlords to get higher than fair market rents, frequently making Section 8 certificates difficult to use. This housing backlog has hampered efforts to move families and individuals into permanent housing; providers reported the need to extend lengths of stay in transitional housing or find housing outside of the area.

A similar situation was seen in St. Paul/Ramsey County, where respondents also reported a rental vacancy rate hovering around 1 percent. Because of the severe shortage in affordable housing, providers said they are being forced to allow clients to remain in transitional housing, converting it to permanent housing through the use of Section 8 vouchers. As a result,

they reported finding themselves having to supplement their ever-decreasing supply of transitional housing. Long Beach, California has also concentrated on developing transitional housing. Facing a shortage of emergency shelter, high housing costs, and zoning restrictions hampering the development of permanent supportive housing, Long Beach has focused on developing transitional housing. This type of housing was also in short supply before the CoC funds became available, and the opportunity to develop these resources using CoC funding fit into the city's plans. Metropolitan Phoenix/Maricopa County, Memphis/Shelby County, Tennessee, Orlando/Orange County, and Washington, DC have continued to dedicate new resources to transitional housing programs as well.

Another trend occurring in several of the communities visited is the conversion of some or all of the abandoned housing on military bases into housing for homeless persons. San Francisco, Alameda County, and Long Beach in California, and Rhode Island have all been working for a number of years to make these conversions. The availability of base housing has prompted heavy investment in rehabilitating units and providing services on former military bases. In Alameda County, for example, the Alameda Point Collaborative, working with the Alameda Naval Air base, is currently rehabilitating over 200 units for transitional and permanent supportive housing.

Permanent Supportive Housing

Permanent supportive housing combines housing assistance and supportive services for homeless persons with disabilities, primarily serving individuals and their families who have serious mental illnesses, chronic substance abuse problems, physical disabilities, or AIDS and related diseases. Permanent supportive housing can be provided through tenant- project-, or sponsor-based assistance in multi-family structures or scattered site apartments. Supportive services are also provided on site or through partnering agencies, depending on the individual and community needs.

Funding for permanent supportive housing comes from many sources, most notably the Supportive Housing Program (SHP) for homeless families and individuals, Shelter Plus Care (S+C), the Section 8 Moderate Rehabilitation Single Room Occupancy (SRO) Program, Housing Opportunities for Persons With AIDS (HOPWA), the Section 811 supportive housing program for persons with disabilities, low-income housing tax credits, and county, state and city dollars. As with emergency shelter and transitional housing, most government programs do not provide adequate funding to cover the high development or rental costs and myriad supportive services needed by the populations served in these programs. If they did, they could not stretch their dollars to cover as many people. Further, many feel that cost-sharing among several government agencies and private sources is an important demonstration of community buy-in to homeless assistance.

While reasonable from a funder's perspective, the consequence is that homeless assistance providers must undertake some degree of capital fundraising or leveraging resources in their community to fund a permanent supportive housing project. A delicate juggling act is also necessary to fund the range of case management, mental health, substance abuse treatment, employment services, and medical treatment necessary. Private insurance and Medicaid usually do not fully cover the costs of the services provided and may not be willing to pay for certain categories of expense at all. Service contracts with mainstream agencies are

also often less secure than the housing components provided in the CoC. They are usually written for shorter periods of time, and contract renewal raises the possibility of less or different resources, timing gaps, and other problems.

As evidenced from the 25 site visits, these factors clearly impact the amount of permanent supportive housing available in communities. Communities including Lake County and Balance of Cook County, Illinois, Memphis/Shelby County, Tennessee, and Denver, Colorado and five surrounding counties offer fewer than 10 permanent supportive housing beds per 10,000 poor people, while other communities such as San Francisco, Boston, Washington, DC, Essex County, New Jersey, and St. Paul/Ramsey County, Minnesota have rates of at least 175/10,000 such units (table 3.1).

Several additional trends appear to be affecting the availability of permanent supportive housing in the communities visited. While need continues to grow in general, every one of our communities is experiencing grave shortages of affordable housing, and the creation of new affordable housing has stalled. Additional obstacles such as restrictive zoning laws force providers to invest time and resources searching for units, and subsequently ensuring that they conform to zoning, accessibility, and community requirements. At the same time, the demand for permanent supportive housing continues to grow as providers in many communities attempt to deal with what they perceive as an increasing number of mentally ill and/or substance abusing single homeless people, and increasingly, adults in homeless families, who need intensive ongoing services.

With HUD placing a high priority on permanent supportive housing, nonprofit providers are eager to respond. But many report difficulties doing so in the current housing market. Some communities have developed creative solutions to this problem. For example, as the amount of affordable permanent housing continues to diminish in the San Francisco Bay Area, Alameda County has worked with the Base Closure Initiative to secure an additional 239 permanent supportive housing units on a decommissioned navy base.

Some communities are able to leverage their resources to provide significant amounts of permanent supportive housing. In Columbus/Franklin County, for example, a major commitment of financial resources from city, county, and state housing funds; the CDBG, United Way, foundation, and other private donations; and the alcohol, drug, and mental health agency will support the development of 800 units of permanent supportive housing. The housing is being designed for the chronically homeless men with substance abuse, mental health, and other disabilities who make up the local "street homeless" or long-term shelter use population. Approximately 175 units are currently in operation or are close to completion.

Some housing authorities have provided a number of units for homeless people, or have established priorities for homeless persons on their Section 8 lists. For example, using the Section 8 SRO Moderate Rehabilitation program, the Boston Housing Authority provides over 450 units of permanent supportive housing for homeless individuals. The housing authority in Columbus/Franklin County, Ohio and several housing authorities in Rhode Island assign priority to homeless families on their Section 8 waiting lists. Similarly, Montgomery County, Maryland's housing authority, the Housing Opportunities Commission, receives a significant amount of the county's CoC dollars for permanent supportive housing projects.

However, local laws and the federal “One Strike and You’re Out” Initiative have made it more difficult to provide housing to some of the most needy segments of the population, including those with substance abuse problems and criminal histories. In Arizona for example, the cities of Mesa and Phoenix passed an ordinance requiring all developers receiving HOME or CDBG funds to indicate on the property deed that they are building a “crime-free zone.” These ordinances prohibit new complexes from allowing any ex-offenders or families of ex-offenders to become tenants until ten years after prison release. The effects of these trends are felt throughout the community, making it nearly impossible for the population to find housing in an increasingly tight housing market. Respondents from other communities indicated that exclusionary zoning problems (e.g., suburban communities requiring multi-car garages, large minimum lot sizes, maximum densities; prohibition of SRO housing; etc.) and “Not In My Back Yard” (NIMBY) issues also make it difficult to site and develop permanent supportive housing.

In addition to funding and siting permanent supportive housing units, communities must also grapple with obtaining supportive services for their residents. First and foremost is the issue of who will offer them. Housing developers typically do not have the expertise to provide supportive services, although their expertise is essential to provide the housing management services that keep units functioning and landlords happy. Homeless service providers, on the other hand, have little familiarity with the complex rules and requirements associated with many federal housing development programs, local ordinances, financing options and their packaging, and similar issues. In addition, the intensive supportive services required to maintain clients’ housing stability often strain resources in these programs. As a result, many communities rely on partnerships between housing developers and service providers. In Columbus/Franklin County, Ohio, for example, providers realized that high-risk families usually lost their housing and forfeited their housing voucher if they did not receive supportive services. Providers found it was neither reasonable nor economically efficient to place high-risk families in permanent housing without the supportive services necessary to assure that they stayed in the unit. To fund these more intensive services, the Columbus Metropolitan Housing Authority partners with the Alcohol, Drug Abuse, and Mental Health Board of Franklin County (ADAMH) and its contract agencies to provide supportive services and does the same with many United Way agencies. A similar partnership exists in Tacoma/Pierce County, Washington between the Metropolitan Development Council, a housing developer, and mainstream service providers.

The most significant short-term issue for providers developing permanent supportive housing is determining how to use limited resources in the most effective and efficient manner. Most jurisdictions must confront community opposition as well as difficulties in acquisition, development, and service provision. Moving the CoCs from crisis management to permanent solutions will require creativity and flexibility with funding sources as well as levels of cooperation among government entities and community-based organizations that are not so essential if one is focused on emergency shelter.

No/Low Demand Shelter and Housing Programs

During site visits we saw examples of, and heard arguments about, shelter and housing programs that could be characterized as making few or no demands that their clients undertake certain activities, change their behavior, or “progress.” This is not to say that the programs have low levels of supportive services—indeed, many are quite service-intensive, but services are offered, not required. Most often the need for such programs is discussed as an issue for

system entry. It is indeed an issue at that point, but in fact, such programs are evolving along the entire CoC, including permanent supportive housing.

The basic idea of a low/no demand shelter, or safe haven, is that having a place for extremely vulnerable people to come in off the street is better for them, and better for the community, than leaving them on the street. Recognizing the need to assist homeless subgroups that traditionally find difficulty in receiving homeless services, several communities have created no/low demand facilities. This parallel set of services work to assist chronically homeless persons with mental illness and/or substance abuse problems who might otherwise be excluded or hard to place in traditional shelters.

The major subgroups among chronically homeless persons often considered in need of no/low demand programs are substance abusers, those with major mental illness, and those with both. As one focus group participant put it with respect to programs in his community, “if you use, you can’t come in; if you’re crazy, you can’t come in; if you have any money at all, you can’t come in.”

The issues of attracting and keeping chronically homeless people attached to programs is often different for the different subgroups. Respondents described some of the differences they had experienced, such as substance abusers being willing to come into facilities, but not if they have to be clean and sober, and not if the facility is going to try to make them do things they don’t want to do. Persons with major mental illnesses are much harder to attract into facilities, and considerable outreach contact may be required to win their trust. Persons with both problems are used to being rejected by everyone.

Some communities, such as San Francisco, have low-demand/no-demand emergency shelters where neither sobriety nor abstinence is required while in the shelter. Other communities resist this approach on the grounds that people will do better if programs have expectations for their behavior, and that required participation in services is a means of helping the homeless “to help themselves.”

In Rhode Island, the Urban League runs two safe haven shelters, with clients able to access intensive mental health services while receiving 24-hour in-house support and counseling. As one client described the Rhode Island program, “the Safe Haven is different from a regular shelter because it feels like you get the full package—a care plan, goals and full services—no matter how [in what condition] you show up at the door.” The flexibility and small size of the programs often enable providers to focus more specifically on individual client needs.

A compromise position observed in some communities is to provide “damp” shelter without demands (except those that involve the safety of residents), but to offer services by making them available at any time and inviting participation. During focus groups, clients with substance abuse problems most often said that they could not and would not handle “demands,” but found themselves able to choose to participate in things that were available and interesting. Providers within the same community may also be split in their willingness to offer no demand accommodations. Providers of no/low demand shelter targeted toward people with severe and persistent mental illness did not seem to become so involved in these debates. The nature of mental illness and the difficulties of attracting people suffering from it to trust service providers create quite different incentive structures for providers than is the situation with

substance abusers. The need is to make the service attractive and nonthreatening, and to build trust gradually through very gentle approaches.

Some communities in this study, notably Columbus/Franklin County, Ohio and Boston, Massachusetts, have made major commitments to provide permanent supportive housing on the same “safe haven” model. Federal demonstration projects (Shern et al., 1997) long ago showed that people with major mental illnesses could be moved directly from chronic street homelessness into permanent supportive housing, with excellent retention rates (upwards of 85 percent at 18 months). Boston was one of the demonstration communities, and continues to develop this type of housing with strong support from the public mental health agency. The same thing is happening in Columbus with respect to people with various disabilities. Interest is very high among street homeless people to move into these units, and once in, most stay. “Transition” is nonexistent; most residents of the first wave of units had about three weeks from application (from the streets) until moving in. Sobriety was not required, nor was a commitment to “progression.” But it did appear from focus group responses that people had reduced their substance abuse, treated fellow residents with respect, refrained from illegal activities on the premises (one of the few actual rules), and were proud of their home.

Overall, low/no demand programs play a key role in the provision of homeless services for many communities, and will probably play an even greater part in the future. These alternative approaches complement the outreach and emergency shelter efforts, providing a haven for those whose needs may not be addressed by other CoC components.

Importance of Supportive Services

Traditionally, HUD dollars support the creation or renovation of buildings (bricks and mortar) and the activities that must be done to keep the buildings operating. They have not gone to pay for services to people residing in the buildings, except insofar as keeping the utilities functioning and the building in good repair can be considered services. When HUD first began to fund projects related to homelessness, many of today’s programs did not exist. Helping to develop them fit into HUD’s traditional role. However, once built, program residents were seen to need a wide variety of services that local communities had been largely unwilling to fund, at least in the past. HUD funding gradually shifted to cover more of these supportive services, and less bricks and mortar and operating expenses. HUD is currently examining how to reverse that shift, as CoC dollars for supportive services took up 48 percent of the FY 2001 appropriation for competitive homeless assistance (down from 53 percent for FY 2000). HUD’s new secretary has indicated that, ideally, communities should get their housing money from HUD and their service money from DHHS or other relevant agencies. As a practical policy matter, this approach would be extremely challenging. To accomplish it, DHHS would need considerably more dollars earmarked for homelessness to replace the nearly \$446 million that HUD spent in FY 2001 funds (down from \$500 million in FY 2000), and joint application procedures would be highly desirable. In addition, neither homeless-targeted nor general DHHS funding is structured to match CoC needs, so some restructuring would be necessary. Discussions are ongoing between HUD and DHHS.

In most of the communities visited, respondents felt that supportive services are a key component to stabilizing individuals in both transitional and permanent housing. When describing their experiences, they seemed to be speaking about people with relatively high

levels of disability and barriers to retaining housing. Providers stressed the importance of intensive supportive services while in transitional housing, providing assistance to those with complex problems that do not allow them to move on to permanent housing as quickly. Also, to best capitalize on the energy and resources invested in attaining permanent housing for clients who have progressed within the system, many providers offer follow-up programs. There is, however, a great need for more information about which types of supportive services are the most effective, in which settings, and whether different types of clients need more or less of different varieties of support.

In San Francisco, for example, the Hamilton Family Center employs two full-time aftercare case managers, who work to build relationships with landlords and help them understand the range of supportive services that will be provided to the new tenants. At the same time, the aftercare case managers assist families moving out of shelter to find employment and child care, and provide them with financial counseling. Aftercare case managers remain in contact with the family on a biweekly or monthly basis for as long as necessary. The case managers believe aftercare services are critical to prevent persons from recycling back into homelessness.

So the dilemma for HUD is how to encourage CoC applicants to use HUD dollars for housing and operating costs and raise supportive services dollars from local sources, while not penalizing them for needing fewer HUD dollars for specific programs that have received both operating and service dollars in the past. We return to this important issue in chapter 9, where we will be able to deal with several issues related to the CoC funding process at the same time.

Permanent Affordable Housing

The principal challenge facing communities in preventing and eradicating homelessness continues to be centered on the lack of permanent affordable housing. As housing demand continues to outweigh supply in many communities, prices soar. Homeless individuals find themselves unable to find affordable and suitable housing. Non-homeless dedicated housing resources available to low-income individuals and families include federally subsidized Section 8 project-based and certificate/voucher programs, public housing, nonprofit-owned housing and other nonprofit operated site-based programs, as well as ongoing rental assistance programs. However, homeless people must compete for these broader resources with low- and very low-income people who are currently housed. Homeless and nonhomeless alike, respondents reported their understanding that many households return Section 8 and other rental assistance vouchers unused because they cannot find housing that meets their needs for the price they can pay (frequently they cannot find units for any price).

Economic growth in many regions has added to the pressure on the limited housing stock. Cities across the country have experienced dramatic changes with regard to housing and the job market over the last five years. The lack of living wage jobs for people exiting welfare and the lack of training and education prevent many low-income and homeless individuals from obtaining employment in the higher paying sectors. As the cost of living continues to rise, low and middle-income households are finding it harder to make ends meet. Additionally, economic opportunities for the homeless population have become even more limited with the current downturn in the economy.

Permanent housing has become very difficult to obtain and retain at any price due to several reasons. Except for public housing and a modest stock of affordable housing units, permanent housing that is affordable to a person or family below the poverty line is for all practical purposes nonexistent in many communities. While homeless people receive a preference from housing authorities in some communities, the waiting lists for Section 8 and public housing are lengthy, often resulting in waits of several years. In addition, very expensive and/or Section 8 saturated rental markets make Section 8 difficult to use for those who get it. Many homeless people and the agencies that serve them have to look outside of the major metropolitan area to find affordable housing.

The decreased availability of affordable housing combined with high rental market costs and low-wages are having a significant effect on communities and local homeless service systems. Providers and administrators stressed that finding affordable housing was their greatest challenge and one of the biggest obstacles for clients trying to secure permanent housing. Many providers interviewed discussed the shortage of affordable housing and the burden it places on the CoC's other services. Respondents also indicated that there is a shortage of housing for particular types of households, such as larger families, persons with mental illness or substance abuse histories, and those who may have a poor credit history or a previous eviction (i.e., most homeless people). Focus groups with current and formerly homeless persons revealed that single mothers with children faced enormous obstacles in finding affordable, appropriate rental housing. For example, a single mother in Rhode Island stated that she had to return her Section 8 voucher even after two extensions, because she was unable to find housing that she could afford within the Fair Market Rent that the certificate would cover. Some providers felt that within their region, Section 8 vouchers were basically useless to the families they served, causing much anxiety among clients interviewed. Clients also expressed that it was difficult to find housing for larger families and intact families.

Recognizing the formidable challenges of creating permanent affordable housing solutions, CoCs nevertheless are beginning to focus on solutions because they recognize that even fully-developed CoCs are not ending homelessness. Many of the communities visited incorporate permanent housing development into their year-round planning, bringing together key stakeholders in the community to discuss the possible solutions. Several communities are working with the local CAP agencies and other nonprofits to stress prevention efforts, rental assistance, and aftercare programs once persons do enter permanent housing. Coordination has also assisted other communities in addressing affordable housing, with increased participation by public housing authorities in the planning process, preference on waiting lists or computerized systems for tracking unit availability.

In Alameda County, the Continuum of Care Council is working to help providers find what permanent housing might be available. Through the efforts of Eden Information and Referral (Eden I&R), case managers are able to obtain listings of affordable market-rate housing available in the county. This information is available to case managers and clients alike via their telephone line. Eden I&R also has "rovers" who travel from shelter to shelter with laptops, using their computerized database to assist clients and case managers with finding housing options. In Rhode Island, the statewide Housing Locator System provides current housing information on assisted units statewide as well as a standardized program of needs assessment and housing search across the state. Identification of permanent housing is a priority at every stage of the Continuum of Care, and the Locator project has created a much more efficient and consistent

mechanism for homeless persons to identify available, albeit limited, affordable permanent housing.

Despite efforts, however, the challenge remains for providers to continue to work with HUD and other mainstream agencies to encourage landlords and private builders to maintain affordable units, while finding solutions in the short term for those clients who need a permanent and stable housing situation now.

Implications

One of the most important findings of this study is the difficulty anyone will have in trying to develop generalizations about the overall strength or weakness of a CoC. Some communities have strong prevention components, others have none. Some communities have extensive permanent supportive housing, while others have little or none. Most communities have significant levels of emergency shelter, but even here, with what might be considered the core of a homeless assistance system, there are communities with little or poor emergency shelter.

It does appear, however, that communities are currently facing interesting and potentially important definitional and boundary issues with respect to the categories of emergency, transitional, and permanent housing. Examining transitional housing arrangements during site visits brought home to the research team the great amount of variability that exists under this rubric. The boundaries differentiating transitional housing from emergency shelter and permanent housing, with or without supportive services, remain fluid. Some clients can move directly from emergency shelter to permanent housing (if they can get it). Sometimes they can do this because their housing crisis is truly limited to housing, and once solved they do not need much else. In other circumstances, especially if clients are able to stay in emergency shelter for several months during which they receive supportive services, they also can move into permanent housing without going through a “transitional” phase. In still other situations, “emergency” shelter becomes “transitional” by sheer dint of there being nowhere else for people to go. Providers then stretch time limits and lengths of stay increase toward the average for “official” transitional programs.

As definitions of types of shelter/housing and the boundaries between them are changing, HUD categories may need to change with them. Some communities are shrinking transitional housing while simultaneously extending emergency shelter to make it more transitional-like, after which people are expected to move to permanent housing or permanent supportive housing. Others are moving toward greater demands for client behavior at the emergency shelter level, which makes emergency shelter into something closer to transitional, but not as long. Subsequent moves to permanent housing often also require longer follow-up than the six months currently allowed. Several issues arise about paying for the housing component when people are placed in permanent units rather than “program” units, especially if they have first been in a “program” unit for a short period of time.

Even more confusing to someone trying to fit a program into one of a few simple categories are the many and varied arrangements that are funded as “transitional.” As already noted, some communities are deliberately trying to reduce this category. They feel strongly that many clients are better off if they can move directly from emergency shelter into permanent

quarters, where they will continue to receive the “transitional” services for as long as they would have if they lived in an official “transitional” housing program. By default, also, people’s stay in transitional programs may be elongated because permanent units are not available.

As controversy continues to exist around the needs and value of transitional housing, providers continue to ask themselves who needs transitional housing, for what, and for how long. Continued research on the value of transitional housing and the clients that most benefit from the specialized services is needed to better understand the continuously evolving role of this Continuum component. One of the issues raised with respect to “transitional” programs in a CoC, whether they occur in actual facilities or as supportive services to people in permanent housing units, is their efficacy and effectiveness. With all the research that has been done on homeless assistance programs, the vast bulk has focused on varieties of permanent supportive housing. We know little about which types of clients, with which characteristics, need to be in a transitional housing facility; which ones will benefit more from transitional services offered to occupants of permanent units; and which ones may not need transitional supports at all beyond a little bit of follow-up by a case manager to see that benefits are stable. Research focused on the benefits of transitional housing for certain subgroups versus permanent housing with supportive services can assist in shaping programs and use of homeless dollars.

There is also the reality of the lives of homeless people that one or two years living in the same place will be the most permanent arrangement they have ever experienced. It is also possible that individuals or families are not ready to move on to permanent housing as quickly as expected. For all these reasons, the lines between transitional and permanent housing have been greatly blurred. To further complicate matters, respondents from some communities have come to realize that in some families, the household head really needs the same types of permanent supportive arrangements that have mostly been reserved for single people with permanent disabilities. The growth of permanent supportive housing for families is the result. Also significant for some clients is the need for no/low demand shelter. Often providing options for the most fragile street homeless, no/low demand shelters can help those clients who might have difficulties adapting to the service intensive, higher demand emergency shelters. The critical question to resolve, however, is how no/low demand shelters should be structured and their sustained role within the Continuum.

Considerable controversy also exists as to the appropriateness of using HUD funding for supportive services, rather than for HUD’s more traditional role of funding physical structures and the operating costs of running them. There is no question in the minds of many respondents that many persons with substantial disabilities arising from substance abuse or mental illness will lose any housing they are given if certain types of supportive services are not given. But which people, and which services, remain controversial. Another vital question is, who should pay for them. Federal agencies currently have an opportunity to step up and coordinate their systems and resources with HUD to alleviate the high costs currently absorbed by the continuum. A secondary but not trivial question is how communities can retain their existing level of HUD funding if they find alternative resources to provide supportive services. Mainstream agencies in quite a number of the communities in this study are providing essential supportive services, a situation that seems highly desirable from the point of view of creating a more extensive and better integrated homeless prevention and service system. However, this extensive integration will it will never happen if the consequence is that communities do not get their full renewal funding. We revisit this issue in Chapter 9.

CHAPTER 4: NAVIGATING THE SYSTEM

The enormous diversity of homeless people and the unique problems and specific needs of each subgroup result in highly complex service systems. The need to provide specialized services for different sub-populations means that some services or programs are appropriate for some groups of clients but not others. Add to this the fact that people entering the system are typically in a state of crisis, often experiencing a complex set of intersecting issues that affect their capacity to navigate the system and locate the most appropriate services for their circumstances. Even when appropriate services exist somewhere in a CoC, most homeless people need some help identifying and accessing them. Good coordination among providers, through streamlined points of entry and improved assessment and referral practices, is important if individuals are to get the help they need from different system components and eventually leave homelessness.

System Entry and Flow

Each community uses its own unique approach and method to deliver services to homeless persons. Before focusing specifically on the ways in which homeless assistance systems interact with mainstream agencies in chapter 5, we first look at the homeless systems as a whole. The following sections describe how these systems work for homeless individuals, including how people enter the system, how they move about in it (if they do), how services are marshaled to help them address barriers to leaving homelessness, and variations related to particular subgroups among the homeless.

System Entry: Fragmented, No Wrong Door, and Centralized Approaches

Entry into homeless assistance networks may be broadly classified as fragmented, “no wrong door,” and centralized into one or a few linked points of entry. By “fragmented” access we are referring to circumstances in which homeless people may directly approach any provider in the network, and may (or may not) gain entry. But the various providers have no systematic way to link among each other, or to assure that anyone approaching them will be connected to the most appropriate services. Clients may have to be on multiple waiting lists, and generally must take the initiative themselves to find needed programs and services. These communities have as many points of entry as there are service providers. Shelters and transitional housing providers receive referrals from a number of sources, including police, the prison system, hospitals, mental health providers, substance abuse providers, other shelters/housing providers, the school system, the local TANF agency, soup kitchens, and day shelters.

These multiple points of entry reflect the difficulty of managing a complex system. To some extent, homeless assistance networks have become catchall human service systems, the system of last resort, serving populations ranging from public inebriates to families with children, domestic violence victims to illegal immigrants. Trying to coordinate among such a huge and highly diverse group of service providers requires a high degree of sophistication, which can be made even more difficult when interagency turf wars and battles over scarce resources arise. Fragmentation is where most communities start.

In contrast to fragmented systems, “no wrong door” approaches maintain the ease of access of being able to approach any program, but augment these first contacts with shared knowledge of what is available and systematic linkages that help clients get to the right programs and services. Many communities in this study have come to recognize the need to streamline the information and referral process. They have developed mechanisms to ensure that people obtain the services they need regardless of the route by which they approach and enter the system. Mechanisms include referral to a “one-stop” service center after the first contact is made, use of hotlines and on-line systems that provide information about service availability, and regular case manager team meetings. Among our communities, the Balance of Cook County, Illinois CoC is a good example of this approach, which we describe in chapter 8.

Finally, some communities have decided to create one, or a few, points of entry to their homeless assistance network. According to proponents, centralized entry minimizes prolonged and misdirected searches for emergency shelter and services, and allows for uniform intake and assessment, which helps ensure equity of access to services. Clients may not be so certain, as described later in this chapter.

A few of the communities in this study have moved to a central intake model for families only (Washington, DC, San Francisco, Columbus/Franklin County, Ohio, and Boston), but only one, Montgomery County, Maryland has a single point of entry for everyone. Montgomery County’s DHHS Crisis Center is this entry point. Single adults seeking shelter are screened for mental health and substance abuse problems, after which people are linked with the appropriate treatment provider. A benefit of the Crisis Center is that it is open 24 hours every day. The Crisis Center also has masters’ level therapists available to conduct clinical assessments, thereby helping ensure that clients get directed to the most appropriate services. This is a clear benefit over systems that employ a no wrong door approach, as the cost of having a masters level therapist at each point of entry would be prohibitive for most agencies. The main drawback to a single point of entry, however, is limited access. This is particularly true for Montgomery County’s Crisis Center, given the suburban makeup of the county. To help address this issue, the Crisis Center has a mobile crisis team that is available to respond in the community. But clients still cite transportation issues, as well as the need to appear in person even after initial intake whenever they want to discuss anything with their case worker. This takes a good deal of time from their days.

While Montgomery County, Maryland is the only community in the study using a true single point of entry, many other communities have attempted to streamline entry into the system through a single point while still maintaining an overall no wrong door approach. This may work in several ways. First, consumers can directly approach providers, and only if the provider is unable to meet the needs of the family or individual will they be referred back to the central point. Ft. Lauderdale/Broward County, Florida, for example, has attempted to streamline entry through 524-BEDS, a telephone hotline service managed by the Broward Coalition for the Homeless and run primarily through volunteer staff composed of formerly homeless individuals. Technically, single people can enter the system through a number of doors. For example, the Broward Outreach Center, one of the county’s regional homeless assistance centers (HACs), receives referrals through the police department, hospitals, and soup kitchens in addition to the hotline. In contrast, the central HAC will only take referrals from sources such as 524-BEDS, as a result of negotiations with the city over the siting of the facility. The city’s consent was contingent on the HAC’s use of centralized referrals to avoid a congregation of homeless individuals standing outside the facility. Families, on the other hand, must enter the system

through 524-BEDS, and providers are also required to call the hotline as families move from emergency shelter to transitional housing.

Centerpoint, one of the homeless assistance programs serving Shreveport, Louisiana and nine surrounding parishes, operates as a central intake office for homeless persons, although potential clients also gain entrance directly through shelters or other programs. While these clients may physically gain access to the homeless assistance system at locations other than Centerpoint, many local homeless service providers use Centerpoint's intake and assessment process, which is documented in the client tracking system, ServicePoint. Moreover, after entering through another portal, homeless clients may later come to Centerpoint to connect to a broad range of services, including case management. Long Beach, California, operates with a similar approach through its Multi-Service Center. Clients may approach shelter and other service facilities on their own, but all may also use the MSC, which is the best way to be assured that one will receive all of the services one needs and that are available.

A number of other localities, including Boston, Columbus/Franklin County, Ohio, San Francisco, and Washington DC, have centralized entry for families, but maintain a more fragmented system on the singles side. In Boston, for example, family access to homeless assistance is controlled almost entirely by the state's Department of Transitional Assistance (DTA), which is the agency that administers TANF. Boston has allocated city, state, and federal resources to provide emergency shelter to families who are ineligible for DTA shelter beds.

Communities may have decided to centralize entry for families but not singles for several different reasons. First, singles may be perceived as representing a more diverse group with more wide-ranging needs, being referred to the homeless system from a greater variety of sources (e.g., prison systems, police, hospitals, mental health providers, detox centers, outreach workers). As a result, it may be more logical to use multiple points of entry. In addition, some communities may simply place a higher value on serving families, as images of homeless children are far less acceptable or politically palatable than those of the public inebriate. As respondents in one community explained, "it is our policy that no child should sleep on the street." Consequently, these communities concentrate their attention and resources on helping families leave homelessness or avoid it in the first place.

Reaching Out to the Hard to Serve

Outreach and engagement strategies are critical for reaching the hardest to serve homeless people and bringing them into the homeless assistance system. Outreach is primarily directed toward finding homeless people who might not use services due to lack of awareness or active avoidance, and who would otherwise be ignored or underserved (Erickson and Page, 1999; McMurray-Avila, 1997). Outreach programs often serve persons with mental health and/or substance abuse issues. These people may be highly vulnerable, and they often cannot meet the requirements of or to bring themselves to trust traditional service providers.

Outreach efforts focus on establishing rapport with the goal of eventually engaging people in services they need and will accept. The goals of outreach are to develop trust, care for immediate needs, provide linkages to services and resources, and help people get connected to mainstream services and, ultimately, to the community (Erickson and Page, 1999). Most communities in this study conducted at least some level of outreach. However, the style

and intensity of outreach varied greatly. For example, some programs targeted specific populations, while others were more general in nature. Most communities used a combination of fixed-site programs such as soup kitchens and drop-in centers, plus mobile programs requiring vans, communication equipment, and medical supplies. Finally, some programs were designed to find individuals and link them to other providers, while outreach workers in other programs continued to serve as clients' case manager during their participation in various programs and services (Erickson and Page, 1999).

In order to be effective, outreach programs must first determine a target population. Some programs limit outreach to a particular geographic area, while others target a specific subpopulation. Many communities visited for this study, including Tacoma/Pierce County, Washington; Winston-Salem/Forsyth County, North Carolina; Memphis/Shelby County, Tennessee; Phoenix/Maricopa County, Arizona; Orlando/Orange County, Florida; St. Paul/Ramsey County, Minnesota; and Butler County (in Southwestern Pennsylvania), conducted specialized outreach to severely mentally ill and dually-diagnosed clients through local PATH or ACCESS programs. This outreach typically included street outreach and day or warming centers, in efforts to bring homeless individuals into the system, and shelter outreach, in an attempt to bring service access to individuals already using shelters.

Lake County, Illinois: Representative Payee Services

Lake County, Illinois, located north of Chicago, is home to a CDBG funded representative payee agency, I-Plus. I-Plus plays an integral role in the local Continuum of Care by providing representative payee services to homeless, mentally ill, drug/alcohol dependent, dually diagnosed and/or developmentally disabled persons. Representative payeeship is a free money management service for persons who are unable to manage their own income due to their disabilities and have chronic histories of homelessness. Case managers and volunteers at I-Plus work with clients of whom approximately 60 percent are Veterans and 40 percent receive Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). I-Plus evaluates each person to determine her/his needs for housing and services such as medication and behavioral health programs—Alcoholics Anonymous and Narcotics Anonymous have meetings onsite. Based on the evaluation, case managers assist clients in setting up savings accounts as well as writing checks for rent, utilities, and other bills. In May 2001, all 165 clients had housing and were continuing to see a case manager regularly.

Currently, I-Plus is participating in a three year research study titled "Homeless Prevention: Psychiatric Care with Representative Payeeship" funded by the Veterans Administration and being conducted by the University of Illinois at Chicago. This study will randomly assign 240 veterans to an experimental or a control group. I-Plus will provide services to 120 veterans in the experimental group. The research will measure the combined effects of psychiatric care in partnership with representative payeeship on the long-term stabilization of homeless persons.

Focus groups conducted for this study were held with clients of outreach and first-intake programs in a couple of our communities. These clients were generally satisfied with the support and services they receive from their homeless-specific program contacts, even when they readily admit that they may themselves be difficult to help. When complaints were voiced about what was hard to get in the system, they generally did not focus on homeless-specific programs but on failures of larger systems. All mentioned the extreme absence of housing they could afford, even when they had cash benefits. All mentioned the paucity of public transportation. And all mentioned the intransigence of mainstream systems (difficulties getting SSI or even information about one's application predominated). However, many also acknowledged that their personal difficulties—mental illness and/or substance abuse, and sometimes physical handicaps—led some providers in their community to deny them access to homeless assistance programs.

Many communities conducted specialized outreach to youth and veterans. In Winston-Salem/Forsyth County, North Carolina, for example, the Department of Veteran Affairs (VA) conducts outreach to homeless veterans to connect them with health care benefits. A program specialist and case manager visit shelters and soup kitchens to help veterans access medical care and mental health services. Depending on the individual circumstances, the VA case manager will either take primary responsibility for the veteran or work as a consultant to the shelter case manager. In Shreveport, Louisiana, the Department of Veteran Affairs employs an outreach worker who teams with a nurse to provide connection opportunities and limited health care to homeless veterans living in remote areas such as under bridges and in wooded camps.

St. Paul, Minnesota (in a joint program with Minneapolis) conducts extensive outreach for youth, a population sometimes overlooked by or excluded from homeless services. In the early 1990s, agencies in these communities were doing a great deal of outreach to youth, but respondents said that the effort was not coordinated and youth were confused about where to go for services. In response, Streetworks was established in 1994 to coordinate the work of nine area agencies that provide myriad services to youth, including emergency shelter, transitional housing, case management, food, mental health assessment and treatment, job training, independent living skills, and culturally specific programs. Each agency is responsible for hiring its own outreach workers, but Streetworks coordinates the effort. There were 28 outreach workers as of June 2001, set to increase to 32 in subsequent months.

After a target population is defined, localities must determine whether to use a fixed site or mobile model. Fixed-site programs such as drop-in centers, day programs, and soup kitchens were ubiquitous in the communities included in the study. Fixed-site programs offer the advantage of allowing a program to reach large numbers of clients with relatively few staff. Providers in St. Paul/Ramsey County, for example, explained that the Dorothy Day Center is one of the first places homeless individuals come. As a result, a number of service providers, including case managers and mental health outreach workers, maintain a presence at the center.

Similarly, soup kitchens within high-density homeless areas may serve hundreds of individuals a day. Washington, DC's Downtown Business Improvement District (BID) Service Center located its services on the site of an existing soup kitchen. It renovated the space, improved the food and lighting, and began to offer medical, mental health, substance abuse, employment and training, benefits linkages, and other services to the meal program's largely single male clientele. City mental health, substance abuse, and welfare agencies have co-

located workers at this site, which has greatly facilitated access to services for homeless people. Use of the meal program has more than doubled in the years since the service center opened, and many users avail themselves of its co-located services.

However, fixed-site programs alone are likely to miss many of the hardest to serve individuals. As a result, CoCs that combine fixed and mobile outreach activities seem likely to encounter a larger proportion of homeless people. For example, Orlando/Orange County, Florida's HOPE Team maintains office hours one day a week at a local soup kitchen, but is out combing the streets and woods at all other times. Similar approaches, albeit on a much larger scale, are used in the cities of San Francisco, Chicago, Boston, and Washington, DC. In San Francisco, for example, eight multidisciplinary teams are deployed to conduct outreach to homeless persons. Community Awareness and Treatment Services, Inc. (CATS) runs Mobile Assistance Patrol vans that provide 24-hour service to assist persons who are homeless. In addition, several providers have their own outreach teams that work within their neighborhoods. The fixed-site components in San Francisco include two major resource centers that provide some direct services and referrals as well as access to showers and lockers, and a number of soup kitchens and day programs.

Chicago also expends significant resources on outreach. The city has a 24-hour crisis intervention center that offers toll-free hotline assistance and mobile assessment and intervention services. The Center responds to over 19,000 homeless-related calls annually. Communication Center staff conduct a crisis screening over the telephone and, as appropriate, locate shelter and other necessary resources. The Chicago Department of Human Services (CDHS) has between four and ten two-person mobile assessment teams at any given time that are dispatched as necessary to provide crisis intervention, transport to shelters, or assistance locating alternative placements for hard-to-place clients. Through cooperative agreements, persons who are homeless are able to report to any police station, hospital emergency room, or other emergency service facility to request shelter and/or await CDHS mobile team shelter transport. This crisis system also involves cooperative agreements with the Chicago Transit Authority to engage and offer services to homeless persons who sleep on the elevated trains and subways at night. Warming centers designed to handle cold-weather overflow, soup kitchens, and low-barrier overnight shelter programs are examples of fixed-site programs within Chicago's continuum that serve an outreach function.

In addition to target population and program design, outreach can also vary in terms of style (Erickson and Page, 1999). Some outreach programs serve as linkages, finding clients and referring them to housing, mainstream mental health, and other service providers, while in others the outreach workers continue to serve as case managers for clients who have accepted services. The majority of examples discussed above were variations of "find and link" programs, such as San Francisco's CATS teams and Orlando/Orange County's HOPE Team. Still, providing linkage-only services to certain homeless populations can result in clients becoming lost to the system. Therefore some agencies do not stop with making referrals, but also help clients follow through to get services, in what has been called a "continuous relationship" model of outreach. The HOPE Team, for example, has established strong working relationships with local mental health and substance abuse programs. As a result, HOPE Team referrals do not have to pay the \$50 charge for detox, and the Center for Drug-Free Living will often find a bed for HOPE referrals even when it is at capacity. The team also assists individuals to obtain identification needed to enter programs, advocates on behalf of clients, and helps arrange transportation when necessary. In addition, having office hours allows team members to

maintain contact with many of their clients and continue to provide emotional support even after placement in other programs. In fact, some of their clients return to work with the HOPE Team as volunteers.

In a continuous relationship model, outreach workers also function as case managers. This may be particularly important for persons with severe mental illness, as trust and continuity of care are critical factors in getting and keeping people connected to the system. This model was being used in at least a few of the communities in this study. In Winston-Salem/Forsyth County, for example, CenterPoint Human Services uses PATH funds to support an outreach worker to conduct street and shelter outreach to individuals in attempt to link them to mental health services. The outreach worker acts as the case manager to these individuals until they are stabilized and can be transferred to mainstream services. One of the primary drawbacks to this model, however, is that it is very demanding for the caseworker and thus requires small caseloads. Winston-Salem/Forsyth County's outreach worker, for example, has a caseload of 15 individuals. While this currently may be unrealistic for many agencies, particularly in areas where need greatly outstrips resources, this is perhaps the direction in which homeless providers should be moving in the future. Low caseloads are critical if case managers are to provide the intensive response that is required to help homeless individuals stabilize and manage their lives. Expecting any effective case management when the case manager has 200 or 300 cases is quite unrealistic; in this as in all other areas, one gets what one is willing to pay for.

Finally, one of the most innovative outreach approaches we saw was in Broward County, which conducts outreach to the hard-to-reach homeless population by teaming a police officer with a formerly homeless individual. The Fort Lauderdale Police Department has dedicated one full-time employee to homeless outreach, while the Broward Coalition for the Homeless supplies the formerly homeless member of the team. The duo brought approximately 1,800 individuals into shelters over a two-year period (although some are likely to be duplicates). This partnership appears to work well for a couple of reasons. First, formerly homeless persons have expertise, skills, and insight that professionals who have never experienced homelessness lack. In addition, formerly homeless persons may inspire greater trust among currently homeless individuals, facilitating a more rapid transition into services. The trust produced through this peer model may also encourage currently homeless persons to serve as voluntary scouts for outreach workers, alerting them to homeless persons who appear to be in need of intervention.

Use of a police officer also offers an interesting dynamic to outreach work. The police officer began conducting outreach wearing plain clothes, based on the assumption that the uniform would either intimidate or alienate homeless persons. However, the outreach team found that the uniform afforded them the respect they needed to engage people, at which point they could begin to build trust and assess for signs of problems.

Regardless of a community's approach to outreach, it seems essential that there are no/low-barrier programs (e.g., safe havens or wet shelters) within the community that will accept the clients referred by outreach and, conversely, that the clients will accept. Not all of our 25 communities had such programs. As mentioned, outreach is critical for reaching the hardest to serve homeless, including persons with mental health issues, substance abuse issues, or both. These individuals are often chronically homeless because they cannot meet the requirements of traditional service providers. It is therefore essential that there be appropriate programs in

which to place these individuals once they have been identified and engaged. Without low-demand shelters, most simply end up back on the streets, thereby defeating a major purpose of outreach.

Whether fixed or mobile, outreach programs can only do their job well if the homeless assistance network contains programs that are willing and able to accommodate people once an outreach worker has convinced them to come in off the streets. More than one outreach staff person interviewed during these site visits, and more than one client focus group participant, expressed their frustration that this was not always the case. We frequently were told of situations in which detox turns people down because their papers are not in order, where emergency shelters refuse to take people who have certain kinds of problems, where some programs turn clients away if they do have money and others do so if they do not have money. Outreach can be good in and of itself, just to keep track of very vulnerable street homeless people and give them a chance to talk with someone and know someone is looking out for them. But outreach would be better if there is always somewhere welcoming to go when one decides to come inside.

Movement Within the System: Ensuring that Individuals Obtain Needed Services

Once individuals enter the system, assessment is necessary to help define problems and match clients to appropriate treatment. Because clients could enter at many points in most of the communities in this study, centralized assessment was rare. Hotline workers and staff at intake centers may conduct a short intake for the purpose of referral, but in-depth assessment generally did not occur until an individual arrived at a shelter and was assigned to a case manager. The sophistication of assessments varied greatly, ranging from basic demographic information to extensive clinical assessment. Most programs and communities fell somewhere in between, discussing client history, identifying barriers to leaving homelessness, exploring housing alternatives, and creating a plan of steps and resources that would be needed to leave homelessness. In a system with multiple “front doors,” having the capacity to conduct a full clinical assessment at each point of entry is largely unrealistic because the cost is prohibitive.

With few exceptions, most homeless persons were subject to multiple assessments as they moved among different system components, even if they never received a comprehensive initial assessment. Some providers we talked with indicated that an initial full clinical assessment—as is done in Montgomery County, Maryland—would aid placement decisions and minimize misdirected searches for assistance. However, most case managers indicated the need to repeat assessment as an individual traverses the system. This was felt to be necessary not only because needs and circumstances change over time, but also because building rapport and establishing trust with a client is critical and must be done each time an individual moves to a new program or case manager. A small number of advocates and case managers even went so far as to say that common assessment could be detrimental to clients, arguing that centralized entry and assessment could cause clients who had experienced difficulty in one part of the continuum to be blackballed from the entire service system.

Some providers felt that the need for multiple assessments would diminish as HMISs are installed and data on clients could be shared more readily. However, the issue of client confidentiality currently acts as a significant barrier to sharing case notes and clinical information, one that is unlikely to dissipate as localities move from paper to computer case

files. In addition, case managers will still be involved in assessment for any number of reasons. These include the fact that assessment conversations are a way to get to know their clients; clients will not tell everyone the same thing, and one caseworker may learn something essential that another would not be told; and client lives change, and therefore the answers to assessment questions will change.

As mentioned, individual service plans (also referred to as treatment or case management plans) were commonplace in the majority of communities included in the study. These plans are typically developed in partnership between the client and case manager, include specific goals and objectives, and serve as a road map by which clients obtain services and move among system components. While development of plans is commonplace, it appears that they are taken much more seriously by some providers than others. For example, some providers/case managers re-assess clients continually, tracking their progress against the goals outlined in the service plan and revising the service plan as necessary. In low- and no-barrier programs, however, plans are generally not mandatory.

Most providers throughout the communities in this study have some in-house services but typically rely on referrals to other programs in order to provide clients with the full array of services that may be necessary. As a consequence, case managers are essential to ensure that clients obtain needed services. In many communities, case management occurs through informal channels, such as networking at local coalition and CoC meetings. Some areas, however, have established formal mechanisms to ensure that providers help clients get what they need. In Madison/Dane County, Wisconsin, for example, local providers have developed meetings among themselves and other interested parties such as the police, at which they discuss the situations and needs of individual homeless persons. The goal is to identify a provider who will take responsibility for the individual's well-being.

Another example comes from Ft. Lauderdale/Broward County, Florida, where all county contracts for homeless services require shelters in one continuum phase to identify shelters or housing with the preceding and/or subsequent phases from which they will accept referrals and make placements. In addition, they must specify the number of referrals that will be accepted from or placed at the collaborating programs on an annual basis. Flexibility is built into the contracts so that if an emergency shelter cannot send enough people to a transitional program, the provider can take individuals from other emergency shelters. If the transitional program reaches capacity, it will then close its waiting list and take only persons from the shelter with the contract. In Washington, DC, TCP also requires contract agencies to identify and work with partners or collaborating agencies as part of their contractual obligations.

To ensure that clients can access mainstream services, Ft. Lauderdale/Broward County, Florida has been working to implement a program known as "Standards of Care." Any case manager working with a client must review a pre-determined list of mainstream services to ensure the client is getting all the benefits and services for which he or she is eligible and has a need. If a client is not receiving a particular service, it is the case manager's responsibility to help the client obtain that service or benefit (as opposed to simply making a referral).

Mainstream services, particularly cash benefit programs, were the most common sources of difficulty and frustration mentioned by homeless people themselves during focus groups. Food stamps were reported to be relatively easy to get in many communities. But SSI, and to a lesser extent either TANF itself or some of the things that TANF was supposed to pay

for, were routinely reported to be hard to get. In addition, even information about progress, the status of an application, or reasons for denial was hard to get. These were the experiences of homeless individuals and family heads who had hardworking case managers. Those without case managers felt they had little chance of success (although clients in one focus group felt they knew more than their case managers about the benefits they needed to access, and that they needed to “be patient and persistent” with their caseworker).

Many localities have also established special CoC committees comprised of service providers to serve as a forum for discussing client needs and service gaps. In Montgomery County, Maryland, for example, two case consultation/service coordination committees meet on a regular basis to insure the movement of clients within the continuum. The Adult Teaming Group, which focuses on homeless single adults, meets biweekly, while the Services Providers Team, focusing on homeless families, meets monthly. The groups meet to coordinate and develop placement plans for homeless individuals, to identify transitional and permanent supportive housing vacancies, to recommend primary and alternative placement options, and to identify and overcome barriers to achievement of service plan objectives.

Centralized intake, where it occurs, also aids in moving clients into needed services because it entails one agency or entity responsible for understanding and overseeing the entire service system. In Broward County, for example, entry for families has been streamlined through the 524-BEDS hotline, and providers are also required to call the hotline as families move from emergency shelter to transitional housing. Providers felt that this approach has helped facilitate access to the system for two primary reasons. First, because the agency managing the hotline does not provide direct services, many providers perceived the workers to be more impartial and therefore better able to prioritize cases and make placement decisions. Second, movement is enhanced because hotline workers understand the big picture, whereas individual providers may concentrate on their program and/or clients only. For example, when a slot opens up at a transitional housing program, 524-BEDS can move a family out of emergency shelter. Subsequently, they can move a family using a motel voucher into shelter, which frees the voucher for a new family. While this movement may eventually occur in systems without a centralized entity to track movement, response time would be significantly slower.

Finally, data systems are an increasingly important tool for tracking clients and ensuring that no one falls through the cracks. Some areas such as Boston, Montgomery County, Maryland, and Shreveport, Louisiana and nine surrounding parishes are quite far along in implementing their HMIS. The ServicePoint system in Shreveport, for example, provides bed availability (with real-time information) and maintains a comprehensive directory of local facilities and programs. Currently, over 40 local homeless providers have adopted the system and are tracking clients from intake and assessment through referral and follow-up. ServicePoint allows providers to use the client tracking function to follow a client’s progress, including which providers clients have seen and what services they have been able to access. In addition, major mainstream service providers, such as the local Veterans Administration Hospital and Office of Mental Health, have pledged to provide the system with relevant information on their homeless clients.

Regardless of the mechanisms case managers use to communicate with one another, it is evident that their involvement is essential to ensure that clients obtain needed services. In Homeless focus groups participants in a number of communities indicated their perception that services were generally available, but also expressed the frustration that accessing those

services sometimes proved difficult at times. In particular, several homeless individuals said that it was basically impossible to obtain Supplemental Security Income (SSI) benefits without the assistance of a case manager. Others explained that access to basic items such as food and shelter was typically not a problem, but that obtaining things such as dental care and eyeglasses was more difficult. Still other clients felt that access to services and benefits was complicated by rules requiring that clients show up in person to discuss issues and/or fill out paperwork (as opposed to discussing things over the phone and faxing paperwork to the appropriate agencies). Clients in one community indicated that even when they did show up for meetings, they were often forced to wait—sometimes for hours—to see their case manager, and that this interfered with their ability to obtain and/or maintain employment.

Still, most focus group participants were generally appreciative of the assistance that their case managers gave them, many acknowledging the complexity and intractability of their own problems. Some complained that the case managers imposed rules that were too strict or did not really listen to what they (the clients) wanted or needed. Most, however, felt that their case managers were aggressive in getting to know them and played an active role in trying to help them, particularly if they were willing to help themselves.

Locked Out: Homeless Sub-groups That Have Not Fared Well

Based on access to resources, local philosophies and priorities, and community need, each of the 25 continuums faces challenges in serving certain sub-populations. Each community identified at least one of the following groups as being hard to serve with existing resources—chronically homeless persons with mental illnesses and/or substance abuse problems, youth, large families and/or families with teenage sons, and ex-offenders. In reality, even though some individual providers intentionally exclude certain subpopulations, very few whole CoCs actually exclude any particular group as a matter of principle. Rather, it is more accurate to say that these populations are underserved, sometimes because of community philosophy or priorities, other times because of insufficient community resources. In still other cases, the groups mentioned may not be underserved so much as hard to place.

Persons with Mental illnesses, Addictions, or Both

Throughout the site visits, the groups most commonly cited as difficult to serve were chronically homeless substance abusers and/or mentally ill persons. In some communities, providers indicated that the system was failing to address the needs of these individuals because of a lack of resources. This is particularly true for persons with mental illnesses. Respondents across many of our communities decried the lack of mental health dollars available in their community and/or states. According to a 1999 San Francisco Coalition for the Homeless report (Locked Out), approximately 31 percent of persons who voluntarily attempted to access mental health services in San Francisco did not receive them, and more than half of the respondents reported a negative experience with the mental health system. Also, as described in more detail in chapter 5, one state's mental health system is so far in debt that even nonhomeless persons have a hard time getting routine services.

Because of limited resources, many communities have taken the step of establishing stricter eligibility requirements for obtaining services. As a result, we also heard that persons

with borderline mental illness had a much more difficult time obtaining services than those with severe problems. On the other hand, several of our communities had extensive networks of services—almost mini-continuums—for people with severe mental illness. Mental health agencies in these communities had recognized that keeping their clients from becoming homeless was better for the clients and more efficient for the system as well.

Quite a number of communities also cited the lack of substance abuse treatment beds as a problem leading to failure to serve. In San Francisco, for example, providers and advocates indicated that there are 1,400 individuals on the waiting list for substance abuse treatment services. Moreover, they explained that the area is home to 19,000 heroin addicts, but has only 2,000 beds to assist them. The severe shortage of beds leaves persons with substance abuse problems unable to obtain needed services.

Obtaining either mental health services or substance abuse treatment is difficult enough in many communities. For persons with both problems, however, it can be almost impossible. Time and again, providers and advocates across the country acknowledged an enormous need for broad-based programs for people with both diagnoses. People in focus groups with both problems also mentioned these difficulties. The issue, of course, is that neither “side” is willing to treat the individual until the other problem is addressed. That is, mental health professionals often will not treat individuals until they are clean and sober, and substance abuse professionals do not want to treat persons with mental illness.

The exclusion of substantial numbers of homeless people with chronic mental illness and/or substance abuse problems is inadvertent in some communities due to a lack of resources. In other communities it is also the result of competing philosophies about the best way to treat or serve homeless individuals. The role of philosophy is especially pronounced when it comes to housing active substance abusers. While the majority of communities had facilities for active substance abusers, there was a noticeable absence of safe havens or damp/wet shelters in a few of the communities we visited. The predominant view in these communities is that homeless individuals need to take responsibility for themselves, and that providing shelter to active users enables their addictions rather than helping them. There was even disagreement in some communities over admitting active substance abusers into soup kitchens and other meal programs, with one provider complaining that the city was attempting to “starve people into submission.” As one focus group participant put it, “they only want you if you don’t really need them.”

In these few communities, it was not uncommon to see a small organization operating outside the CoC system attempting to accommodate active users. Other CoC providers in these communities sometimes acknowledged that these agencies offer a valued service, yet the agencies typically operated in isolation. Rarely did they participate in CoC planning meetings, and they were often excluded from community funding opportunities. Limited resources, in turn, made it difficult for such shelters to provide adequate supervision and services to a group with such intensive needs. The actual conditions in these facilities often created even more skepticism and aversion to such program within these few communities.

In contrast, other communities have made the decision to provide true safe havens for people suffering from mental illness, substance abuse, or both. More importantly, they have demonstrated that it is possible to effectively provide shelter and programming, including permanent supportive housing, for active users in an environment free from crime and violence.

Their rationale for doing so is that people are better off inside than outside—that is, they are less likely to come to harm themselves and less likely to have a negative effect on the larger community. Further, they reason that once inside, people may be induced to accept services and move toward a more stable living situation.

Rhode Island: Collaboration of Mental Health Services and Housing

The Rhode Island Department of Mental Health, Retardation and Hospitals (MHRH) and the Rhode Island Housing and Mortgage Finance Corporation (RI Housing) collaborate very successfully in providing community mental health services and housing for homeless persons with serious mental illnesses. Among its other functions, MHRH supports eight community mental health centers that provide 24-hour emergency services, inpatient services, psychiatric services, medication maintenance, community residences, assistance in finding work and housing, and counseling services.

Under a cooperative agreement between MHRH's Division of Integrated Mental Health Services and RI Housing, MHRH pays most of the salary of RI Housing's Coordinator of Mental Health Housing Programs. The Coordinator's duties include providing technical assistance on a full range of housing options and connecting community mental health centers with housing consultants or community development corporations. Among the housing programs for which technical assistance is provided are Shelter Plus Care, Supportive Housing, Section 8 Moderate Rehabilitation SRO, HOME, Supportive Housing for Persons with Disabilities (Section 811), Section 8 Housing Opportunities for Persons with Disabilities (Mainstream Program), Low-Income Housing Tax Credits and Thresholds. The Thresholds Program administered by RI Housing uses MHRH bond-funds to develop about twenty-five units of housing per year for persons with serious mental illnesses.

The Coordinator is also knowledgeable about mental health programs and programs that reach out to homeless persons with serious mental illnesses, such as the PATH program. He focuses the attention of both the state's housing network and mental health system on the housing needs of persons with serious mental illnesses, including those who are homeless, poorly housed or living with families. The partnership between MHRH and RI Housing and the employment of a Coordinator who speaks the language of both worlds creates an essential bridge between the professions of mental health services and housing.

One of many examples of the success of this collaboration can be seen in Safe Havens I and II. The two safe havens serve homeless people with mental illness who have a history of chronically being on the streets. Together they serve 17 persons at the present time, providing safe, group home environments and making available extensive and varied supportive services. The Urban League of Rhode Island manages the safe havens and provides overall case management. Most of the mental health services are provided by The Providence Center, one the private community mental health centers with which MHRH contracts. Outreach is handled mostly through the joint efforts of the Urban League, the Travelers Aid Society, and The Providence Center. RI Housing was instrumental in the development of Safe Havens I that then served as the model for Safe Havens II. The Continuum of Care played a crucial role by recognizing the need for Safe Havens I, by confirming its rehabilitative effects, and by devoting even more of the Continuum's resources to Safe Havens II.

Experience has often proven them correct, most especially when they take the approach of making services available and inviting participation, but not making demands or requirements. Focus groups with homeless clients in a number of communities indicated that this “offer, repeatedly invite, but don’t require” approach was the only one that they personally would have accepted. Providers in Columbus, Ohio, for example, developed permanent supportive housing units for active users that has been extremely successful at both attracting long-term street homeless people and keeping them in housing. The project does not require clients to be “clean;” rather, the only rules concern illegal activity, violence, noise, respect for others, and maintenance of property. All residents are assigned a case manager from the local substance abuse agency, and many services—including life skills classes, GED preparation, job search, and NA and AA meetings—are available on-site, but clients are not required to participate.

Three residents of the program, all of whom had been homeless for many years before entering the program, participated in a focus group discussion. All three indicated that they hate being required to do or attend anything, and would resist if there were such requirements (which, as they acknowledged, was part of the reason they were homeless for so many years). All three were recruited into the program directly from the streets, and all have been there for approximately one year. They articulated the success of the program’s approach, and said they did attend many of the classes and offerings (including the AA/NA groups), both because they found them useful and because they were not required to attend. All three echoed the words of one—“the minute anyone tells me I have to do something, I’m out of there.”

Youth

Youth was the second most common group cited as underserved by homeless assistance networks, including emancipated youth/runaways and teen parents. Youth appear to be underserved within the homeless assistance system for a number of reasons. In general, it appears that the homeless provider community assumes that other agencies are providing services for youth (e.g., local Department of Social Services or Child Protection Services), and as a result, communities do not rank programs for homeless youth as a high priority within the homeless assistance system. Youth also appear to be excluded because of liability issues. Many shelters will not take unaccompanied youth under age 18, and likewise, numerous providers indicated that teenage girls with babies were extremely difficult to place. Because placement in foster care may mean being separated from their child, many communities, such as Orlando/Orange County, Florida and St. Paul/Ramsey County, Minnesota have developed transitional housing programs targeting teen mothers to help them learn the behavior and attain the skills needed to become self-sufficient.

Youth may also be underserved within homeless programs because they are hard to find. During a client focus group in one community, clients identified “cat-hole kids” (i.e., kids sleeping on the streets) as one of the most underserved groups in the community. However, providers did not mention beds for youth as a gap.

Families

In many respects, the homeless assistance systems in many communities do a better job serving families than singles. More resources are targeted to preventing families from becoming homeless, entry is often streamlined to ensure rapid placement and access to relevant services, and resources are earmarked for emergency services such as motel vouchers to ensure that no child sleeps on the street. Nonetheless, it is evident that families do face unique challenges when navigating the homeless assistance system.

For example, we frequently heard that it was almost impossible to place large families and two-parent families, and that as a result, families are sometimes forced to choose between shelter and staying together. Large families are hard to place simply because they require more space. Few shelters and transitional housing programs can accommodate large families, and finding affordable housing for households needing four or five bedrooms is almost universally impossible. Two-parent families are of course hard to place because shelters and transitional housing programs are typically designed to serve either men or women—not both. Women with teenage sons also have difficulty being placed.

Homeless families also have difficulty accessing mental health and substance abuse services because of their family responsibilities. While outpatient services may be available, there is simply a lack of treatment beds in most communities for women or men with children. As a result, parents often forgo treatment rather than risk being separated from their children. A final difficulty mentioned by homeless family heads in focus groups was child care. Even when the program where they were living provided child care, it often did not cover the hours that parents had to be out looking for work or housing, and sometimes changed its hours without notice.

Ex-Offenders

Communities across the country are just now beginning to feel the effects of sentencing policies from the 1980s and early 1990s as record numbers of individuals leave state and federal prisons to re-enter society. These individuals have spent long periods behind bars, typically receive little assistance with reintegration, and as a result, are not well-prepared for life on the outside (Travis, Solomon, and Waul, 2001). Even in 1996, before the anticipated influx of ex-offenders, national data on homeless service users indicate that 24 percent of homeless males reported having spent time in state or federal prisons, and 61 percent had spent five or more days in a city or county jail (Burt et al., 2001, table 3.8). Homeless service providers are feeling the effects of prisoner re-entry perhaps as strongly as anyone, and reported their perception that ex-offenders are an ever-growing sub-population among the people who use their services.

While not excluded from the homeless assistance system in the same ways that might happen to people with other characteristics, providers almost universally noted the enormous challenge of placing ex-offenders in permanent housing. Some providers indicated that even if the individual has a well-paying job, permanent housing may not be a realistic goal since housing authorities and most landlords refuse to rent to individuals with criminal histories. Often the only possibility is for the ex-offenders to return to friends and family in their old neighborhoods, which may be the source of many of their problems. Issues also arise with

respect to particular types of ex-offenders who are perceived as posing specific risks, both because of their offenses (arson and pedophilia) and because these tend to be compulsive behaviors and likely to be repeated.

The services needed for each of these groups vary widely as does the reason for their exclusion from the homeless assistance system. As such, the solutions for addressing each of these gaps in the continuum of care system will be different. In some cases, policy or legislative changes may help solve the problem. For example, changes in discharge policies and re-entry assistance may be necessary to help prisoners return to their communities and connect with jobs and housing. Other cases may be addressed by a greater integration of mainstream services and resources into the homeless assistance system. Common among all these groups, however, is the need for communities to find additional resources to meet their needs.

Unfortunately, the very presence of these groups among the homeless population testifies to the failure of many mainstream agencies to provide adequate resources for their clientele. Whether the homeless assistance system is the “right” place for these clients or not, there can be little question that more resources are needed somewhere in these communities to assist people in need.

Implications

An important goal of most homeless assistance systems is likely to be effectively responding to the needs of all people who come into contact with the system. A second may be to assure that all homeless people in the community are known to and helped by the system. The first of these goals is hard enough; the second is complicated by the presence of people who actively avoid the system and the notorious difficulties encountered by efforts to count “all” homeless people. It will be nearly impossible for communities to know the numbers and characteristics of homeless people being missed by the homeless assistance system until better data systems exist. These systems must do two things. First, they must be able to identify individuals entering and leaving homeless-specific programs. Second, they must be able to identify homeless people approaching mainstream programs and services to see how many homeless people may use mainstream programs but not homeless-specific ones. Communities that do not conduct outreach to the hardest to serve homeless, however, can be sure that they are missing many individuals.

The goal of effectively responding to the needs of the people who come into contact with the system is perhaps more attainable, but the availability of resources will limit the comprehensiveness of each community’s response. Even in the highly ranked CoC communities participating in this study, it would appear that many client needs go unmet due to lack of appropriate services.

Even when appropriate programs and services are available, however, it is clear that most homeless people need assistance identifying and accessing them. Coordination among providers is essential if individuals are to get the help they need from different system components. However, given the complexity of most service systems and the high staff turnover sometimes associated with social service agencies, formal mechanisms are needed to ensure that providers are aware of resources available within their communities. Formal mechanisms include streamlined and/or centralized entry and assessment, use of hotlines and

data systems that provide real-time information on program and service availability, regular case manager meetings, and Memorandums of Understanding or contractual agreements between service providers.

Many communities continue to struggle with serving certain subpopulations, particularly active substance abusers and those with both substance abuse and mental health problems. Having outreach programs to help identify and engage the hardest-to-serve, and even with the existence of sophisticated data systems to help track the movement of individuals into and through the system, communities will fail to serve a significant number of individuals if they do not establish no or low-barrier programs that will welcome, and be welcomed by, hard-to-serve homeless people once they have been identified. Without such programs, these chronically homeless individuals will only continue to cycle in and out of the system, acting as a drain on already limited resources. It is clear that such programs work, even at the highest level of permanent supportive housing. The issue is creating sufficient capacity to serve the people who need this type of help.

Finally, we were not able to answer the question of whether the CoCs in our 25 communities were accessible to and actually served all homeless people within their boundaries. We can identify subpopulations that have a harder time getting services, as we did in this chapter. We can also be pretty sure that communities without an effective outreach component will miss opportunities to serve the most fragile mentally ill homeless people, and possibly also substance abusers and dual diagnosis people with the longest histories of homelessness, who may be reluctant to approach service programs. But neither we nor the communities themselves can quantify these impressions—that is, we cannot say that the CoC in Community X completely misses 25 percent of local homeless people, or that Community Y's CoC misses only 5 percent. Nor can we quantify amounts of particular services that are needed but not available—that is, we cannot make statements such as “only 40 percent of people needing mental health services actually receive what they need, and as much as they need, for as long as they need it.”

No community we visited (and, we suspect, no community in the United States), has the data that would be needed to make the first type of statement that would require having an accurate count of all homeless people as well as an accurate count of all homeless people who have been in contact with at least one homeless assistance program. These data are not available—at least at the present time. The only example we encountered of a community able to make the second type of statement was San Francisco, which invested resources in estimating the number of homeless people needing both mental health and substance abuse treatment and published a comparison of need versus available treatment slots. It will take a considerable investment in homeless enumeration before communities are able to say with confidence that their CoC reaches the vast majority of people experiencing homelessness within their boundaries. It will take an even greater investment in enumeration, service integration, and service tracking before they can say with confidence that homeless people are able to get the services they need.

CHAPTER 5: INVOLVEMENT OF MAINSTREAM AGENCIES AND SERVICES

Introduction

Homeless individuals and families require a wide range of services that no single agency has the resources or expertise to provide. A homeless client may need the help of numerous agencies including housing, mental health, substance abuse treatment, primary health care, employment and training, cash assistance, and social service agencies. To distinguish these agencies and systems from the homeless-specific programs that have thus far been the focus of this report, we refer to them as “mainstream.”

HUD urges communities to take maximum advantage of mainstream services in responding to the needs of homeless people. This has been a major thrust of HUD CoC requests for proposals—not just for planning, but for coordination of services, and supportive services to accompany the housing components. HUD contends that, to the extent possible, homeless people should participate in all of the support programs for which they are eligible, and mainstream programs should be made to accommodate the special needs of homeless persons. Mainstream programs commonly mentioned in this regard include public housing and vouchers programs, food stamps, SSI, SSDI, general assistance, TANF, job training, health care, mental health care, substance abuse treatment, and veteran programs. Certainly these mainstream programs have more money than homeless-specific programs, and would be able to help more people. In addition, serious and effective efforts to prevent homelessness and develop permanent affordable housing for all will have to come through these systems rather than through homeless-specific services, if they are to come at all.

Ideally, communities should be able to access mainstream services for their homeless populations. There is ample evidence, however, that mainstream programs often prefer not to serve homeless clients, often are not readily accessible to homeless people, and usually do not have enough resources to serve their non-homeless target populations. They therefore historically have not done a good job of serving homeless people. Indeed, some of these systems, such as mental health and corrections, actually contribute to the problem of homelessness in some communities by failing to provide adequate planning and support to individuals leaving institutional settings.

Offering expanded services through homeless-specific programs has historically often been the only way to assure that agencies sympathetic to and able to interact with homeless people are the ones delivering the service. Consequently, homeless-specific job training, health, mental health, housing, and substance abuse programs have been established. Sometimes it has seemed, in the era of service cutbacks, that services under the homeless assistance rubric are the only ones with any growth potential. So people turn to homeless assistance programs when they need mental health or health care, or even child care, rather than to mainstream programs. This pattern distorts the purposes and abilities of homeless and mainstream systems alike.

As communities plan their CoCs, they must make decisions about the role they want mainstream programs to play, and the likelihood that the mainstream programs will be able, and willing, to play those roles. Decisions include how much to rely on mainstream programs, how

much mainstream programs can be relied on, and how much mainstream programs can be brought into the homeless service network through outreach and other mechanisms. In the past, in most communities, it often seemed easier to create mini-systems within the homeless assistance network to mirror the offerings of mainstream programs. However, it is increasingly clear to many communities that the integration of mainstream services and delivery systems is critical to the success of their homeless assistance system.

Despite recognizing the importance of mainstream services, relatively few of the 25 communities in this study were successful in integrating mainstream agencies and systems whose clients include but are not limited to homeless people. The continuum of care planning process in almost all of the 25 communities has led to an increased level of collaboration between homeless service providers, largely because the process directly benefits them. Through it they have an opportunity to obtain funding, share resources, discuss clients, and generally learn from one another. By contrast, mainstream agencies that serve many types of clients may not be willing to invest the time and resources required to participate in the HUD CoC application process. Nor should they have to do so, unless they are directly involved in providing supportive services for particular projects or expect to manage or co-manage HUD-funded projects, and their presence is required in the planning process. For the most part, the interests of mainstream agencies in homeless programs and services lie primarily in other parts of a homeless assistance system.

To integrate mainstream agencies into the homeless assistance system, a jurisdiction must go beyond merely planning for HUD's CoC application, toward a more comprehensive planning process (and ultimately to a more comprehensive and coordinated service delivery system) that truly has prevention and elimination of homelessness as its goal. For various reasons, this has not happened in many communities, but it is starting to happen in some, including a few in this study. To "count," this type of involvement must go beyond simply offering support for the CoC application process, as important as that is, or serving as fiscal agent for HUD CoC funding. It certainly does not mean that a public agency actually applies to HUD for funding for activities that are part of its own public charge. Rather, we are talking about local public agencies (or occasionally, state agencies), actually making investments of their own funds, and their own energies and prestige, in homeless-related programs and services, and even more importantly, in homelessness prevention. This type of investment is not widespread, even among our 25 high-ranking communities. Public housing authorities and/or housing and community development agencies are actually investing their own resources in homeless-related activities in six of our communities, mental health agencies in nine communities, health and human service agencies in eight, veteran affairs agencies in four, and substance abuse agencies in two. Nine of the 25 communities in this study do not have any significant mainstream agency investment of local government resources in their CoC.

Strategies for Involving Mainstream Agencies

A number of communities in this study have taken actions to integrate mainstream services and systems into their homeless assistance system. They have used several different strategies, singly or together, which have achieved varying levels of mainstream agency involvement. These strategies, all of which the CoC approach has encouraged and sometimes funded, include (Dennis, Coccozza, and Steadman, 1999):

- Having staff with the responsibility to promote systems/service integration,
- Creating a local interagency coordinating body,
- Having a centralized authority for the homeless assistance system,
- Co-locating services mainstream services within homeless-specific agencies and programs, and
- Adopting and using an interagency management information system (MIS).

Winston-Salem/Forsyth County, North Carolina: Integrating Mainstream Agencies

Integrating the services and delivery systems of multiple systems is extremely labor-intensive work. Having paid staff persons not only from the homeless service system but also from mainstream agencies that are dedicated to systems integration can greatly increase the likelihood of success.

Winston-Salem's success in integrating two mainstream agencies, the Department of Veteran Affairs (VA) and the Division of Mental Health, into its homeless service system and the CoC planning process is largely due to the creation of staff positions in those agencies dedicated to integrating these systems. Four years ago, North Carolina's Division of Mental Health created a new position, Housing Development Specialist, at each of their area programs. This individual works with landlords, the Housing Authority, housing developers, and advocates to locate permanent supportive housing for mentally ill clients and is responsible for coordinating all available resources within the community to develop affordable, supportive permanent housing.

Similarly, the VA has integrated some of its services and delivery systems into the homeless service system. Five years ago, the VA received a federal mandate to partner with community agencies for transitional housing and intermediate care. The federal agency began monitoring the partnership efforts of its local branches. As a result, the VA focused most of its efforts and funding on acute care and relied on partnerships for the other services. Winston-Salem was one of the communities in which the VA conducted a pilot program on homeless outreach. As a result, the VA, through its outreach worker, has become very involved in the Continuum of Care planning process. In addition, the VA's Health Care for the Homeless staff have taken the lead in establishing a regional coalition of organizations who serve veterans, which includes many area homeless providers.

In contrast to the Division of Mental Health and the VA, the Forsyth County Department of Social Services (DSS) and the Housing Authority of Winston-Salem (HAWS) do not have paid staff persons dedicated to systems integration, but both have been instrumental in collaborating with CoC agencies to serve homeless clients. For example, DSS participates in special CoC meetings related to programs and policies for homeless families. They spearheaded the effort to obtain TANF housing grants to either help clients prevent eviction or place individuals and families back in housing after an eviction. DSS co-located a staff member at the largest provider of the emergency assistance to help with the effort. They are also very involved in parallel planning activities such as the Human Service Providers Council, which includes most CoC agencies.

Similarly, HAWS is a key administrator of several CoC programs, including Shelter Plus Care for persons with HIV/AIDS, HOPWA rental assistance, and HOME tenant-based rental assistance for both homeless individuals in transitional case management as well as persons with mental illness and/or substance abuse. They have also been a cooperative partner in terms of helping CoC agencies use those and other homeless programs as a bridge to Section 8 rental assistance.

Strong leadership is the common thread among all of the communities that have successfully coordinated the service delivery efforts of homeless service providers and, in some cases, have begun to integrate mainstream systems into the homeless assistance system. To make large-scale system change possible, these leaders need vision, an understanding of the various systems, and access to other decisionmakers and resources.

Staff with Systems/Service Integration Responsibilities

Integrating the services and delivery systems of multiple agencies is extremely labor-intensive work. Having paid staff persons not only from the homeless assistance system but also from mainstream agencies who are dedicated to systems integration can greatly increase the likelihood of success. Many of the communities in this study have paid staff that, at a minimum, focus on the Continuum of Care planning process and the application. However, many of these communities do not have the resources to create the senior-level, full-time staff position necessary to institute systems integration and plan for the homeless assistance system in general. Consequently, with such a limited focus, staff members in most of the 25 communities do not have the time, authority, or directive to advance the integration of mainstream systems with the homeless assistance system. Perhaps HUD could develop some incentive structure whereby local dollars devoted to a coordination function could be matched by CoC dollars for transitional or permanent supportive housing programs.

St. Paul/Ramsey County, Minnesota: Collaboration with School Districts

Ramsey County and Catholic Charities very successfully collaborated with St. Paul Public Schools to minimize disruption in the schooling of homeless children living in Downtown St. Paul at the Lowry Family Shelter. In 1997, the Ramsey County Board of Commissioners decided to build a new Family Service Center upon learning that the building in which the Lowry Family Shelter was located would be unavailable when the shelter's lease expired on December 31, 2000. The location of the existing facility was in St. Paul School District 625. The location chosen for the new 55-bed short-term transitional housing facility for families and single adult females is in the North St. Paul/Maplewood School District 622. Concerns were raised about forcing children to change schools. Long before the new Family Service Center was ready to open, Ramsey County and the two school districts began planning how to work within the guidelines of the McKinney Act to address this problem.

One of the primary features of the plan that was agreed upon and implemented was the appointment of two student advocate/liasons, one from each school district. These advocates assist in the enrollment or re-enrollment of the homeless children, coordinate transportation schedules, expedite the continuation of any needed special education, and connect the students with counseling services. Each works directly with families at the Family Service Center in addition to working at their school district offices.

To avoid requiring children to change schools, vans were purchased by School District 622 to provide transportation from Maplewood to St. Paul for students who were previously in school district 625. For those homeless children who were not previously in school district 625, they are enrolled in school district 622, and the Family Service Center has been added as a regular school bus stop. However, to ensure the privacy of the students who are living at the Center, they are picked up first in the morning and dropped off last in the afternoon. While this means they ride the bus for longer periods than other students do, it also means that the other students do not know where they live.

Most of the funding needed to pay for these additional services provided by the two school districts for students living at the Family Service Center comes from Title I of the Elementary and Secondary Education Act, with a small amount coming from the McKinney Act.

Those communities that have invested the resources in staff dedicated to mainstream service integration have moved this process significantly further along than those who have not been able to make this investment. Ft. Lauderdale/Broward County, Florida's success in involving mainstream agencies in the homeless assistance system is partially due to its commitment to funding the position of Homeless Initiative Partnership Administrator. This senior-level, full-time staff position located within the county's Department of Human Services focuses on coordinating homeless assistance within the county. Montgomery County, Maryland has two senior staff persons, based in the county's Department of Health and Human Services Crisis Center and Emergency Services, who are not only responsible for the Continuum of Care application but also co-chair the Policy Development Committee. These and other communities

such as Rhode Island, Long Beach, California, and Columbus/Franklin County, Ohio have invested resources in staff who can focus on the overall planning process for the homeless assistance system and begin to encourage systems integration. An essential characteristic of these resources is that they are coming from the mainstream agencies, not just from the homeless assistance system. An extended example from Winston-Salem/Forsyth County, North Carolina was presented in an earlier box.

Winston-Salem/Forsyth County's success in integrating two mainstream agencies, the Department of Veteran Affairs and the Division of Mental Health, into its homeless assistance system and the CoC planning process is largely due to the creation of staff positions in those agencies dedicated to integrating these systems. Four years ago, North Carolina's Division of Mental Health initiated an effort to address housing issues for mentally ill clients. The Division of Mental Health created a new position at each of its area programs, called a Housing Development Specialist. This individual works with landlords, the Housing Authority, housing developers, and advocates to locate permanent supportive housing for mentally ill clients and is responsible for coordinating all the resources available within the community to develop affordable, supportive permanent housing. Even before the Housing Development Specialist position was created, however, the Division of Mental Health was involved in the homeless assistance system and had an outreach worker (through the PATH program) working with the shelters.

Similarly, the VA, through its homeless outreach worker, has integrated some of its services and delivery systems into the homeless assistance system. Five years ago the federal Department of Veteran Affairs received a mandate to partner with community agencies for transitional housing and intermediate care for homeless veterans. The federal agency began monitoring the partnership efforts of its local branches. As a result, the VA focused most of its efforts and funding on acute care and relied on partnerships for the other services. Winston-Salem/Forsyth County was one of the communities in which the VA conducted a pilot program on homeless outreach. VA funding for homeless outreach is now generally available, and as a result, the VA, through its outreach worker, has become very involved in the Continuum of Care planning process.

Creating a Local Interagency Coordinating Body

Agency staff that participate on local interagency coordinating bodies have the opportunity to establish formal and informal methods of communication, benefit from one another's expertise, and find ways of collaborating and delivering services more efficiently. Additionally, a local interagency coordinating body that includes mainstream agency representatives who have decision-making authority can facilitate the integration of service systems and the sharing of resources. Most communities have been effective in using this type of coordinating body to increase the collaboration among homeless service providers. However, far fewer communities have created coordinating bodies that have resulted in increased coordination between mainstream systems and the homeless assistance system.

From site visit interviews with mainstream agency as well as homeless service representatives, it appears that part of the difficulty with involving mainstream agencies lies specifically with the demands of the HUD CoC application process. Since serious planning for many of our communities only began with the CoC application, it tends to be their core planning

activity. If that is all that a community does, there is probably little hope of gaining serious commitments from mainstream agencies. The details of the application itself come to overwhelm the planning aspects of the process. It is not surprising that representatives of mainstream agencies, as well as business representatives and even homeless service providers who are not submitting applications, may get bored, resent the time spent, see no appropriate role or relevance for themselves, or drop out. The focus of serious mainstream agency involvement needs to be in the larger planning process that many but not all of the communities in this study pursue. There, the issues relevant to mainstream agencies are the top priorities, and time can be devoted to resolving them.

Recognizing that the homeless assistance system must also use mainstream funds and services if they are to provide their clients with the necessary level of services, a number of communities have begun to establish coordinating bodies in an effort to create broad-based community support. Boston and Memphis/Shelby County, Tennessee provide two examples of jurisdictions that have recently begun to use a local interagency coordinating body to better integrate mainstream services and delivery systems into the homeless assistance system. Of longer standing, for a decade Columbus/Franklin County, Ohio has had an effective interagency coordinating body that has successfully accomplished this goal.

Boston's Strategic Homeless Planning Group (SHPG) is a local coordinating body that was created because homeless advocates, service providers and city officials recognized that it would not be possible to address the problem of homelessness without broad-based community support. They wanted a more comprehensive community-wide planning process to look beyond McKinney Act funds to mainstream resources and other funding opportunities, and to determine the need for policy and programmatic changes. Because McKinney Act funds are increasingly needed to maintain the existing system through renewals, Boston recognized that the expansion of its homeless assistance system could only come through improved access to mainstream programs and through identifying possible new financial resources. While Boston's homeless assistance already broadly taps mainstream resources, a major goal of SHPG's five-year strategic plan, which was issued by the Mayor in November 2000, is to improve its efforts in marshalling these mainstream resources.

In Memphis/Shelby County, Tennessee, City and County Mayors established the Mayors' Task Force on Homelessness, consisting of senior level public-private policy and grant makers to oversee development and implementation of a "Blueprint" to break the cycle of homelessness and prevent future homelessness in Memphis and surrounding Shelby County. The Task Force is charged with assisting the integration and coordination of mainstream resources with homeless-specific programs.

The impact of these local interagency coordinating bodies remains to be seen since all are in the early stages of development. However, in Ohio, the Community Shelter Board (CSB) and Columbus/Franklin County have been very effective in developing functioning collaborative arrangements with mainstream agencies for the past decade. CSB has a philosophical orientation to using community resources rather than developing parallel capacity within the homeless system. The involvement of mainstream agencies in Columbus/Franklin County includes providing resources to the homeless assistance system. For example, the Alcohol, Drug Abuse, and Mental Health Agency (ADAMH) is building an "Engagement Center" that will accommodate 50 substance abusers as a low/no barrier emergency shelter. The county commissioners devoted \$1.7 million of capital funds to this program, and ADAMH will use local

tax dollars to operate it. This availability of local backing and local resources makes Columbus/Franklin County a stand-out in being able to act on its vision for preventing and eliminating homelessness.

Having a Centralized Authority

Connecting the homeless assistance system to a centralized authority has provided some jurisdictions with access to mainstream delivery systems that might not otherwise have been available. The initial phases of systems and service integration require building relationships and trust between agencies. When staff that support the homeless assistance system are part of a city or county agency, often they have easier access to decision-makers within their own agency and other agencies and an understanding of how the agencies operate. This access and understanding, if used to promote more and better services, can help build trust across mainstream-homeless service boundaries as the system itself develops. However, under some circumstances, a centralized authority can impede rather than facilitate collaboration between the homeless assistance system and mainstream systems. This may happen if homeless service providers and advocates do not trust the city or county agency or do not view the process as inclusive, open or fair. A centralized authority could also have a detrimental impact on systems integration if decisions were primarily based (or perceived to be based) on politics rather than on the quality of services. Ft. Lauderdale/Broward County, Florida and Montgomery County, Maryland exemplify the ways a centralized authority can positively influence systems integration.

A community's philosophical stance also plays a role in shaping its actual commitment to various goals. While some communities, such as Columbus and Broward County, have the overarching system goal of eliminating homelessness and are taking steps to integrate homeless individuals back into society, others are just beginning to develop their homeless service system. In Columbus, mainstream agencies are doing a good deal of the job of preventing homelessness, ending homelessness through housing options, and providing supportive services to specialized populations. The lead entity for Broward County's Continuum of Care planning process is the Homeless Initiative Partnership Advisory Board, which is staffed by the Homeless Initiative Partnership (HIP) Administrator. Serving in an advisory capacity to the county's Board of Commissioners, the HIP Advisory Board makes recommendations regarding the development, implementation, and coordination of homeless assistance programs within Broward County. The philosophy of the county's homeless assistance system is to integrate homeless individuals back into society by providing them with the resources, relationships, and skills necessary to prevent them from returning to homelessness. Consequently, providing homeless people with access to mainstream resources is a priority for Broward County. The homeless assistance system's close connection with DHS has broadened the system's access to and integration with mainstream services.

Broward County's DHS has helped provide the homeless system with greater access to mainstream resources such as child care and prevention services. For example, the Children Services Board had previously only allocated six childcare slots for homeless families. Through the intervention of the HIP Administrator and the DHS Director, the number of child care slots for homeless families was increased to 20. Coordination with DHS also has helped improve the delivery of homeless prevention services. Ft. Lauderdale/Broward County, Florida went from a disjointed system of providing rent and utility assistance to a one-stop shopping model.

Homeless prevention services are administered through the Broward County Family Success Administration (part of DHS), which last year provided 1,804 families with rent/mortgage assistance and 2,684 families with utility assistance. The three regional Homeless Assistance Centers, which are full-service emergency shelters, link clients to state and local government entities and other human service providers through both on- and off-site services. Their connection to DHS and the Board of Commissioners has facilitated these linkages.

The lead entity for the Montgomery County, Maryland Continuum of Care planning process is the Homeless Policy Development Committee (HPDC), which is co-chaired by the Montgomery County Department of Health and Human Services (DHHS). DHHS does not have a designated division for “homeless services,” but instead integrates these services across each of its six service areas. It was decided to structure the organization in this way because homelessness has the potential of affecting everyone the department serves. Additionally, DHHS’ relationship with the Housing Opportunities Commission (Montgomery County’s housing authority) provides them with greater access to existing housing resources (Section 8 and other subsidized housing units). The central role of DHHS in the homeless services system has allowed the development of a single point of entry into the system through the DHHS Crisis Center, where a homeless individual will receive a mental health and substance abuse assessment by a masters’ level therapist. DHHS’ involvement in the planning process has also led to the development of a centralized homeless management information system, as described in chapter 8.

By contrast, one CoC visited has been successful in bringing homeless service providers into the planning process but has been less successful in involving government mainstream agencies and local businesses. This may be due to the fact that the lead entity of the continuum of care planning process is the only local entity dedicated to coordinating services for homeless people and is not housed in or connected with any government agency. This homeless system tries to include mainstream agencies in its planning but the reverse does not happen, even when a mainstream agency is planning services specifically for the homeless people among its clients. For example, when the substance abuse treatment system in this community received a federal grant to provide services to homeless individuals, it failed to involve the CoC lead agency in its program or even inform it about plans for new services.

Co-Locating Services

Co-locating services provides a direct means for integrating services and delivery systems among multiple providers. Co-location has the immediate effect of improving client access to services. It also can have a broader impact on the overall effort to integrate the service delivery systems by building relationships among staff of different agencies and providing them with the opportunity to gain a better understanding of what other services agencies have to offer. Long Beach, California has concentrated on co-location as its major mechanism for assuring that people and services connect. Its Multi-Service Center (MSC) and the Villages at Cabrillo are two examples of co-location. Both have been developed with CoC grants, but also have a good deal of other funding and commitments. Washington DC’s Downtown BID Service Center is an example of co-located services for which local business and other donors provide all the support.

Long Beach, California: Collaborative Structure of Services

Long Beach has focused on ensuring that people coming to the homeless service system can get whatever services do exist. This has been accomplished through co-location, coordination, collaboration, communication, and collective planning. The complex known as The Villages at Cabrillo is one way this continuum of service access has been achieved.

The Villages at Cabrillo is located on 26 acres of a decommissioned Navy base within the City of Long Beach. Eight residential and a host of supportive service programs are co-located in the Villages, occupying attractively renovated buildings that form a campus and community. Catholic Charities runs an emergency shelter for 14 families. The Salvation Army has just opened a transitional housing program for 16 families. U.S. Veterans Initiative runs transitional housing for veterans (160 beds), the Veterans in Progress (VIP) job re-entry program (55 beds) for veterans seeking employment, and a 20-bed Shelter Plus Care program for senior and handicapped veterans. The Long Beach Veterans Affairs Medical Center operates a 50-bed Substance Abuse Treatment Program. U.S. Veterans Initiative is about to open the ADVANCE Program, a 35-bed job re-entry program for women, and the 1736 Family Crisis Center is about to move in with its youth shelter. In addition to residential services, the Villages complex includes a 30-computer Career Center used for classes offered by Long Beach City College and for employment services using U.S. Department of Labor funds; the Bethune Transitional School, a 2-room K-12 school for homeless children that is part of the Long Beach Unified School District; a child care center; tutoring for all children; a pre-apprenticeship program in the building trades; State of California Employment Development Department job services; and Changing Spirits, an addictions recovery program for Native Americans. Because so many people live at the Villages, mainstream agencies are proving willing to develop services there or outplace a worker. Outplacement is being negotiated with the Department of Public and Social Services (the welfare office) and the Department of Mental Health, each of which expects to place one worker on site one day each week. The Long Beach Parks and Recreation Department is developing a plan to bring recreational activities to the site.

Staff meet monthly to discuss a variety of issues, including those related to co-location of many different types of people, shared clients, client needs, and possible avenues of cooperation. Staff expressed the belief that these meetings have fostered many approaches to collaboration to help clients, have reduced duplicative efforts, and serve to create a “let the experts do what they know how to do” environment.

Long Beach, California’s MSC houses 14 partner agencies including, Beyond Shelter (rental assistance, housing placement, and other prevention); Children Today (child care); Health Department case managers (for assessment, case management, and assistance obtaining other benefits), the Mental Health Association; the Substance Abuse Foundation and Atlantic Recovery, the Travelers Aid Society (case management, life skills, and prevention); the VA (Veteran’s benefits); medical care provided by the Public Health Nursing and Westside Neighborhood Clinic (adult and children’s medical care), adult and children’s medical care;

Disabled Resources; Goodwill Industries; the Los Angeles County Department of Mental Health, the Career Transition Center (job search and readiness); and the U.S. Vet's Initiative.

Co-location at the MSC has meant that clients can meet very quickly with representatives of any services that might be necessary, thus facilitating service delivery for clients needing help from different agencies. Having child care on site means that heads of homeless families are freed to conduct job and housing searches, and obtain other services, while their children receive appropriate supervision and participate in age-appropriate activities. The MSC's van is able to transport clients to and from shelters and service agency locations, again improving client access. And personnel of co-located agencies have become more familiar with services throughout Long Beach, improving their ability to connect clients to appropriate services.

In Washington, DC, the Downtown BID funds a multi-service center that has been very successful in working with street homeless people and those using 12-hour shelters. The Service Center is open from 7 in the morning to 4 in the afternoon, Monday through Friday, occupying space that has long housed meal programs. Food is served through the morning hours. Services available, in addition to the basics of food, showers, laundry, phones, and mail service, include a medical doctor two afternoons a week receiving about 300 visits a month; two psychiatrists two days a week, who see about 150-200 people a month; a representative of the Department of Employment Services three days a week, a representative from Vocational Rehabilitation to help people with disabilities; a welfare worker five days a week to help people obtain cash benefits and food stamps; a worker from the city's substance abuse treatment agency, who pre-clears people for detox and other services; and GED classes four days a week.

In addition, hospitality and sanitation workers who are BID employees have been trained to respond with offers of assistance to homeless people they encounter. Business owners have received a well-designed loose-leaf notebook of resources they can call if they encounter a homeless person who needs help, and the BID maintains its own outreach worker to cover its geographical area. Attendance at the Service Center has more than doubled from before the space was renovated and services began to the present.

We describe the numbers of people using Service Center services because we want to emphasize the likelihood that every visitor probably uses at least one service a month in addition to the basics. The program's philosophy is very important to the ways it structures the availability of its services, and to the ease with which clients can access them. A commitment to helping street people move toward and eventually succeed in leaving homelessness motivates the program's structure and the activity of all of its staff and out-stationed public agency personnel. These people invite service use and make it easy, but do not require it. They do require respectful behavior, with no drinking, smoking, fighting, or illegal activities on the premises. Far from posing barriers to program use, the program now serves more than twice the number of clients as used the previous soup kitchen, and has also helped many move out of addictions and into jobs and housing.

Interagency Management Information Systems

Chapter 8 provides a detailed description of the status of homeless management information systems (HMIS) in the 25 communities of this study. In this chapter, interest in these systems focuses not on their development or characteristics, but on their role in promoting the involvement of mainstream agencies in serving homeless people.

Interagency management information systems can provide a critical planning tool for communities that are attempting to integrate service delivery and systems. An MIS can be used to assess needs for housing and supportive services by seeing trends in causes of homelessness and thereby identifying the gaps in services. It might also provide a basis for examining how effective and efficient a system truly is and where improvements should be made.

In Shreveport, Louisiana and nine surrounding parishes, over 40 local homeless providers currently use an automated client tracking system, ServicePoint, which covers a significant portion of the homeless population. Major mainstream providers, including the Office of Mental Health and Veterans Hospital, have also indicated their interest in using ServicePoint. The commitment of major public service providers to the client tracking system will have a significant impact on the homeless assistance system's ability to coordinate services. Many program directors felt that confidentiality concerns could be overcome and the benefits from centralized client tracking would be helpful in providing service to homeless persons as well as identifying gaps and needs in the system.

In Montgomery County, Maryland, DHHS has been in the process of developing a centralized homeless management information system since 1996, when the county reorganized to combine several smaller departments. As a result, data on homeless clients previously maintained by four separate departments suddenly needed to be accessible across service areas. Databases for the emergency shelter system for singles and families had been maintained by the old Department of Social Services, while mental health and substance abuse treatment information on homeless clients was maintained by the Department of Addictions, Victims, and Mental Health Services. The new DHHS HMIS accomplishes these objectives of merging data systems and increasing access. The ability to share data using the new system across service areas and among DHHS and its private partners has been essential to coordinating services and linking components of the continuum and mainstream agencies.

“Reverse” Integration

Regardless of the success in building relationships across systems and identifying gaps in services, mainstream agencies cannot become a supportive part of a system of services to help people avoid or leave homelessness unless they have resources to invest. An odd outgrowth of the CoC funding process in some communities has been that mainstream agencies, far from spending their “own” money to help homeless people, apply to HUD to fund activities that, it might reasonably be argued, they should be doing themselves. Another example of “reverse” integration happens when mainstream agencies actually refer clients to homeless shelters and services because the responsible public system is not serving them. A third is when clients whose circumstances clearly put them in another system (e.g., refugees, domestic violence victims) appear on the doorstep of homeless assistance systems because

there is nowhere else to go. A disturbing pattern has surfaced in some communities where the homeless assistance system has been expanded into a generic provider of last resort. This was especially noticeable in more than one community where refugee families and/or families affected by domestic violence made up significant proportions of people served in the homeless family system.

Mainstream agencies, which often do not have sufficient resources for their own hardest-to-serve populations, view HUD funding as an opportunity to obtain large amounts of funds in a single package. For example, in one of the communities visited, the local health department applied for and received a CoC grant to create medical beds (essentially nursing home beds) for homeless people released from a hospital who are too sick to return to the emergency shelters where they usually stay. Communities that are concerned about this type of “reverse integration” need to use the priority and ranking process to prevent this from occurring because as long as an applicant agency is eligible, HUD cannot reject proposals from them if the proposals meet fundable criteria.

Representatives in another community voiced their concerns that a sub-mental health system is beginning to develop through their homeless system. According to various estimates, the mental health system of the state in question is \$20 to \$40 million in debt. Since the homeless system now is perceived to be more responsive than the mental health system, individuals who should be assisted by the mainstream mental health system are being referred to the homeless system.

Many mainstream systems provide services that require training and expertise, as they serve clients with complex and specialized problems and issues. It would not be impossible for homeless-specific programs to maintain on their staff people with the relevant training and expertise, but many may not be able to afford to do so. Relatively untrained staff may therefore be called upon to respond to people with substance abuse problems, mental health problems, chronic physical conditions, and various combinations of these things, without adequate knowledge of how to proceed or supervision that can help them out when they get in trouble. Not only can clients suffer, but staff can burn out, feel unsupported, and leave. It would be much better for all concerned if mainstream systems can be induced to supply the expertise and the supervision, leaving those most familiar with homelessness to help these professionals feel at home and effective when dealing with homeless people. Thus each would be using their own talents and training to their best advantage.

Business and Corporate Involvement

Most of this chapter has focused on involvement of public agencies in homeless CoCs, showing how the CoCs have been strengthened to the extent that one or several of these agencies have made serious commitments to serving homeless people. This investment occurs in many of our 25 communities, but we still found nine of these very high-ranking CoCs that did not have such investment from any public agency. Substantial business involvement is even less common than public agency participation, but such involvement has been a powerful force in the communities where it does exist. Fort Lauderdale/Broward County, Florida and Columbus/Franklin County, Ohio are important examples of this influence, as described below. Another example described earlier in this chapter is Washington, DC’s Downtown Business Improvement District and its Service Center. Business leaders are the type of person most

likely to be included in the proposal ranking committees of our 25 communities, and some communities such as Boston are making concerted efforts to increase the involvement of business and corporate interests.

Fort Lauderdale/Broward County, Florida

The Broward Partnership for the Homeless, Inc. (BPHI) formed in 1997 to address the homeless problem confronting Broward County. BPHI's community and county based Board of Directors is comprised of leading representatives from the corporate, nonprofit, governmental, and civic sectors. Its mission is to reduce homelessness by providing quality services and advocacy for homeless people that promotes self-sufficiency and independence and supports their dignity and self-worth.

BPHI's first item of business was to help the Broward County Homeless Services Section find a housing solution for residents of Tent City—a makeshift outdoor temporary shelter that was at times home to as many as 400 individuals in Broward County during the mid 1990s. Located in downtown Fort Lauderdale directly across from City Hall, Tent City served as a constant reminder to the community of the scope and urgency of its homeless problem.

The solution was to build the Broward County Central Homeless Assistance Center/Huizenga Family Campus (HAC) and supporting infrastructure with the understanding that its first mission was to resolve this critical issue. The HAC is a 200 bed, 57,000 square foot, emergency shelter that provides comprehensive services to homeless men, women, and families. The Partnership was charged with raising \$4 million in construction funds and establishing an infrastructure that would assure the operation and management of the Center for the first three years. Broward County provided an additional \$5 million in capital dollars for the Central HAC—\$2 million for land and \$3 million for construction. Wayne Huizenga, owner of the Miami Dolphins and Blockbuster Video, spearheaded the effort. BPHI met its capital campaign fundraising goals by September 1998 and opened the Center under budget and on time in February 1999. While the County provides funding for operations (\$2.3 million in the first year, and \$2.2 million annually thereafter), the Partnership has raised an additional \$2.6 million through grant writing and other fundraising efforts.

Columbus/Franklin County, Ohio

The success of Columbus Ohio's Community Shelter Board in achieving its goals is due in large part to CSB's long-standing partnership with the corporate community. Business involvement in fund raising and strategic planning lends credibility to CSB's mission, increases resources for program development, and provides opportunities for unique partnerships and collaborations.

From its inception, CSB's governing board of trustees has consisted almost exclusively of leadership from the private sector business community. The perspective of well-respected business leaders engenders a bottom line business focus to CSB operations that translates well to the general public, other funders, the government sector, and even provider agencies. This business approach to management and attention to the bottom line is passed on to CSB-funded

partner agencies. CSB has employed an outcomes-based funding model for nearly five years, creating an atmosphere of success, accountability, and results.

CSB had an extremely effective business champion, Mel Schottenstein, who was instrumental in its founding. An attorney who founded what is now the largest law firm in central Ohio, this community leader was also a partner in an extremely successful residential housing development company. It was his personal mission that no person should ever go without a safe place to stay for even one night. As a highly successful businessman and influential community member, his vision and political clout created the business foundation for CSB. He died in 1995 and CSB's annual corporate funding raising event is named in his honor.

While many nonprofit homeless service organizations rely exclusively on the support of government grants to fund operations, CSB leverages public grants with corporate fund raising from the local business community. Private dollars make up over 20 percent of CSB's annual revenue. This allows CSB to reward innovative thinking by providing seed funding to pilot programs and new ventures. A new "direct housing" program implemented two years ago after a successful pilot promotes the relocation of homeless families to permanent, affordable housing as quickly as possible, followed by home-based case management to help families stabilize. This program is funded almost exclusively by donations from the private sector, which has allowed a collaborative of five partner agencies to work together in creative ways to solve homelessness one family at a time. The innovative nature of this program is a direct result of private sector support.

Other examples of business involvement in Columbus include a highly successful annual corporate fund raising campaign that brought in over \$1million in 2001, donated steel from Worthington Industries for construction of supportive housing developments, and a privately-funded shelter staff training program designed to increase skills and competency of partner agency staff.

Implications

Respondents in most of the 25 communities in this study cited a lack of prevention services, permanent affordable housing, and aftercare supportive services in their CoCs. These resources must come from mainstream public agencies or other sources of funding beyond HUD CoC funds. However, in many instances mainstream resources are not provided or made available for the homeless. Not surprisingly, those jurisdictions with the strongest ties to mainstream agencies and the business community were the most effective in being able to obtain these services and use them to prevent or end homelessness for many clients.

The question to answer then is why some of these communities are more successful than others in integrating mainstream services into their homeless service system. While there are a variety of models effectively used for integration, some patterns appear among the communities in this study that have succeeded in involving mainstream agencies.

Communities that recognize that mainstream agencies need to be seriously involved in the larger planning process rather than in the CoC planning and application process have experienced greater success. Unlike the CoC application process, the larger planning process, and the coordinated system of programs and services that can result from it, delve into the

issues relevant to mainstream agencies and time can be devoted to resolving them. However, many communities in this study have not developed a larger planning process so they do not have the framework in place to involve mainstream agencies.

Other key components to successful integration are strong leadership in the homeless assistance system and a commitment from both mainstream agency leadership and homeless-specific program and service providers. Strong leadership is necessary to coordinate the service delivery efforts of homeless service providers and integrate mainstream services into the homeless assistance system. The commitment from mainstream service agencies more often occurs when the homeless assistance system is connected to a centralized authority that provides access to mainstream delivery systems that might not otherwise be available. To be truly effective, mainstream agencies should be actively involved in their own planning processes, to assure that their clients are not at risk of homelessness. Once they have identified their own limits, they can come together with homeless-specific agencies and discuss how together they might coordinate and deliver a broader system of supports so that fewer people would ever become homeless but once they did, their stay in that condition would be short.

Mainstream agencies in many communities have neither the interest nor the resources to participate and make a difference. But there are stunning examples of “good” ones, and what happens when they do participate and carry the weight of their own public charge. HUD may be able to encourage mainstream agencies to invest by making administrative changes in how it handles renewals. Right now, there is no incentive for communities to substitute local mainstream dollars for HUD dollars used for services, because they have no way to transfer the freed-up HUD dollars to the housing/operating expense aspects of NEW projects. Instead, they stand to lose (or believe they stand to lose) the renewal funding. HUD should restructure the incentives to reward communities that replace HUD dollars used for services with funding raised from local mainstream agencies by allowing them to use the freed-up money for new permanent housing (or whatever they need most, but not services).

Another barrier to the integration of mainstream and homeless-specific services in the interest of helping particular individuals is the plethora of separate funding streams, eligibility criteria, even definitions of what constitutes a qualifying mental illness or substance abuse, and the extreme isolation of mainstream agencies from each other. Substance abuse counselors often do not have mental health training or access to trained mental health counselors, and the reverse is also usually true. Corrections staff (e.g., probation and parole officers) do not have access to either, nor, often, do they have any training relevant to either substance abuse or mental illness. Categorical funding streams and incompatible eligibility criteria sometimes flow from federal sources, but just as often arise from state and county organizational criteria. Any ways that HUD could develop to influence federal agencies, or use the carrot of CoC funding to encourage change at the state and local level to reduce the barriers created by categorical funding and eligibility criteria and narrowly focused staff training would help homeless people immensely.

CHAPTER 6: PLANNING FOR AND COORDINATION OF SERVICES TO HELP HOMELESS PEOPLE

We turn now from the broader discussion of local homeless service systems and the involvement of mainstream agencies to a detailed discussion of how HUD's CoC application requirements have affected planning for homeless programs and services. Responses to successive years of HUD's CoC funding opportunities have produced increased communication, coordination, and joint planning among homeless providers in many communities in this study. Many communities have also increased the linkages between mainstream service providers and homeless programs, and a few have succeeded in involving the local business community. The impact of funding for renewals on the flexibility of planning for and coordinating homeless programs and services is also described.

A community's planning for homeless programs and services includes several components. The overarching "planning process" may focus exclusively or heavily on HUD's requirements for the CoC application or may go well beyond it. With respect to the CoC application, HUD requires that communities present a "gaps analysis" showing the gap between "need" and "current inventory" of programs and services to meet that need, and then propose projects for HUD funding that meet at least part of the identified need. We describe the process as we found it in our 25 communities, which usually divided it into several distinct components. These included (1) the preliminary work needed to gather the data to determine need and current inventory for the gaps analysis; (2) the process through which communities assigned high, medium, and low priorities to identified gaps and what they did with the priorities; and (3) the process of ranking all proposals submitted for funding.

The chapter goes on to examine in greater detail the full scope of planning in our 25 communities, considering the ways that planning goes beyond the needs of the CoC application in many communities—sometimes well beyond. We provide several specific examples to show the extent to which planning for homeless programs and services may include mainstream service providers. A brief discussion of larger planning efforts that might affect homeless or potentially homeless people follows. The chapter also considers the flexibility and stability of planning and the impact of renewals on the planning process. It concludes with a discussion of issues or problems facing communities that influence their ability to plan and deliver programs and services effectively to homeless people.

The Gaps Analysis

As part of the CoC application, HUD asks communities to identify the "Need/Extent of the Problem." Applicants must document the urgency of various aspects of the homelessness problem (e.g., need for emergency shelter, transitional housing, etc.), rate their relative importance, and propose targeted activities/programs to address them (DHUD, 2001). The gaps analysis chart is designed to assist communities in determining the need and extent of their gaps in programs and services as well as to communicate this information to HUD in a uniform manner. The gaps analysis chart presents information on estimated need, current inventory, unmet need/gaps, and the relative priority—high, medium, or low—of beds/units, supportive service slots, and subpopulations for both individuals and families. Communities are

also asked to describe the data sources and methods used to complete the gaps analysis chart, the process for prioritizing gaps, and how each proposed project will fill a gap.

While HUD uses the gaps analysis chart to inform the CoC application process, HUD intends communities to use these as tools to aid in planning for and developing homeless programs and services independent of what HUD CoC funds can support. The gaps analysis process and the ways in which different communities use both the process and the resulting prioritization to aid in their planning for programs and services varied substantially from one place to the next. Aspects of the gaps analysis process considered here are the data and methods used, the process for setting priorities, and limitations.

Data Sources and Methods Used in the Gaps Analysis

To determine the number of individuals and families in need of programs and services as well as the number of available beds/units and the remaining gaps in programs and services, the CoC communities in this study rely on many sources of data. They refresh inventories of program beds and other services to indicate current capacity, and pursue many approaches to obtain estimates of need. Over half of our 25 communities report using each of the following data sources to assess need:

- Focus groups or surveys of service providers;
- Local studies or state data analysis;
- Point-in-time counts of people in shelters and on the street in the applicant community; and
- Focus groups or surveys of homeless individuals.

Less frequently used data sources—about one-third of the 25 communities for each—include point-in-time shelter counts (without a street or beyond-shelter component), Consolidated Plan data (if different from the gaps analysis), and shelter tracking data (both automated and unautomated). Infrequently used data sources include turn-away statistics, help line phone calls, and client tracking.

For some weeks or months before HUD issues its Notice of Funds Availability for the CoC dollars, paid staff (if there are any), consultants, and/or volunteers assemble and analyze data for the gaps analysis. In most communities visited, these data were presented and discussed at the kickoff meeting of the CoC application process. They were often then adjusted or modified in light of comments at the meeting, and used to produce the basic numbers in the gaps analysis chart.

Whatever the data sources, the reader should be very clear from the outset that determining both gaps and priorities is more an art than a science, and that no one-to-one correspondence exists between gaps reported in the gaps analysis chart and a community's choice of what to support with HUD or other funds.

Limitations and Criticisms of the Gaps Analysis

The gaps analysis chart and prioritizing process were the subjects of more criticism, and more spontaneous criticism, than any other aspect of homeless planning. In community after community, people asked us “What does HUD do with these data?” and expressed skepticism that the chart could tell anyone, including themselves, anything real about their communities. Criticisms covered many fronts, including the meanings of “current inventory,” the meanings of “current need,” and hence gaps, the value of the service and population statistics, and the complete absence of any requests for performance information, or even information that a project asking for additional money did what it said it was going to with the money it had already received.

The Meaning of “Current Inventory.” The only numbers in the gaps analysis chart with any reliability across communities are the six “current inventory” numbers, giving current emergency, transitional, and permanent supportive housing beds separately for singles and families. One presumes that people can count real beds/capacity that really exist. Even here, though, there is considerable room for doubt. In fact, “current inventory” can vary dramatically from year to year in some communities, going down as well as up. Clearly many communities do not define even existing program beds the same way from year to year. “Permanent supportive housing” is a particularly problematic category. The line between permanent supportive housing developed for and actually available to homeless and formerly homeless people, and generic “disabled” units in 811, 202, and even Section 8 and other public housing sometimes gets blurred. It is possible that one or two homeless people could be placed in these latter units, but to count all of them as current homeless inventory is more than questionable. Also, as the lines between emergency, transitional, and permanent supportive housing become more blurred (as discussed in chapter 3), which units are counted as what becomes less obvious and more problematic for the gaps analysis chart (although not necessarily for actual practice).

The Meaning of “Current Need.” Communities use all kinds of data to estimate their current need. Some of it is very current information, but some of it is admittedly quite old, or only tangentially related to the jurisdiction in question. So “need” is a term of art as used in the gaps analysis chart. This may not be too controversial, since need, however defined, usually exceeds capacity in most communities for most types of service and housing. But as communities get closer to having what they think they ought to have in their CoC, finer-tuned assessments of current need may become important.

The Value of the Service and Population Statistics, Especially As Used to Estimate Need. The gaps analysis chart asks communities to estimate the number of people in certain subpopulations and the number who can be accommodated within the community’s homeless assistance network. It also asks for estimates of the need for and current inventory of service slots, such as job training or case management. These are the most dubious of the statistics in the gaps analysis chart. No one with whom we discussed these statistics took them seriously. The basic information, on need, is frequently estimated from national or sometimes state-level data. Few communities, by their own admission, have a good handle on these breakouts based on data they collected themselves on their own populations. Further, the column on “current inventory,” meaning the number of “slots” available to serve particular populations, is heavily duplicative, as most local people readily admit. That is, more slots are listed as available to serve the different subpopulations than exist in the system. When a slot could serve someone

with severe mental illness, or someone with a substance abuse problem, or someone with both, it is often counted as available with respect to all three subpopulations. Many respondents said they do not find this information useful for planning, but they do feel they jump through hoops to put something in each box, and could use their energy for more productive purposes.

Communities indicated that it would be beneficial for HUD to convene a several-day working session during which community representatives could describe the types of data they would find useful, and that HUD, in turn, could ask for. They would then feel justified in expending resources to get what they really need, and not have to waste time filling meaningless boxes.

While some communities are confident that their data reflect the true gaps in programs and services in their communities, some communities acknowledge that their data are of mediocre quality, out-of-date, or are used to inform the process but not to drive it completely. One community we spoke to limited its prioritizing to a few key issues that it was confident were major problems and gaps. Another community placed little emphasis on the prioritization process because its needs far exceeded the available resources in many areas. And, not surprisingly, some communities said that they strategize about HUD's current funding priorities before determining their own priorities.

In some cases, CoC communities were honest in saying that the gaps analysis was only a piece of the puzzle in determining gaps and priorities. In its 2000 CoC application, Alameda County, California states that "the Gaps chart is a critical, but not isolated, piece of information used by the community to help set priorities for the annual application cycle. It is used in conjunction with the progress and annual work plan for the Continuum of Care Council, the number and breadth of renewals for the year, the geographic analysis of gaps in each sub-region of the county, and other current issues or information, to establish the priorities for the year's submission."

Complete Absence of Any Interest in Performance. Despite promoting the use of performance data for local decision making, the CoC application does not ask for any. Many respondents asked why not, and said they thought that programs should be held accountable for what they accomplished with the money already in hand, before requesting and receiving more.

Setting Priorities in the Gaps Analysis Process

Following the identification of gaps, communities are asked to assess the urgency of filling each gap, assigning a high, medium, or low priority to the type of beds/units and supportive services that would be required to fill gaps. Priorities are also requested with respect to meeting the needs of the particular subpopulations included in the gaps analysis chart (and in the McKinney-Vento legislation governing CoC funding). Most communities describe the process of prioritizing the gaps as an open process that often includes homeless and mainstream service providers, local government, advocates, and representatives from organizations serving some of the same people (e.g., Veteran Affairs) and, in some cases, homeless people. On the other hand, a few communities exclude homeless service providers being considered for CoC funding from the prioritizing process to reduce bias.

While a few communities described prioritizing their gaps as an informal process, the majority had a well-developed formal system for determining priorities. For instance, to increase

the inclusiveness of the prioritizing process, the lead CoC agency in two locations—Ft. Lauderdale/Broward County, Florida and Memphis/Shelby County, Tennessee—hosts an annual retreat that numerous participants from the community attend. In Broward County, nearly 70 people representing service providers, mainstream agencies, city and county government officials, housing developers, advocacy groups, and the business community attended a two-day planning workshop. Facilitators presented the data collected for the gaps analysis and moderated a discussion that resulted in a consensus on the community's relative priorities. The lead agency's advisory board subsequently reviewed, discussed, and finalized the priorities. The final priorities were advertised with the request for proposals from individual programs and distributed at applicant workshops. The priorities were then used as the basis for the ranking committee to prioritize the proposals.

In most communities we visited, the gaps analysis and prioritizing process was extremely inclusive. Anyone with even the remotest interest in homelessness was invited, and could participate. Many did, including providers who might be applying to HUD for money, or might be current recipients of CoC funding from HUD. Most communities held open meetings or forums. Some invited participants to take gaps information and prioritizing materials back to their home agency, share them, and report back on preferences and priorities. We encountered little controversy about the openness of this process.

We did, however, encounter controversy about its meaningfulness. Most communities did their priorities with a clear eye to what HUD would fund. Very few examined their entire CoC, including the elements that were not eligible for funding under the HUD CoC application, and developing clear priorities that might rate something HUD would not fund higher than something HUD would fund. In that sense, the gaps analysis and the priority-setting process (not the process of ranking individual proposals once written, but the process of setting high, medium, and low priorities for which gaps to fill) was construed and acted upon narrowly, with strict attention to HUD priorities. This is not to say that some communities did not also go through a process to determine what their true, continuum-wide, priorities were. They did. At least one community used to do priorities twice—once for HUD and once “for real.” Others did this less formally, deciding what they really needed and looking for ways to support it, even when it was clear that the HUD CoC application was not that way.

It is not clear how communities have come to believe that they should establish their priorities “just for HUD”—that is, so the proposals they send to HUD correspond to gaps they have identified as having the highest priority for new programming. But it is very clear from the vast majority of respondents with any role in the gaps analysis process that most believe this as an article of faith. For example, suppose a community lacked emergency shelter, and that everyone interviewed said this was its top priority. Obviously HUD CoC funding will not support emergency shelter. Should the community set emergency shelter as a high priority in the gaps analysis, reflecting its reality, perhaps simultaneously setting some types of transitional or permanent supportive housing at medium priorities—and then apply to HUD for transitional and permanent supportive housing projects? Most of our respondents would say “no.” They fear their proposals for transitional and permanent supportive housing will be rejected because they do not meet a high priority need. Some even thought that if they gave emergency shelter a high priority they would have to submit a proposal with their CoC application for emergency shelter (because it was a high priority). They knew this would be “throwing away” a high-ranked slot among their proposals, because they knew that HUD would not fund emergency shelter with CoC dollars. So they adjusted their gaps analysis priorities accordingly. Thus their gaps

analysis priorities were not useful to their own community, being wrong. Few were willing to take a chance on losing points because their proposed projects were not identical to their highest-priority gaps from the gaps analysis. In reality, HUD does not use the high, medium, and low priority levels from the gaps analysis chart in this way, being fully aware that communities may have high-priority needs that cannot be funded with CoC dollars. Justifications within the individual project applications are given the greatest weight. Justifications could include anything from having alternative funding to meet a higher priority need to having a lower-priority project ready to go while a higher-priority one would not be feasible for a year or more. It would really help communities if HUD would clarify its desire that the gaps analysis and priority-setting process satisfy community needs, and that applicants need not “game the system” to have their projects funded.

Ranking Homeless Proposals

Another piece in the planning process, in addition to developing the gaps analysis chart and determining relative priorities, is ranking prospective proposals to determine which ones should be ranked highly in the CoC application. The majority of the 25 CoC communities have a proposal ranking process to determine which programs will receive the highest ranking in the CoC application. There is great variability in the methods the 25 CoC communities are using to rank proposals—most have formal ranking criteria, some rely on performance data, but a few have only informal standards and processes. Jurisdictions also vary in the number and types of people involved in the proposal ranking process.

The Proposal Ranking Process

The large majority—20 of 25—communities in this study rely on a formal ranking system that most often includes a system of assigning points to a set of criteria. In 18 of these 20 communities, the ranking criteria are available to potential applicants in advance of the application process while in two communities formal ranking criteria had been developed but were not known by the applicants in advance. Ranking criteria vary by community but include quality measures such as linkages and coordination with other providers, capacity, and past performance data such as client outcomes compared to proposed goals. Other criteria include renewal bonus points, the need for the project/services, the gap being addressed, the mix of populations served, cost effectiveness, leveraging, adherence to quality standards, and the geographic distribution of services and providers. Seven of the 20 communities with formal ranking systems also provide training for those who will be reviewing and ranking the applications.

In addition to formal ranking criteria, 10 of the 25 CoC communities have a pre-application process or requirement. For example, Essex County, New Jersey invites potential applicants to submit a letter of intent, which must include a description of the project, the experience of the applicant, the amount requested, project leveraging, the population and number of people to be served, and a complete budget. The proposal review committee reviews the letters of intent, and each applicant is informed in writing of the results of the review and provided with suggestions for improving the proposal.

Ten of the 25 CoCs visited also have a minimum threshold an applicant must meet, and 10 consider performance data in the application review and ranking process. Performance data may come from site visits, performance reporting, and/or adherence to quality standards. Chapter 8 describes the use of performance data by our communities in more detail. Three communities use performance data quite extensively. While these are in the minority at present, the anticipated use of performance data has been increasing across the 25 communities as many seek ways to make the application process more fair, improve the overall service delivery system, and ensure that homeless persons can move within the continuum and out of homelessness. And, while site visits to programs may not make sense for smaller continuums where the interaction among providers is greater and knowledge about the system and homeless persons is greater, it is likely that communities of any size could benefit from increased performance standards and reporting requirements.

In a few communities—4 of the 25 visited—despite the application ranking process, the ranking may be revised either by the ranking committee itself or by another higher ranking committee or politician with the power to overrule the recommendations of the ranking committee. The revised ranking may occur due to political influence, or to move a renewal project down to insure that newer projects are funded, or because a program that is highly ranked is likely to be able to obtain non-CoC funding.

Who Is Included in the Proposal Ranking Process?

The proposal ranking process includes a number of different categories of people and organizations, among whom are providers, funders, representatives of mainstream organizations, government officials, and various other groups. In the majority of communities, fewer people and organizations participate in ranking proposals than participate in the planning process and gaps analysis. However, in 5 of the 25 communities the same people and organizations participate in both ranking and overall planning. First we consider providers, funders, mainstream organizations, government officials, and others that participate in ranking proposals.

Of our 25 communities, all but two have homeless service providers participating in the ranking process. In most cases, communities have elected to include only those providers without a conflict of interest—that is, providers who are not current CoC applicants or who are not ever likely to receive CoC funds. Fifteen of the 25 communities restrict the participation of service providers to non-conflict-of-interest providers. Specifically, 12 communities limit the ranking process to homeless service providers who are not current CoC applicants, and 3 limit the ranking process to providers who are unlikely ever to receive CoC funds. However, 7 of the 25 communities include providers who are current CoC applicants.

Over time many CoC communities are moving in the direction of excluding providers who may receive CoC funding in an effort to make the ranking process more impartial. In Phoenix/Maricopa County, Arizona, the local United Way was selected to facilitate the ranking process because it is an independent and neutral entity. Committee members for the Rating and Ranking Committee were nominated by and solicited from throughout Maricopa County. Committee members were selected based on their knowledge of homelessness and related issues, business experience, geographic representation, and diversity. Committee members refrained from discussing and voting on any applications where any potential conflict of interest

existed. Ranking committee members represented housing developers, the faith community, public health agencies, businesses, domestic violence service providers, various government agencies, Veteran Affairs, and other interested organizations. In 1999 Delaware's Homeless Planning Council implemented a new process for ranking proposals to ensure that the process was fair. Twelve independent evaluators with a reputation for integrity and objectivity, a familiarity with homeless issues, and no ties to applicant organizations were nominated by the applications committee and related subcommittees. The 2000 panel also included two formerly homeless persons.

Other communities take a different view of including CoC-funded providers in the ranking process. Respondents in these communities said they feel these providers are the people who best know programs and how to meet needs. These communities do not want to lose the advantage of this knowledge in the ranking process. The key to respondent attitudes in these communities was their experience that local providers could be trusted to put the needs of the overall system before those of their individual agencies. Under these conditions, participants felt the results were fair even when CoC-funded providers were heavily involved in ranking.

Funders comprise a second group participating in the ranking process, including representatives from foundations, state and local funders, and, in a few cases, the local United Way. About one-quarter of the 25 communities included a representative of a foundation on the ranking committee. About one-fifth included a representative of a local funding entity. Two ranking committees included state funders. United Way participated in the ranking process in three local continuums of care, and ran it in one.

As we explore further below, the CoC ranking and planning processes in many communities overlap with planning for other homeless funding and programs and services. It is likely that in many communities funders have an intimate knowledge of the local area and many of the programs and services available and programs being ranked, without having a particular bias that might favor one proposal over another. In some cases, funders who may not be integrally involved in the ranking process may rely on the CoC process to inform themselves of current gaps in programs and services and funding priorities. For example, in Balance of Cook County, Illinois, state and local homeless programs and services funders have begun to consult the Task Force on Homelessness to obtain information about gaps in service and the quality of current local homeless programs. This in turn enables the CoC planning group to think about seeking alternative funding sources for projects not eligible for HUD CoC funding with some real knowledge of funding probabilities.

In addition to providers and funders of homeless-specific programs, representatives of government agencies frequently participate in the proposal ranking process. In over half of our 25 communities a city government representative participates in the ranking process. Ten of the 25 communities include a county government representative in the ranking process. And a few larger communities—generally encompassing an entire state or area larger than one county—include a state government representative in the ranking process.

Representatives of numerous local mainstream and other organizations also participate in the ranking process. The most common ranking participant was a corporate or business representative, participating in 10 of the 25 communities. A representative from a public income maintenance or employment and training agency was involved in about one-third of the communities. A representative of the public housing authority, a youth organization, and a state

and/or local mental health or substance abuse agency participated in ranking proposals in about one-fifth of the communities. A representative from Veteran Affairs, the local public schools, and a behavioral health agency participated in ranking proposals in a few communities. In one community—Rhode Island—the police and the Department of Corrections participated in ranking proposals for homeless programs and services.

In addition to providers, funders, government, and mainstream and other organizations, many other individuals participated in the proposal ranking process. Most notable were homeless people—10 of the communities reported that homeless persons actively participate in ranking proposals. One-third of the 25 communities also have representatives from advocacy organizations actively participating, and one-fifth have the local university represented through a faculty member or other affiliated person. A few communities invite members of the general public to rank proposals, though this is unusual.

Tacoma/Pierce County, Washington: Giving Consumers a Voice in the Process

A few years back members of the CoC in Pierce County, Washington, decided they weren't doing an adequate job incorporating client input into the process. They had a few formerly homeless members on the Board, and once in a while one or two clients would attend meetings to express their opinions on a particular issue, but there was no sustained presence in the process. They realized it was unrealistic to expect currently homeless clients to arrange their schedules to meet regularly during the day, or even for formerly homeless clients to leave work to attend meetings on a consistent basis. Further, the presence of one or two individuals on the Board would not provide the type of representation that they sought for the various sub-populations of homeless clients. They came up with an alternative means of reaching these clients—focus groups.

A Focus Groups Sub-Committee was formed and immediately began to set up forums with clients in programs representing several distinct sub-populations of homeless persons. Within a year, they had conducted sessions with clients in HIV/AIDS, mental health, substance abuse, and domestic violence programs. Since then, they have continued with youth, single men and women, families, and veterans. They asked questions like, "What led you to become homeless?" and "If you had a pot of money to fight homelessness, what would you do with it?" to get a better sense of client needs and perspectives on the homeless system. As one can imagine, they received a wealth of feedback.

According to the coordinators of the process, engaging clients in this way has enabled the CoC to achieve sustained communication with clients regarding general needs as well as issues that are of immediate concern to the CoC Board. When specific issues come up in CoC Board meetings, the Focus Groups Sub-Committee will often set up a focus group of clients to discuss the topic, and will report the results back to the Board at the following meeting. It has given clients a forum where they are comfortable talking about their own needs and concerns, and it has given the CoC a means of engaging the primary source of information regarding homeless services.

In general, there is great diversity in the ways that CoC communities rank applications for funding and who is involved in the process, making it difficult to generalize across the 25 communities. Some smaller communities, where the number of homeless service providers and other involved organizations is smaller, have an informal ranking process with only a few key players involved in the ranking. Other smaller communities, however, have moved to a system with formal ranking criteria and participants without CoC funding to ensure that the ranking process is fair and, perhaps more importantly, to ensure that homeless programs and services are monitored for quality from one year to the next. All the larger CoCs—those with several counties or a large metropolitan area—have moved to a formal application and ranking process with criteria available to providers in advance. Organizationally, a formal system is easier to manage and, with many providers competing for limited funds, respondents said they felt a fair, open process was a necessity for their communities.

Jurisdictions that allow CoC-funded providers to participate in the ranking process may be small, medium, or large. Many CoC communities that include CoC-funded providers in the ranking process see this as helping them reach the right decisions. Respondents from one such community pointed to the experience and first-hand knowledge of these providers as being beneficial to the process. On the other hand, respondents in other communities pointed out the difficulties that can result when these providers are included and do not focus on the “greater good” of the whole community. Over time as the renewal burden increases, the results of proposal ranking will determine who gets funded and who does not. As communities continue to seek ways to distribute limited funds to a growing number of programs, it seems likely that those communities not currently operating with a formal, unbiased ranking process emphasizing quality programs and services will begin to move in that direction.

Scope of Planning for Homeless Programs and Services

In the 25 communities in this study, planning for homeless programs and services ranges from planning focused solely on the CoC application process and its HUD-funded programs and services to year-round, multi-year planning for homeless programs and services whatever their funding sources. Mainstream agencies are often integrally involved in these larger processes. As expected, given that these 25 CoCs are highly ranked by HUD, many of the 25 communities have developed planning processes that are at the very least year-round and that consider multiple sources of funding. Nearly all the communities report that the CoC application process has improved planning for homeless programs and services over the past several years. In general, those communities that report that the CoC application has not increased planning for homeless programs and services are communities that have long histories of planning for, providing, and coordinating homeless programs and services using many funding sources.

In this section we consider three levels of planning: (1) planning limited to the CoC application that may be part-year but is usually year-round; (2) year-round planning with a focus on the larger system of homeless programs and services including the integration of at least some mainstream programs and services; and (3) multi-year, strategic planning for homeless programs and services well-integrated with mainstream services, and usually with a goal of ending homelessness. Some of the CoC communities may not fall neatly into one category, and these three levels of planning should be viewed as a continuum. When appropriate, we

include examples to illustrate these different levels of planning for homeless programs and services.

Scope of Planning: Limited to the HUD-funded Continuum of Care

In eight of the 25 communities, local planning for homeless programs and services is limited to coordinating, providing, and planning only for those programs and services funded using HUD CoC dollars. While the majority of these communities have a year-round planning process, the planning group membership and process is often dominated by homeless service providers. In some cases, efforts to increase participation by public sector mainstream agencies (e.g., Veteran Affairs, state/local mental health or substance abuse agencies, public housing authority) and the business community have been unsuccessful or, in a few cases, no efforts have been made. In other cases, attendance at the planning meetings occurs, but participation by those in attendance is minimal. One CoC lead agency staff member described mainstream agency involvement as “those systems happen without [the lead agency]. We try to bring them in, but they do not bring us in.” In this case, the CoC lead agency felt that it was not well known, so mainstream agencies may not think of bringing it into their own planning process.

Some communities created a specific entity—a committee, board, or even agency—to put together the CoC application and obtain HUD funds. Sometimes this entity, with a relatively narrow focus, continues to work on the CoC application while a separate long-standing parallel group with a broader focus, plans more generally for homeless programs and services. If these two independent groups do not eventually merge, the CoC planning and application process may remain a narrow function, separate from broader planning processes. Often the CoC planning process is evolving and communities, aware that their planning efforts are limited in scope, are actively working to expand their planning efforts over time. Some CoC communities, however, content with their high ranking by HUD, take the “if it ain’t broke, don’t fix it” attitude and are less concerned with broadening their planning processes.

Scope of Planning: The Larger Homeless Assistance System

In another approximately one-third of the 25 CoC communities, planning is year-round and focuses on the larger system of homeless programs and services that includes but expands beyond the HUD CoC application and funding process. Planning at this intermediate level includes the integration of at least some mainstream programs and services and includes serious concerns about mainstream problems such as housing affordability. With an inclusive planning process, these communities focus primarily on homeless programs and services while recognizing the need to develop long-term solutions. These communities have developed planning structures and processes that clearly meet and often exceed HUD’s expectations for the CoC process. The planning structures and processes of Madison/Dane County, Wisconsin and Shreveport, Louisiana and nine surrounding parishes (counties) exemplify this approach.

Planning in Madison/Dane County is a year-round process facilitated by the Homeless Services Consortium (HSC)—the lead CoC agency in the county. Begun in the 1980s, HSC is a group of 30 to 40 people that meets monthly to discuss priorities, service needs and duplication, and coordination of homeless programs and services. Given HSC’s long involvement in

Madison/Dane County homelessness issues, the CoC planning and application process is a small portion of its planning for homeless-related activities in Madison/Dane County.

HSC is an inclusive group of service providers, advocates, local public agency representatives (e.g., police, the Madison Metropolitan School District, the Veterans Administration), other funders (e.g., state and CDBG representatives), and state and county officials (e.g., Dane County Department of Human Services and the State Division of Housing). No direct homeless service providers are excluded from HSC's monthly planning sessions, and some mainstream service providers participate. For example, a social worker from the Madison Metropolitan School District is an active member of the HSC and has been working on homeless issues in the schools for the past ten years. The social worker coordinates with local service providers—by receiving and making referrals—to ensure that families have housing, case management, medical services, transportation, and emergency services monies (e.g., security deposits). These social worker positions are funded through the school district budget and this funding has increased in response to increasing homelessness and children's needs.

Many other mainstream providers also participate in planning for homeless programs and services. As in many other communities, however, some mainstream providers elect not to participate, since they do not serve homeless persons exclusively and may be spread too thin to make such services a priority.

In Shreveport, Louisiana and nine surrounding parishes, the lead entity—the Northwest Louisiana Homeless, Housing and Service Development Corporation (“the Coalition”)—facilitates the CoC application and planning processes. Planning for homeless programs and services is conducted through Coalition committees with significant involvement from homeless service providers, mainstream service providers (particularly the Veterans Administration and the Office of Mental Health), and other government agencies. The Coalition has an “open door” policy with regard to participation in all activities including planning. Membership in the Coalition has continued to rise over the last several years and both coordinators and service directors are pleased with the breadth of participation and thinking of ways to expand their network.

Homeless service providers, mainstream agencies, and local government view the planning process of the Coalition as beneficial and worthwhile to Shreveport, Louisiana and nine surrounding parishes. The model has worked so well for planning, information sharing, and service coordination for homelessness that a group of providers (both homeless and mainstream) decided to create a new organization, Shreveport-Bossier Service Connection, to do for the entire social service system what the Coalition was able to do for the homeless assistance system. Thus, the mission of Service Connection is “to plan, network, and communicate to build a better community.” It hopes to (1) improve knowledge of community resources and needs; (2) improve communication among business, government, civic leaders, social service providers, the faith community, and the general community; (3) coordinate client services; and (4) plan for the community.

Both Madison/Dane County, Wisconsin and Shreveport, Louisiana and its nine surrounding parishes exemplify planning for homeless programs and services at this intermediate level. Each community has included many players at the planning table and has developed a year-round, comprehensive plan for programs and services beyond those funded by HUD through the CoC application.

Scope of Planning: Strategic Multi-Year Planning for the Larger Homeless Assistance System

About one-third of the 25 CoC communities engage in multi-year, strategic planning for homeless programs and services that are well-integrated with planning for mainstream services. While the planning processes and strategies vary even among these communities, planning generally exceeds that required by HUD and is truly inclusive and comprehensive. In addition to having a multi-year strategic plan for managing, coordinating, and providing homeless programs and services, some of these communities also periodically rethink their goals and their plans to achieve those goals. Maintaining this flexibility is difficult given the renewal burden many communities are facing. However, the ability to alter the planning process to meet the changing needs of homeless subpopulations and to evaluate the quality of programs and services and replace them with better programs and services are important factors in developing a clear strategy for planning homeless programs and services. Planning in Columbus/Franklin County, Ohio and the regional planning efforts in Illinois are particularly noteworthy examples of innovative planning efforts.

Chicago, Illinois: Strategic Planning

Chicago has been providing assistance to homeless persons for over a quarter century, beginning in the early 1970s with a city government emergency-response team that worked with the police to deal with non-crime calls—the majority of which came from people who were marginally housed. Later, the city established a homeless task force that, over time, was comprised of representatives of various levels of government, a large number of private service and shelter providers, advocates, homeless and formerly homeless persons, and representatives of the foundation and business communities. By the time HUD issued its first SuperNOFA, therefore, the number and variety of entities involved in Chicago's homeless assistance system, as well as the services provided, effectively constituted a full continuum of care, although it was neither formalized nor coordinated as such. The sheer size of the system, multiplicity of funding sources, variety of participants, and locations of services resulted in a system that was relatively unorganized and uncoordinated on a city-wide basis, and that was often motivated by city government and external events.

Although it has a long-established homeless assistance system, Chicago has recently engaged in an ambitious effort to better coordinate and improve its continuum of care. As such, its system is currently in transition and is a "work in progress." For one thing, numerous providers and others have been involved in a facilitated strategic planning process that attempts to build consensus among stakeholders as to the long-term objectives of the CoC—going well beyond seeing it as a funding process for HUD's SuperNOFA. At the same time, the city has begun to develop more of an equal partnership between the government and non-government parties to its continuum of care. The CoC's formally nominated Governing Board is co-chaired by both a city and non-city government person, and all interested parties can participate in a CoC Committee. It is currently attempting to formalize goals and a governance process, develop policies, and fashion an application process that includes an evaluation system. Along these lines, the CoC has formulated a site-review aspect to the application review process that is also intended to provide "a community building experience." Service providers and others who participate have the opportunity to

visit and converse with representatives of organizations they may otherwise not be aware of, turning the funding process away from straight competition of one-against-another into a process that focuses on community-wide needs and resources.

Finally, the city is an active participant in a Regional Roundtable that includes the city of Evanston and six counties that surround Chicago. Its first project—funded with a half million dollars of primarily private but also some public money—involves the collection of an extensive body of region-wide data and the development of a process for continued standardized collection of such data in years to come. This will result in an annual point-in-time homeless needs assessment across the metropolitan area that will yield an inventory of existing services, information on service needs, and data on the characteristics of the homeless population by sub-region and sub-population. There is also some hope that inter-regional communication and networking will spill over into some amount of cross-community cooperation over the long term.

CSB was founded in 1986 in Columbus/Franklin County, Ohio by a group of business leaders, city and county government agencies, foundations, the United Way, and other players to take responsibility for organizing all the planning, managing, supervising, and strategic thinking about what homeless programs and services should look like in Columbus/Franklin County. The intent was to create in CSB an objective entity—a nonprovider, nongovernment, independent, nonprofit agency. CSB runs the planning process, and every element of Columbus/Franklin County related in any way to homelessness is part of this planning, which extends far beyond the CoC application and its funded programs.

Planning in Columbus/Franklin County is inclusive, year-round, and multi-year. Homeless persons are involved through the Citizens' Advisory Council, although this involvement is relatively new and includes a limited number of homeless consumers. Homeless service providers also play an integral role, however, unlike in many communities, providers do not lead the planning process. Both the business community and mainstream agencies are remarkably involved in the planning process and subsequent program and service delivery and coordination. They are largely responsible for the strength of CSB and the overall system and approach to homelessness.

Part of CSB's philosophy is that resources and services currently being provided in the community should be used whenever possible and not duplicated in the homeless assistance system. While controversial with some homeless service providers, this philosophy has resulted in integral involvement and investment of mainstream systems in the community, including the Columbus Metropolitan Housing Authority and the local mental health and alcohol and drug abuse agency. Both agencies are involved in planning for programs and services that includes homeless persons and homeless issues within their own organizations and in CSB's planning for the homeless system. This has meant that when needs are identified, the appropriate mainstream agency often steps up to the plate to provide the needed services or housing resources.

Planning for homeless programs and services in Columbus/Franklin County is a constantly evolving process. And, while there is a five-year strategic plan in place, CSB does

not hesitate to rethink its direction and goals periodically. For example, Columbus/Franklin County has a relatively new central intake mechanism for families. About 85 percent of homeless or near-homeless families enter the homeless assistance system through the YWCA, which has the resources to divert and prevent homelessness for about 40 percent of the families who contact the system. This new central intake process replaced a more decentralized process that lacked the focus on and resources for prevention/diversion.

Another noteworthy example of strategic planning for homeless programs and services involves the Illinois Regional Continuum of Care Roundtable (RRT). Formed in May 1999, the RRT is an intergovernmental collaboration of counties in Illinois that meet to plan regionally in addition to counties' local planning efforts. Meeting monthly, RRT's goal is to improve strategies for understanding and addressing homeless service gaps throughout the region. Current members include the cities of Chicago and Evanston; Cook, DuPage, Kane, Lake, McHenry, and Will Counties; the Illinois Department of Human Services; and HUD. Within this forum, communities have shared the challenges and frustrations of assessing and planning for the needs of homeless people within their communities and identified the need to work together to understand homelessness across political boundaries.

The Metropolitan Chicago Homeless Needs Assessment project is an outgrowth of these monthly discussions. In May 2000, the RRT commissioned The University of Illinois at Chicago to develop a statistically sound research methodology for conducting an annual point-in-time homeless needs assessment within member communities in the metropolitan Chicago region. This methodology is being developed in conjunction with members of the RRT and other affected stakeholder representatives from each jurisdiction (e.g., homeless service providers, local governments, funders, ancillary service providers, and advocates). The goal is to develop a methodology that can be used by all communities, to produce information on the needs, the inventory of existing programs and services, and characteristics of the population by subregion and subpopulation. While the results of this project are not yet known and the RRT is a relatively new planning body, regional, cross-jurisdiction planning of this scale is unprecedented and warrants observation as it continues to evolve.

Planning for Homeless Programs and Services in Relation to Other Planning Efforts

In some CoC communities, planning for homeless programs and services has been coordinated with planning for related issues, most notably affordable housing. This section discusses several examples of communities that have gone one step further than simply involving mainstream agencies in planning for homeless programs and services, to coordinating planning efforts around a particular issue or subpopulation. Though not all discussed in detail here, some of the issues around which CoC communities have coordinated planning efforts include affordable housing and use of Section 8 vouchers, income maintenance, and services related to mental health, veterans, substance abuse, youth, and employment.

Fort Lauderdale/Broward County, Florida: Fuel Tax

In the early 1990s, Broward County found itself lagging behind other communities in regard to the provision of homeless services. The Homelessness Initiative Partnership (HIP) Advisory Board was created in 1993 after Broward County determined that it had 5,000 homeless people and only one general population homeless shelter. An immediate goal was established to create full service emergency shelters, or Homeless Assistance Centers (HACs), as points of entry into a CoC system. The County instituted a one-cent fuel tax to help pay for this emergency phase.

Originally, Broward County requested that the state amend a statute limiting the fuel tax for transportation only to allow the county to use the tax directly for homeless services. The paving lobby and legislative leaders opposed the request; it was not heard on the floor and never came to a vote. The County Commission passed the additional fuel tax anyway, used it for mass transit, and removed an amount equal to the fuel tax and earmarked for mass transit out of general revenue, dedicating that same amount to homeless services on a recurring basis. The 29 cities in Broward County receive approximately one-third of each penny under the law, so in order for there to be a regional Homeless Fund under the Board of County Commissioners and the HIP Board, the cities had to agree to give their share to the county. All 29 cities agreed.

The gas tax now raises approximately \$6.5 million annually. The one-cent fuel tax is primarily used to fund roughly one-half of the cost to operate Broward County's three HACs. Together, the HACs include 530 beds for men, women, and families. Most are limited to 60 days, although one HAC includes some transitional beds. Another significant portion of the tax funds 110 beds of transitional housing and treatment, mostly for persons graduating from the HACs and still in recovery from substance abuse, and a 75-bed mental health Safe Haven. It also funds portions of a number of other programs and supportive services including, but not limited to, medical respite shelter, data sharing, SRO consulting, the county's 524-BEDS shelter hotline, and administrative salaries and operating expenses of approximately 4 percent.

For example, in Boston, Massachusetts the Strategic Homeless Planning Group's five-year strategic plan identified one of its six major long-term goals as expanding the supply of and access to permanent affordable housing. And, while Boston's homeless assistance already broadly taps mainstream resources, a major goal of the five-year strategy is to do an even better job of marshalling these resources. Housing affordability is a very serious concern and the city is taking concrete steps, as described in its five-year strategic plan, to increase the supply of affordable housing. The SHPG's five-year strategic plan has been coordinated with the development of the five-year HUD Consolidated Plan and is considered an amendment to the Consolidated Plan.

For many years, TCP in Washington, DC was the only agency orchestrating most homeless planning in the District. However, in the last several years, the District government

convened the Homeless Services Strategic Planning Group (HSSPG) whose formal mission is to articulate the vision, mission, design, and priorities for the CoC. This relationship is still evolving, but its goal is to make mainstream agencies into active participants in serving homeless people and supplying resources to homeless-specific programs. These are just a handful of the District organizations with which TCP participates in planning activities: the HIV/AIDS Planning Council; Coalition of Homeless and Housing Organizations and its three focus groups (men, outreach, and families); Women Service Providers; District of Columbia Advocates for the Mentally Ill; the Coalition of Nonprofit Housing and Economic Development Organizations; the Metropolitan Council of Governments' (MSA-wide council) Homeless Services Planning and Coordination Committee; and the Department of Housing and Community Development's Affordable Housing Strategy Task Force and its Special Needs Housing Subcommittee.

Stability and Flexibility of the System and the Impact of Renewals

Funding for project renewals is having a profound impact on the flexibility of CoC systems in all the 25 communities in this study. When Congress first approved federal funding through HUD for supported housing, no provisions were made for renewals. The expectation was that three years of federal funding would get programs off the ground, after which their demonstrated effectiveness would convince local funders to take over support for the programs. Obviously this expectation has not been the reality in most communities or for most programs. Congress has responded by providing funding to renew support for projects that would otherwise lose a significant portion of their financial support, but even this step has not given these communities much flexibility in deciding what to fund.

Providers in many of the communities we visited for this study had been very successful in their efforts to obtain HUD funding for transitional and permanent supportive housing in the years before HUD switched to a CoC approach and community-wide applications. They continued to be very successful after the change to CoC applications, and thus were able to sustain their existing projects and initiate many new projects in the early CoC years. Most received significantly more HUD money than they would receive today based upon their published "pro rata need amounts," because they scored very well in early CoC competitions. As a consequence they now have a large number of projects needing renewal funding, which typically consume almost all of their annual CoC grant awards from HUD—awards that have been steadily declining in size due to increased competition for CoC funding.

Project renewals have affected the flexibility of CoC systems in these communities sooner and more profoundly than in most other communities because of the history of early success just described. The pressure of project renewals on system flexibility in other communities is mounting, however, as the need to renew projects is widely perceived to squeeze out possibilities for shifts in homeless assistance strategies and other new initiatives. That communities are behaving in this way means that HUD has to do something to address renewal issues so the invigorating effects of potential "new blood" are not lost.

The remainder of this chapter provides background information on project renewals, describes how renewals are adversely affecting the flexibility of CoC systems, and highlights what some communities are doing to retain system flexibility.

Background on HUD CoC Funding and Renewals

Most CoC funding has been awarded to transitional and permanent supportive housing projects through the Supportive Housing Program, and many of these projects were originally funded for three years. As the original funding began to expire, applications for renewed SHP project funding were submitted to avoid creating new gaps in local CoC systems. In the 1992 amendments to the McKinney-Vento Act, Congress in effect created an “entitlement” to renewal funding and community pro rata shares are adjusted to take renewal needs into account. While communities have the option of requesting one, two, or three years of renewal funding for SHP projects, in the early years of renewals most chose three years. More recently, shorter periods of renewal funding have become more common in order to ensure continued funding for a growing number of renewal projects and to make funding available for a few new projects.

Of the \$900 million in the FY 2000 CoC competition, 87 percent (\$784 million) was awarded to SHP projects. Just over 71 percent (\$648) of the \$900 million was awarded for renewals. Had it not been for congressional action taken after the FY 2000 applications were submitted, approximately 85 percent of the \$900 million would have been used for renewals. Congress overrode the statutory S+C program provision that had required that each S+C grant be made for a five-year period. Instead, S+C projects were renewed for one year. This action allowed over \$100 million of S+C renewal funding to be deferred to later years, freeing up more CoC funds for SHP renewals and new projects in FY2000.

Boston, Massachusetts: Moving Beyond Homeless-Targeted Resources

Beginning in the late 1990s, there was a growing recognition in Boston that it is not possible to adequately address the problems of homelessness with homeless-targeted resources alone. These resources, such as McKinney funds, would never be sufficient to assist every adult and child who becomes homeless, or is at risk of becoming homeless, to regain housing stability and quality of life. With this recognition, the CoC of Care process began looking more intently beyond McKinney funds to mainstream resources and other funding opportunities, as well as policy and programmatic changes.

Concrete expression of this new direction is found in the Summary Report of the Boston Strategic Homeless Planning Group, issued by the Mayor’s office in November 2000. The report sets forth a new five-year strategic plan, including six major long-range recommendations. The six major recommendations are:

1. Expand the supply of and access to permanent affordable housing;
2. Expand employment opportunities and economic services to assist homeless people in becoming self-sufficient;
3. Prevent homelessness through improved discharge planning and on-going coordination among State and local criminal justice and social service agencies;
4. Maintain and strengthen the existing infrastructure and current capacity of Boston’s homeless system;

5. Improve coordination and collaboration among homeless providers to meet the needs of under-served populations; and
6. Work with Federal, State, and local agencies to increase public awareness and access to mainstream resources.

Consistent with this new strategy, Boston is seeking funding for virtually all new programs from non-McKinney mainstream resources. Boston's 2000 CoC application proposed that McKinney funds be used to maintain the existing system through the prioritization of those renewals that are effective and outcome-oriented. The only exception was a new permanent housing project to take advantage of HUD's new permanent housing funding bonus.

The FY 2001 competition was unaffected by S+C renewals because Congress established a separate fund for S+C renewals in FY 2001 that provided for one year of non-competitive funding. This has provided some relief from the pressure of renewals, but it is likely to be only temporary because many more SHP renewal project submissions are expected in FY 2002, including those previously renewed for only one or two years. If Congress should decide not to continue separately funding S+C renewals, it is likely that the budgets of all the SHP and S+C projects up for renewal will equal the available CoC funding, and communities will face some hard decisions if they want to do anything new.

Not all project costs are eligible for renewal funding. Project expenditures for acquisition, rehabilitation, or construction activities are needed to start a project and do not need to be renewed. In contrast, project expenditures for leasing, operating, and supportive services are called "term activities" and are initially funded for one, two, or three years. To continue these term activities after the initial funding period has expired, they either need renewed CoC funding or another source of funding. Operating and leasing costs are the most difficult types of activities to fund from alternative sources such as foundations, because these sources are very reluctant to provide funds in situations where a cessation of funding support could result in people being evicted from their residences. Alternative funding sources often prefer to make one-time contributions for facility-related costs, such as acquisition, rehabilitation or new construction.

As already noted, the heavy draw on funds for project renewals has had a more profound impact on CoC system flexibility in almost every one of the 25 communities visited than in many other CoC communities, because the communities in this study were among the most successful at getting funding for SHP projects both before and after the CoC application process was installed at HUD.

Impact of Project Renewals at Sites Visited

Disincentives for Change. Project renewals are stifling flexibility and innovation to the greatest degree in communities where the amount needed to renew project funding for one year exceeds the preliminary pro rata need amount. At present, this circumstance affects relatively

few communities, but that number will increase in future years if policies and funding levels remain the same.

To ensure that the CoC systems most heavily impacted by renewals would receive at least enough funding to cover renewal projects included in their applications, for the FY 2001 competition HUD adopted a strategy of renewal-adjusted pro rata need amounts. When the total one-year renewal need amount of all eligible SHP renewals submitted in the competition exceeded the preliminary pro rata need amount for that CoC, an amount equal to the difference was added to the CoC's preliminary pro rata need amount. Although this strategy provides sufficient funds so that all eligible SHP renewals can be funded for one year, it also has the effect of providing strong disincentives to making any CoC changes. Under these circumstances, if a locality decides that an existing project should be eliminated rather than renewed, the amount the CoC system would see an equivalent reduction in the total amount of money it would receive. Similarly, if the locality seeks other funding for services to substitute for HUD-funded services so that HUD funds could be used for higher priority needs, such as new permanent housing, the result would be a reduced grant because fewer dollars would be needed for renewals.

No Flexibility to Address Highest Priority Needs. In many of the communities visited, the only reason that any new project was funded in the FY 2000 and 2001 competitions was HUD's funding bonus for first priority new permanent housing projects. This is how the bonus works. If a CoC's number one priority project qualifies as a new eligible permanent housing project, then the full amount of that project's eligible activities, up to the limit set by HUD (\$250,000 for FY 2000 and \$500,000 for FY 2001), is added by HUD to the renewal-adjusted pro rata need amount for the CoC. Many of the funds awarded to these communities were for renewals, leaving little for new initiatives to address the locality's most pressing needs. Many persons interviewed indicated that needs have been changing as the homeless population has been changing, but the same projects were being renewed because not renewing them would create new gaps. This situation has made it virtually impossible for some CoC systems to move in new directions.

Waning Interest in the CoC Planning Process. Another impact of project renewals on CoC systems is the waning interest in the CoC planning process. Determining gaps between needs and resources, prioritizing those gaps, and negotiating a project priority list were seen as important challenges and opportunities when resource allocation was an issue. But the usefulness of these time-consuming activities is being seriously questioned for two important reasons. First, structuring priorities to ensure the ongoing operation of existing projects means that projects must be modified or restructured to match new priorities before reapplication as a renewal project. The process of restructuring a project, while allowing some flexibility, is time-consuming and may not require a community-wide planning effort. Second, new ideas and projects are not accommodated well in this renewal-dominated environment. Although HUD does fund new projects, many new providers see themselves as locked out of CoC funding competitions. The renewal burden discourages new participants from joining the CoC planning process. It is important to note that the 25 CoC communities in this study are likely to be an extreme example of these issues since other communities with less evolved CoCs may not yet be facing the same renewal burdens and need for restructuring to maximize funding.

New homeless providers and other providers who did not receive CoC funding in the past see themselves as now being locked out of any realistic possibility of receiving funding

through CoC competitions. Even though HUD does fund new projects, the reality in many communities is that new providers cannot get these—that there are “ins” and “outs” locally and the “outs” cannot break into the CoC funding even when it is available (i.e., when the community is not already at its max). Small providers see the bulk of CoC funding going to larger, established providers to continue their projects, and question whether there is any point to participating in the CoC system. In short, renewals are discouraging new participants and, in some communities, fostering resentment.

Strategies for Retaining CoC System Flexibility. Some of the communities visited are actively working to counteract the negative impact of project renewals on the ability of CoC systems to grow and move in new directions. This section describes approaches being taken. A critical point to remember in each of these examples, equal or greater in importance to the examples themselves, is that these and other communities that are actively seeking additional funding sources are those that view the CoC planning process as broader than simply a mechanism for tapping HUD’s CoC funding. It is most likely true that if you cannot be broader, you will not be able to be flexible. At the end of the chapter we will suggest ways that HUD can encourage greater breadth and reward communities that are able to attract significant amounts of mainstream resources to support their CoC.

Balance of Cook County, Illinois: Emphasis on Collaborative Projects

As part of its commitment to support existing homeless assistance programs, Cook County's CoC—like most others—gives an advantage to projects seeking renewal funding when it prioritizes proposals for its annual SuperNOFA application. However, unlike many other communities, renewals receive only a modest 5-point advantage in the County's CoC pointing system. This shows commitment to existing projects while at the same time not greatly disadvantaging new projects and programs.

Beyond renewals, the Cook County CoC places high priority on projects involving joint ventures. It does so by giving a significant point advantage in the application ranking process to inter-organizational partnerships as a means of encouraging such collaboration. While collaboration across provider organizations is considered a desirable way to effect service coordination, establishing such partnerships is not easy and can be very time and energy consuming—especially when many partners are involved. For one thing, entering into a collaborative relationship is not always acceptable to organizational boards whose leadership may prefer independence, direct fund raising, and being the prime recipient of the funds that are raised. Thus, there is always the issue of who will be the lead agency and who will not—the latter position usually being a “tough sell.” However, when such partnerships are established, the collaboration can result in quite creative and innovative projects that deal with real gaps in service provision.

An example of a collaborative venture established for Cook County's 2001 SuperNOFA application is Project W.I.N. It brings together a mental health agency, county medical clinics, and both the west and south suburban PADS (shelter) programs to both deliver health and mental health services directly to shelters and allow for follow-up and continuity of services. For this collaborative to come together, all kinds of issues relating to confidentiality of information and agency service boundaries had to be worked out. In addition, this is the first collaborative in Cook County to involve two of its three regional service clusters (the south and west regions), and also the first where a government body (the County Health Department) is the lead agency in a public-private endeavor.

Amending Projects—an Option to Increase Flexibility. Making significant changes in projects that will be up for renewal by using amendments is an option for increasing CoC flexibility. HUD will permit significant changes to a project in the form of an amendment. Even when a project is considered a SHP renewal under the rules of the CoC competition, it may be modified to include either a new activity or expansion or reduction of an existing activity. A locality may modify existing projects to match new priorities and may receive renewal funding for the modified project. However, for the revised project to count as a renewal, these changes must be formally accepted by HUD before the CoC application is submitted.

For example, a locality that has placed new emphasis on providing permanent supportive housing opportunities for homeless persons with disabilities may transform an existing transitional housing project into the desired permanent supportive housing. If the modifications are done through an amendment before reapplying, then the reapplication may be considered a renewal of the amended program and its funding is not jeopardized. On the down side, restructuring a project is time consuming and may not require or encourage participation in community-wide planning.

Bringing New Sources of Revenue to the Table. Most communities realize that their best hope now for expanding housing and service opportunities for homeless individuals and families is accessing sources of revenue beyond CoC funding from HUD. But this is by no means easy to do. As mentioned earlier, private funding sources often prefer to make one-time contributions for facility-related costs, such as acquisition, rehabilitation, or new construction. They are far from eager to provide funds for leasing and operating expenses. This seems to be especially true for foundations, which reportedly are also showing less interest now than in the past in supporting homeless assistance activities.

Madison/Dane County, Wisconsin: Generation of Non-HUD Funding

The Homeless Services Consortium in Dane County, Wisconsin is the lead agency for the Continuum of Care (CoC) application and planning process. The Homeless Services Consortium is not limited to the CoC funding and application process, but rather, focuses on planning for homeless services more broadly using funds obtained from numerous non-HUD sources. In 2000, CoC funds represented only about 15 percent—about \$1.8 million—of all money spent in Dane County on homeless services including emergency, transitional, and supportive permanent shelter and services. Additional funds totaling \$6.0 million were generated from the City of Madison, Dane County, the State of Wisconsin, and other federal sources. Private monies—including donations from United Way, area churches, private companies and foundations, and private citizens—totaled an additional \$3.1 million and income from rental units was approximately \$1.1 million. In total, Dane County generated \$11.9 million for homeless services in 2000, the vast majority non-HUD funds.^a

^a 2000 Annual Report on the Homeless Served in Dane County: An Analysis of the Population Served by Dane County Shelter and Service Agencies. Report from the City of Madison Community Development Block Grant Office, 2000.

Some communities are working to obtain more funding from state and local governments. For example, in Rhode Island the organization and collaboration of the CoC system was helpful when the state government was approached for funding. Traditionally, the state had played no role in funding housing programs for homeless or very low-income persons. However, in June 2001, the state approved \$5 million in such funding. In Phoenix/Maricopa County, Arizona, with the governor's office represented in the CoC process and aware of funding issues, the state legislature is being prodded to look at housing issues for homeless persons with serious mental illness. Other examples include San Francisco, where the Local Homeless Coordinating Board has created a Funding Committee to identify additional funding sources. Long Beach's HSAC also has a goal of identifying state funding sources for the city's homeless and housing programs. In Boston, the Strategic Homeless Planning Group is working to strengthen support from the business community.

Improving Access to Mainstream Programs. A complementary approach to seeking new funding sources for homeless-specific programs is to improve access to mainstream programs as a means of increasing housing and services available through the CoC system. This normally requires serious collaboration with the mental health agency, the public health agency, the housing authority, and other gatekeepers of mainstream resources. As proven in Columbus/Franklin County and some of our other communities, that level of collaboration can occur. There, the housing authority and the alcohol, drug addiction and mental health authority include homeless issues in their own planning and contribute to the Community Service Board's planning for the homeless system. In addition, the Franklin County Department of Jobs and Family Services provides on-site services in family shelters. Part of CSB's vision is that homeless programs should be linking their clients to services available in the community, not providing the services themselves. This attitude has led to some conflict with providers that have incorporated many supportive services into their own staffing and budget arrangements, but in general it seems to have resulted in fairly ready access to mainstream resources, and the resources themselves appear to be adequate and appropriate.¹

To date, mainstream public agency investment in homeless-related programs and services is not widespread, even among our 25 high-ranking communities. Not counting public agencies whose sole involvement with the CoC is to support the application process, or to handle the money, or to apply themselves as recipients of HUD funding, public housing authorities are actually investing resources in homeless-related activities in five of our communities, mental health agencies in eight, health and human services agencies in seven, veteran affairs agencies in three, and substance abuse agencies in two. Ten of our 25 communities do not have any significant mainstream agency investment of local government resources in their CoC.

¹ Many homeless assistance providers follow the practice of "doing it themselves" because mainstream agencies in their communities have not been willing to supply the needed services, or supply them in ways that homeless people could access. To the extent that these inadequacies or nonresponsiveness of mainstream agencies are still the norm in a community, homeless people will still be better helped when providers "do it all" themselves. In communities where mainstream agencies are stepping up to the plate and fulfilling their responsibilities, it will be reasonable to promote the changes desired by the CSB.

Applying Performance Criteria to Projects Applying for Renewal Funding. In many of the communities visited, steps have been taken, or are beginning to be taken, to evaluate the performance of projects applying for renewal funding, and to require a certain level and quality of performance of any projects recommended for renewal. Essentially, this strategy is “if you can’t get more or different, get better, and more efficient.”

In Rhode Island, for example, the CoC lead agency established teams to evaluate the accomplishments of any projects applying for renewal. Set criteria were used including progress in accomplishing goals, cost effectiveness, leveraging, and coordination. It was also determined that renewals would not automatically be given priority over new applications, but would be ranked very well if the review process found them to be effective and continuing to meet a priority need. As one person there stated, “The CoC system is still valid because they don’t just give people the money, they must prove their worth.”

In Essex County, New Jersey, the lead agency has developed an evaluation process that involves looking at spend-down rates and evaluating progress in reaching goals. Each provider seeking renewal must present its project to the Comprehensive Emergency Assistance System committee. In some cases, projects do not seek renewals because of slow start-up spending or because they have found other funding sources.

For the FY 2001 CoC competition, Chicago initiated a new system using peer-review. Teams of providers visited and evaluated projects (both new and renewal) and organizations that met application threshold criteria. A formal site evaluation tool was developed. In addition to written submissions, applicants needed to make certain materials available for reviewers at the site visit. Key staff representing executive, program, and fiscal areas, as well as several consumers, needed to be available to meet with the site team. Client case management files also had to be available. The reviewers used a formal rating scheme that looked at program impact and quality.

Performance monitoring of this type helps ensure that projects that are not performing adequately will not automatically be renewed. For most CoCs, non-performing projects can apply for reduced levels of funding, or even be eliminated from the CoC priority list, freeing some additional funds for new projects. In a few CoCs with one year renewal needs in excess of their pro rata share, reducing renewal grant requests or eliminating projects will result in a reduced funding level for the CoC. When combined with the other strategies for retaining CoC system flexibility, there is the potential for significant additional resources that can be used for new projects designed to address current priorities.

Other Issues and Problems with the Planning Process

Several additional issues and problems related to planning for homeless programs and services arose in our discussions with the 25 CoC communities. While some problems were relatively rare, others were pervasive, affecting many of the communities.

In many CoC communities, the homeless system is failing to address the needs of individuals with chronic and severe mental illness due to a lack of resources. While not a result of HUD’s CoC process, mainstream service systems often do not provide adequate resources for these and other hard-to-serve individuals, such as alcohol and drug addicted persons. In

some communities, these subpopulations are taxing the homeless assistance system, which is attempting to compensate for lack of funding or funding cuts in mainstream agencies. A complicating factor is the prevalence of dually-diagnosed homeless persons requiring treatment for both severe mental illness and alcohol and/or drug addiction.

Another problem facing many CoC communities is trouble in filling gaps in homeless programs and services. This difficulty filling gaps may occur for a variety of reasons. Restrictive local legislation is one. In addition to a lack of local funding, Long Beach, California has difficulties fulfilling its priorities because city ordinances ban the development of single-room occupancy housing and social service agencies in the downtown area. The Long Beach Homeless Coalition is working to change these ordinances. Similarly, in Phoenix/Maricopa County, Arizona, permanent supportive housing represents one of the continuum's highest priorities, in the face of an increasing shortage of affordable housing. To exacerbate the shortage, the cities of Mesa and Phoenix recently passed crime-free housing legislation stating that any developer receiving HOME or CDBG funds must include "crime-free zone" status on the property deed of the building. Crime-free housing will not allow ex-offenders or families of ex-offenders to become tenants (or employees) until ten years after release from prison. Many homeless people cannot meet this criterion.

Another problem some communities have faced is how to encourage participants in the CoC planning process to continue to come to the table, especially if they are not receiving CoC funding or if they represent a mainstream agency. Many communities cited this as a problem while others said a "commitment to solving the problem of homelessness" kept people coming to the table. For examples see boxes below for Phoenix/Maricopa County and San Francisco.

Phoenix/Maricopa County, Arizona: Maintaining Synergy

Every Continuum faces the challenge of gaining the attention of the public and political eye and, then, maintaining it. The Continuum of Care of Maricopa/Greater Phoenix maintains a synergy at the planning table and in the public eye. Well-respected and high-ranking elected and appointed government representatives from city, county, and state levels either hold lead roles in the planning process or have helped further successes of the Continuum through other means of support.

Various Maricopa Continuum participants described how they have been able to maintain on-going energy and interest in the Continuum process at such high political levels. They described several approaches. One lead agency releases a newsletter recognizing those involved and giving out awards acknowledging participants and their roles. In addition, the Continuum hosts an annual recognition lunch—done in January—in an area hotel (making it a formal event, not one held at a local shelter) that draws visibility to the Continuum's efforts through media coverage. This event, drawing the Continuum community together, represents an opportunity to celebrate the Continuum itself, to recognize individual and Continuum accomplishments, and to acknowledge the Maricopa Continuum mission and common vision. With the media present, the Continuum can voice its direction and goals while maintaining issues related to homelessness in the public eye. Continuum members are working on new ways to further business support at this event such as naming awards after businesses that have contributed to the Maricopa Continuum and will continue to do so over the long haul.

A final issue facing many of the CoC communities is the cost associated with completing the HUD-mandated application process. As discussed in chapter 2, any number of agencies may be responsible for the bulk of work involved in completing the gaps analysis and prioritization, coordinating the proposal ranking process, and writing the application. In some communities, particularly those without a government entity responsible for the application or those larger communities where the amount of work involved is great, the CoC application places a strain on limited resources. Since the drain on resources is rewarded by receiving homeless funding, there is a rationale for continuing to support the CoC application process. However, many CoC communities have developed a system for completing the application so that it does not strain government resources or unfairly tax any one person or group. Some communities have solved this problem by hiring consultants to write the application, while others rely on a nonprofit agency such as the United Way to manage the proposal ranking process. Others communities have sought foundation funding or local government money (e.g., local housing authority) to fund a nongovernmental agency to lead the process and assemble the application.

San Francisco, California: Diversity of Opinions

Bringing all opinions to the table and reaching one conclusion is never easy, but it is not foreign to San Francisco. Strong in its diversity and work to be inclusive in its Continuum of Care process, the Local Board, providers, homeless persons and advocates work together to meet the needs of San Francisco's homeless population.

An open process, the San Francisco Continuum of Care planning process brings together various groups of people for all topics considered. Advocates and providers from many groups serve on several Continuum of Care committees, ensuring that the diversity of options and opinions is raised and heard in all planning.

The diversity of opinions present during the planning is illustrated in many forms throughout the San Francisco Continuum. For example, in developing a new CoC Five-Year Strategic Homeless Plan, the Local Board reportedly involved over 225 San Francisco residents, including people who are homeless, businesspeople, program directors, policymakers, activists, social workers, and advocates. All Continuum of Care meetings were open to the public, and all proceedings and documents were published on the City web site. Hundreds of people who are homeless regularly attend Continuum of Care meetings to discuss improvements to San Francisco's homeless service system. Several subcommittees of the Local Board's Continuum of Care also address diversity and civil rights.

Advocates have worked both inside and outside the system for changes in the city's homeless policies for several decades. Notably, efforts by advocates and providers have resulted in all shelters within the Continuum adopting a harm reduction model of care. Advocates have also supported and worked to institute tenant rights for all persons in shelters.

The lead entity for San Francisco's CoC planning process is the Local Homeless Coordinating Board (Local Board), a 34-member body comprised of homeless advocates,

formerly homeless persons, representatives of service providers, nonprofit housing organizations, neighborhoods, education and training, labor, business and foundations, as well as key City departments. The Local Board is charged with bringing varying perspectives of City, community agencies, and consumers together to guide the development and implementation of the continuum of housing and services for homeless people.

The Coalition on Homelessness, San Francisco, represents homeless and formerly homeless people as well as representatives of over 50 service, shelter, and housing providers, advocacy groups, and neighborhood and religious associations. It was formed to develop and advocate for civil rights, effective and humane services, employment, and housing for homeless and low-income people. The Coalition on Homelessness conducts surveys of homeless weekly, issues reports, and advocates on behalf of the homeless at Local Board meetings.

Implications

The implications of information presented in this chapter stem from the prominent issues affecting the 25 communities' planning for homeless programs and services. It is likely that in general these 25 highly ranked CoCs have more advanced planning processes than many other CoC communities, with more formal ranking processes and broader scope. In addition, many of the problems facing these CoCs are not (yet) generalizable to other CoCs funded by HUD. For instance, while the renewal burden is less likely to be an issue in CoCs that are not highly ranked, other issues such as keeping players at the planning table and filling gaps in the homeless assistance system may actually be more problematic. Finally, while these 25 communities should be lauded for their planning efforts, and are rewarded by their yearly CoC funding levels and national ranking, several lessons can be learned from their varied experiences.

- Limited planning produces limited results. By focusing on three key areas—broadening the scope of planning, incorporating additional funding sources, and increasing the participation of mainstream agencies—local CoCs will be better able to meet the constantly changing needs of homeless persons and increase their ability to be flexible in the years to come.
- Planning and coordination of programs and services that is part-year or limited to CoC funding, while meeting HUD's requirements, does not benefit from coordinated funding and long-term planning. Likewise, year-round planning and coordination that only include limited participation by mainstream providers or do not include multi-year planning efforts, do not reap the same rewards as multi-year, comprehensive, strategic planning. Comprehensive, broad-based planning encompassing mainstream services and multiple funding sources benefits from sharing the burden of solving homelessness among many players and relying on having access to a broader array and higher level of resources.
- Communities would be well served to think more broadly about incorporating additional funding streams into the CoC planning and coordination process. For the

most part, important potential contributors such as mainstream agencies and the business community are most likely to become involved in planning, and ultimately in financial support of programs and services, when the scope is broad. They should be spared the final throes of preparing the HUD CoC application to the extent possible, and their energy saved for addressing larger system issues. Communities need to think strategically about how to increase and/or maintain the involvement of the entire provider community, both homeless-specific and mainstream, and the larger community as well.

- Likewise, under the weight of CoC renewals, local CoCs have lost much of their flexibility to plan, develop, and change their homeless service assistance systems. HUD could promote additional flexibility with administrative changes related to renewals. For example, HUD could elect to hold CoCs harmless for generating mainstream support for services. That is, any amounts of HUD funding currently going for services (as opposed to housing) that a community could replace with local resources would stay in the community and be available for alternative uses within the CoC. This would both allow communities to broaden their base of financial support for planning, coordination, and service delivery, as well as increase the role of mainstream providers.
- Communities indicated that, given the limitations of the gaps analysis, it would be beneficial for HUD to convene a working session during which community representatives could describe the types of data they would find useful, and that HUD, in turn, could ask for.

CHAPTER 7: THE HISTORY OF THE SYSTEM

Unmentioned in the applications to HUD are the diverse histories of the homeless assistance systems in each applicant community. It is important to remember, however, that when HUD introduced the idea of the continuum of care in several stages from 1993 through 1995, the new requirements were imposed on systems with, in many cases, firmly established local relationships and power dynamics. These relationships and the planning structures that existed before the CoC funding approach, or the lack of them, have had a major impact on current homeless systems as well as on the applications to HUD.

In this chapter we examine the transitions our communities have made in adapting to the requirements of the CoC application, classifying our communities by the extent of system-wide planning in place before the first CoC application. Our description of these histories, and the relationships and structures on which they rest, is somewhat more conceptual than most of the chapters in this report, resembling most the classification we attempted with regard to CoC leadership in chapter 2.

Three categories emerge from our analysis, with each of the 25 communities falling into one—seamless transitions, from informal/fragmented to structured/comprehensive, and from nothing to something (table 7.1). These categories reflect key local informants' views of the effects that the CoC application has had on improved planning and coordination of services. They also reflect participants' overall level of satisfaction with the planning processes in place for the HUD application and for homelessness in general.

The first column of table 7.1 shows our summary categorization of the type of transition reported by respondents. The second column indicates the level of planning that was already in place before HUD began requiring consolidated CoC applications. The third and fourth columns indicate whether changes in leadership in planning for homeless programs and services occurred during the first year of CoC applications, as well as indicating the nature of the entity providing the leadership (e.g., government, independent entity, provider coalition, and so on). Thus five of the seven communities in the first group (seamless transitions) retained the same leadership structure as had been in place before the CoC, while all of the eight communities in the last group (from nothing to something) developed new structures. The fifth column summarizes respondent views of the effect of HUD's introduction of the CoC process; respondents in communities in the second and third groups attributed much greater impact to the CoC process than did respondents from communities in the first group.

The last three columns of table 7.1 indicate changes since the first CoC application and the nature of current planning efforts. Again, communities in the first group evince the steadiest state (no leadership changes), while one-third of the communities in the other two groups have changed the entity that heads the planning function. The final column of table 7.1 indicates whether a community focuses only on obtaining HUD homeless funds or engages in long-term, year-round planning, whether the planning entity is able to exercise a significant amount of influence over providers ("clout"). Note that "one-focus" communities occur in all three groups, although there is only one in the seamless transitions group and a higher proportion in the other two groups.

Table 7.1 The History of CoC Planning Approaches

Table 7.1 The History of CoC Planning Approaches							
Transition to the First Application	Planning Before the CoC	Leadership Changes in First Year of CoC		Effect of CoC	Changes Since First CoC Application		Nature of Current Planning
		Same Leadership	New Leadership		Same Leadership	New Leadership	
Seamless Transitions	Significant		government w providers	little effect			one-focus
	Significant		group appointed by mayor	a bit more collaborative			Long-term, year round with clout
	Significant	government		more inclusive			Long-term, year-round
	Significant	independent entity		a bit more collaborative			Long-term, year round with clout
	Significant	provider coalition		little effect			Long-term, year-round
	Significant	hybrid board		more collaborative			year-round
	Significant	group appointed by county		little effect			long-term, year round with clout
Informal / Fragmented to Formal / Structured	Informal		government, providers and independent entity	new collaboration			long-term, year-round
	Informal	coalition of providers		improved collaboration		government	one-focus (though larger planning is year-round)
	Informal	government		improved collaboration		different level of government	long-term, year round with clout
	Informal	hybrid board		more coordination			long-term, year-round
	Informal	providers w government		improved coordination			long-term, year round with clout
	Fragmented		government	much improved coordination			one-focus
	Fragmented		government w providers	general improvements			long-term, year round with clout
	Fragmented		hybrid board	formalized, improved coordination			some larger planning
	Fragmented	provider coalition		little effect		government	one-focus
	Sporadic	provider coalition		formalized process			year-round, coordinating function
From Nothing to Something	None		government	some improvement			none/one-focus
	Very little		government w local providers	entirely new coordination			one-focus
	None		government	new collaboration			one-focus, but year-round
	None		government	new planning, collaboration		hybrid board	one-focus

Table 7.1 The History of CoC Planning Approaches

Transition to the First Application	Planning Before the CoC	Leadership Changes in First Year of CoC		Effect of CoC	Changes Since First CoC Application		Nature of Current Planning
		Same Leadership	New Leadership		Same Leadership	New Leadership	
	None		providers w government	new planning, collaboration		mainly providers	one-focus
	None		independent entity	entirely new coordination			long-term, year round with clout
	None		government w providers and others	new collaboration		providers and others, w/out county	long-term, year-round
	None		government	new planning, collaboration	new personnel		year-round, a bit broader than CoC

Once our analysis of our communities' planning efforts has been presented, we examine significant changes that have occurred since the introduction of the CoC application in the mid-1990s. The final section of this chapter discusses issues currently facing these homeless systems that may or may not require changes in the future.

Planning for the First CoC Application: Seamless Transitions

While all of the homeless assistance systems in the study have evolved gradually over time, the introduction of the CoC funding system forced an abrupt, dramatic change in the way many of these communities served homeless people. Most notably, the CoC initiative emphasized an integrated as opposed to fragmented application process, it required communities to bring the entire homeless assistance community to the table, and it placed increased emphasis on local planning, data collection, and analysis.

Even with these new formal requirements, seven of our jurisdictions experienced few changes in the way they plan for homeless programs and services as a consequence of CoC requirements, although they may have changed for other reasons. All of these communities had established a formal, system-wide planning process for homelessness before HUD required them to do so, and all but two of them had pre-existing lead entities that assumed a leadership role in the CoC process as well. Naturally, these communities were well-prepared for the requirements of the CoC application and were able with relative ease to adapt planning processes to meet these requirements.

Despite these similarities, the dynamics of power in these seven communities differ markedly. In two of the communities the primary planning entity is a group set up by the local government to plan for homeless programs and services, one by the local county government, the other by the mayor of the city. In another the primary planning entity for the CoC was and continues to be a group composed primarily of providers that plan for the application among themselves. Another has an independent entity that was established to coordinate planning for homelessness and distribute funding across the community. This organization established its

credibility long before the introduction of the CoC application, and provided stable leadership as the system adapted to include planning for the CoC. County government staff facilitate the process in two of the other jurisdictions, while planning efforts in the final site of this group are led by a board that includes all relevant components of the homeless assistance community, including city government, advocates, and providers.

Effect of the CoC Application

Although respondents in several of these communities felt that the CoC process had increased coordination of services or communication among the various components of the homeless system, the overall effect of the CoC application in these seven jurisdictions was much less dramatic than in our other communities. For the most part, these systems did not have to make significant changes to their existing planning structures or spend large amounts of time recruiting representatives from other elements of the homeless system to join the planning process. Variation does exist across these communities, however, in the way they incorporate their CoC application to HUD into their existing planning process. In five of the communities within this subgroup the process and the structures associated with the CoC application supplanted existing planning for homelessness, while in two others it was basically added as one piece of a much larger planning effort. In one jurisdiction in particular, the process is controlled by a group of providers who only “tweak” the application from year to year, while more significant planning exists outside of the CoC application.

Beyond the relative ease with which these jurisdictions were able to plan for the CoC, they all enjoy relatively widespread support for the planning process among most participants in that process. Part of this may be due to the fact that in these communities the CoC did not disrupt entrenched power structures or displace any one group from a leadership role. In fact, in some communities the application process had only a limited effect on the local dynamics of power, while in others it reinforced the structures that had already been in place. This is not to say that everyone we spoke with was entirely content with the process, of course. Providers complained about the almost unchecked authority of the lead entity in one of these communities, while in others representatives from different elements of the system were critical of the way funds were dispersed or the way decisions were made. But in general, respondents from the communities in this grouping were more likely than in other communities to accept and support the mission and vision of these lead entities and to approve of the progress that has been made in planning for the CoC application and for homelessness on a broader level, and for the comprehensiveness of the resulting system.

Planning for the First CoC Application: From Informal/Fragmented to Structured/Comprehensive

The next ten communities in this study had done at least some system-wide planning for homelessness before the HUD CoC requirements took effect, but the extent of these efforts varied among the communities, as did their effectiveness. We have further subdivided this group into two subcategories. The pre-CoC planning efforts in five of these communities we label “informal,” meaning people were talking about system-wide strategies to confront homelessness, but there were no formal structures to incorporate the entire system into such discussion. The other five communities had some planning, but it was “fragmented or sporadic”

according to respondents, meaning it included only certain elements of the system, or it centered around a specific issue or problem.

Alameda County, California: Planning Efforts

Many efforts and collaborations have laid the groundwork for the development of a countywide homeless Continuum of Care plan in Alameda County. Over the past two decades, various efforts have brought together multiple service providers, funders and governments to address needs through coordinated planning and organizing.

In 1983, the Emergency Services Network was the first semblance of a coordinating body in Alameda County to address the needs of the homeless. Other efforts included the creation of the Homeless Base Conversion Collaborative in 1993 and the establishment of the Alameda County Food Bank in 1995. In response to HUD's CoC initiative, a series of idea-gathering meetings were held and recommendations were discussed. These discussions led to a countywide consensus to formalize the planning process through the establishment of a working group to oversee the development of a countywide plan. The first formal CoC plan was developed in April 1997 and outlines the key players and goals of the Continuum, as well as action steps.

An inclusive community-based council, the Alameda County CoC Council oversees the implementation of the CoC Plan and supports all coordination and planning to prevent homelessness. In its third year of operation, the council works to implement 40 long-term strategies with more than 160 action steps.

The council consists of 60 members. Fifteen of the seats are dedicated to countywide providers of service/advocacy, with seven seats for additional providers, advocates, and community-based agencies. There are 10 consumer seats and 18 jurisdictional seats (i.e., Berkeley has two seats, Oakland has 3, the HOME Consortium has 8, and Alameda County has 5). There are also 10 seats for broader community players (e.g., representatives of the faith community, funders, and business) who are appointed. The jurisdictional seats are also filled by appointment, and the consumer and provider seats are filled through an annual community-wide election process.

The primary work of the council is through standing committees. Committees include the Executive Committee, Self-Sufficiency and Safety Net Committee, Standards of Service Committee, Data Collection and Management Committee, and a Policy Committee. The City of Alameda funds a full-time CoC Coordinator to provide staff support to the Council and to facilitate the implementation of the CoC Plan. The Coordinator's role is to ensure inclusive, County-wide communication within and about the Council and its work and to broker relationships between all stakeholders within the CoC. All cities in the County have also contributed to a full-time fund development position, which is currently job-shared. The council is also staffed by one full-time AmeriCorps*VISTA volunteer.

Four of the five communities in the “informal” group had planned informally for homelessness and retained the same basic leadership as the planning process formalized into the CoC application process. One community was led by a hybrid board of city government staff along with providers and advocates, another was led solely by representatives from the local city government, and the two others were led by groups made up primarily of providers and advocates. In the first community the task force that had previously led most planning efforts had all of the fundamental components of the homeless system in place before the CoC. However, planning efforts were sporadic, and often wavered depending on the interest of the mayor and city government. It took the HUD CoC requirements to establish this group as a permanent planning entity.

In the case where the city government led the process, a more extensive group of providers and advocates was formally brought to the table, as was true in the two other communities, where local government also began to play a significant role in the planning process. In all of these communities, the CoC application and planning process built on the planning that was already in place, resulting in a more structured, inclusive, and collaborative planning process with the same players taking the lead.

The final community that had been engaged in informal planning before the first CoC application was the only one to change leadership to plan for the CoC. In this jurisdiction, an organization that was set up as a public-private partnership designed to assist providers with data collection was brought in to help facilitate the planning for the CoC application. Even here, however, local government and a coalition of providers that had previously been involved in planning responses to homelessness retained leadership roles in the planning process.

All five of the initially “informal” communities seemed to be on a path toward collective, system-wide planning before HUD introduced the CoC application process. However, they had not quite formulated the structures necessary to get there. The CoC requirements pushed them to do so.

The five communities in the “fragmented/sporadic” group had not taken steps toward broad-based planning for homelessness before being confronted by the CoC application process. They had, however, engaged in fragmented planning efforts that were focused on a specific issue or problem. Among these communities, two retained the same leadership and the same planning structures as had existed before the CoC application. In both of these communities, coalitions of providers had formed well before the first CoC application and remained as the most prominent elements in the planning process when the CoC approach was introduced. In one of these two sites particularly, the CoC application has lent legitimacy to this group of providers, as they now have a great deal of control over the funding that is attached to their planning efforts.

In the other three “fragmented/sporadic” communities, significant structural changes accompanied the CoC application process. In two, leadership of the process shifted from providers to local county government, mainly because of the resources and staffing necessary to facilitate the formalized process. In the third, a new entity that included providers and advocates as well as representatives from city and county government took the lead in the process, replacing several other previous planning entities that had formed around a specific population or issue.

Effect of the CoC Application

Respondents from almost all of the ten communities in this category reported significant improvements due to the requirements set forth in the CoC application. The common responses indicated that the transition from informal or sporadic planning for homelessness to structured, system-wide planning has promoted increased communication among the various elements of the homeless system, and ultimately has resulted in improved services. The extent of these improvements varies with the extent of the planning that was undertaken before the first application, but respondents from all but one of these ten communities agreed that there were tangible effects attributable to the HUD CoC application requirements. In the one community in which planning has not improved, the consensus among respondents was that the members of the CoC planning body, especially the providers, are simply unable to work effectively with one another, making the process unpleasant for all involved as well as being ineffective.

The maturity of these planning structures and respondents' support for the planning process also varies across the ten communities in this grouping. Three of the communities have undergone dramatic changes in their planning structures since the first CoC application, another was dangerously close to losing funding after submitting a poor application to HUD but seems to be turning itself around, and others have had trouble maintaining broad-based involvement from elements of the homeless assistance community that are not directly affected by the CoC funding. In jurisdictions with unstable leadership or a planning process that has functioned imperfectly, respondents tended to report widespread discontent among participants, as would be expected. An example is a community in which control of the process shifted from city government to a broader regional association of governments. Respondents from this community reported regional tension among representatives from the city that used to lead planning and the other parts of the jurisdiction that now play more of a leadership role. Where the process was reported to be running smoothly, respondents were generally satisfied, though there was always at least some criticism or suggestions as to how the process might improve.

Planning for the First CoC Application: From Nothing to Something

The CoC application process has had the greatest impact on eight of our jurisdictions that previously had little or no system-wide planning process in place for homeless programs and services. These are jurisdictions that were forced for the first time to bring together a diverse group of providers, advocates, representatives from local government, and other community members who had previously been working on the issue independently, or with minimal collaboration.

In the majority of these communities, local government entities provided the impetus for these various components of the system to come together to plan for the CoC. In five, representatives from the city, county, or state government actually assumed the lead role in facilitating the planning process. In another regional community the state government convened representatives from several of the counties within the region to plan for the CoC application. A coalition of providers took the lead role in one other jurisdiction, while an independent entity was established in the final site specifically to plan for and facilitate the CoC application process.

As one might expect, these initial planning efforts and the entities established to facilitate them were not as stable as the planning structures in communities that had undertaken significant planning before HUD initiated the CoC application process. Indicative of the fragility of these initial planning efforts is the fact that since the CoC approach first required community-wide applications in 1996, half of these jurisdictions have undergone significant changes in the structures set in place to facilitate or lead the planning for the CoC application. In addition, one site still does not have stable leadership with resources adequate to plan for homelessness on a system-wide level.

Delaware: An Evolving Statewide Continuum

The Delaware State Continuum has improved greatly since the inception of the Continuum of Care competition. Delaware received *no* funding in response to its 1997 CoC application, although it had been funded in earlier years. From this complete funding loss in 1997, Delaware moved to a high-ranking application in 2000 with awards two times its pro-rata share. To get there, the Delaware Continuum tackled the CoC grant requirements and created a planning process with high levels of commitment from the entire provider and mainstream agency community. Before 1997, the State Housing Authority worked with service providers to respond to HUD's CoC funding announcement purely as an effort to obtain HUD funds. The larger-scale planning component required by HUD was not seriously undertaken. While the 1997 CoC application was less than complete, many Continuum participants today recognize that everyone—not just those responsible for writing the application—was to blame for the loss of funds since they had not been operating as a true CoC. In the words of local representatives, in not awarding Delaware any CoC funds, HUD showed that they had "found us out."

As a direct result of the loss of funding, a meeting was called with the purpose of developing a true CoC planning body with ongoing responsibility for strategizing about homeless services. Meeting participants included representatives from the University of Delaware, government agencies, and mainstream nonprofit agencies as well as some Delaware bank officers with responsibilities related to the Community Reinvestment Act. A Steering Committee was established in 1998, which evolved into the current Homeless Planning Council of Delaware (an incorporated nonprofit agency). In an effort to be inclusive, invitations to join the steering committee were widely distributed throughout the state. The experience of losing CoC funds made organizations more apt to participate in the effort. Today, the success of their efforts is revealed in the consistently high funding levels awarded to Delaware through its CoC

Effect of the CoC Application

The fact that the homeless systems in these eight communities have experienced the greatest effect since the inception of the CoC application process does not imply that they are models of communities with stable continuums of homeless programs and services. One of the four did not receive any funding a few years ago, another still does not have stable leadership, and each of the eight communities is markedly different in terms of the sophistication of its

planning processes, its efforts at collaboration, and its success in establishing a continuum of services. What can be said about these jurisdictions is that respondents from all of them attribute directly to the CoC funding process any success that they have achieved in collaboration, information-sharing, and improvement in services. In each site, the requirements in the application were the primary impetus for the different elements in the jurisdiction to come together to plan for homelessness, and respondents in these communities seemed convinced that without such requirements integrated planning would never have occurred.

The level of support for the process as expressed by respondents in these communities reflected the fragility of their planning processes. Where there was unstable leadership respondents tended to report tension among different components of the system or dissatisfaction with the process itself, even as they noted improvements in services or coordination. In almost all communities the relationships among those involved and the level of support for the planning process have improved as the process itself has improved and stabilized. For instance, in one community strong leadership has emerged from multiple sources, enabling those in leadership positions to engage the entire homeless assistance network in common planning for the first time. The local health department has emerged to play a major role in leading all planning for homelessness, a group appointed by the mayor leads the CoC planning process, and a group of providers plays a prominent role in planning for the application and in coordinating services. The collective efforts of these three entities have resulted in a coherent vision for homelessness that had never existed before, a vision that has engendered the support of virtually all respondents with whom we spoke.

Developments Since the First CoC Application: Shifting Directions

While the primary changes in homeless systems came about in response to the requirements for CoC funding, many jurisdictions have adjusted or overhauled their planning processes at some point since their first CoC application. In these years several jurisdictions have made significant changes to their homeless planning systems, while others have refined these systems in attempts to address deficiencies or shortcomings in their CoC applications. Seven communities have made significant changes since the inception of the CoC process, further classified into those communities that made changes because they were in danger of losing funding and those that made changes of their own volition.

Three communities in the study either lost CoC funding or have been in danger of losing funding at some point since their first CoC application. The specific deficiencies in the applications varied among the three communities, but in each case there was evidence that the communities were not truly planning for a continuum of programs and services or were not including the entire homeless service community in the planning process. Respondents in each of these communities tended to be open about these deficiencies, admitting that they either did not take the CoC requirements entirely seriously, or that they simply were not able to plan for a continuum of programs and services. Another commonality among these communities is that the threat of losing funding (or the actual loss of funding) had a dramatic impact on planning efforts. In one community, government agencies that had previously been absent from the process added resources and staffing, in another efforts to coordinate long-term planning were established for the first time, and in the third significant changes meant to broaden participation have been implemented in the planning process.

The four other communities that have undergone significant changes since the first application have done so for a wide range of reasons, and with mixed consequences. In the first of these communities, the change was made because the process simply was not functional. The history of homeless programs and services in this jurisdiction revolved around only a few providers that had controlled almost all homeless resources in the jurisdiction before the CoC application process. When the new requirements forced these providers to plan cooperatively with other elements of the system, the result, according to many respondents, was a politically charged, hostile, and ultimately ineffective planning process. In an attempt to improve the planning atmosphere, drastic changes were made to the planning board, including the exclusion of all providers from the board and a shift of leadership responsibilities from the local city government to county government. For a year or so after these changes the process became more functional, but since that time providers have been allowed back on the board, including those with direct conflicts of interest because they have submitted applications for HUD CoC funding, and the general view was that the process has deteriorated again.

Two other communities also underwent a change in the entity leading the planning process, with opposite effects. In one community the county government had played a major role in staffing and providing resources for the process, but has recently decided to discontinue its staffing, leaving both leadership and staffing to a coalition made up primarily of providers. In the other, a jurisdiction that covers the entire state, a state housing commission has become the lead entity, replacing an informal coalition of provider agencies. While the effects of each of these changes are not yet clear, respondents in both communities indicated that the resources and staffing provided by the county or state government seem to be stabilizing factors that are critical to the process. In the former jurisdiction the provider agency that has been left to lead the process on its own has struggled to find enough time and resources to meet the demands of the CoC application, while in the latter the process has become more stable since an organization with ties to the state government has assumed a leadership role.

Our final example is a site in which the only changes made were personnel changes rather than structural changes. The first such change occurred when a homeless specialist was hired by the city department that leads the process. Guided by a mission to bring as many people to the table as possible, he has almost single-handedly made the process more inclusive and cooperative, according to all respondents. The second change was an overhaul of the main planning entity, a group of community members appointed by the mayor. Recognizing that the group had been largely ineffective, a new chair was elected and most members voluntarily left the board. The new group of volunteers, led by an effective chairperson, has taken significant steps toward strategic long-term planning and coordination of homeless programs and services.

Next Steps: The Primary Issues Facing These Systems

No matter the stage of development that a community has reached, a lack of affordable housing emerged consistently as the most prominent issue facing all of these homeless assistance systems. This is especially true for large metropolitan jurisdictions, but it is also true for the smaller cities and even most nonmetropolitan jurisdictions. As homeless assistance systems evolve, the inevitable issue becomes where to find permanent housing for those who used the continuum. Almost all of the 25 communities in this study have yet to develop an answer.

Related to this issue is the trend among these systems to emphasize permanent supportive housing as opposed to short-term emergency shelter or even transitional housing. Of course, HUD's requirement to spend 30 percent of its 2001 appropriation on permanent supportive housing spurred some of this focus, as did the \$500,000 bonus for a new first-ranked permanent supported housing program. A focus on developing permanent supportive housing is especially characteristic of those systems that have more comprehensive continuums in place, and that can afford to focus on long-term solutions rather than immediate needs. The communities that had less comprehensive programs and services tended to identify specific gaps as the major issues they faced, such as emergency or transitional housing for specific sub-populations.

Other than programs and services, respondents in several of the communities with less stable planning structures identified specific elements of the planning process to which attention needs to be paid, such as the use of outcome and/or efficiency measures to rank projects or more formal methods to identify gaps in programs and services. Such responses were common especially among respondents from communities that have undergone major changes in the way they plan for the CoC application and the broader homeless assistance system.

Changes That Could Pose Difficulties

To supplement the information we gathered in regard to the effects that the CoC application process has had, we asked respondents from each community to speculate about the possible effects that certain changes might have on their CoC process or its outcomes. Responses varied not only across but also within communities. We asked about having a guaranteed but lower fixed amount of money, about having funds placed directly in the hands of a federally-designated government agency rather than letting each community develop its own leadership structure, and about focusing on cities and counties as the relevant jurisdictions rather than letting localities decide where to draw the boundaries relevant to their homeless assistance systems.

The responses we received varied according to the nature of local politics, the degree of strength and stability of the local CoC, and the respondent's role in the local CoC. While respondents indicated that both the current funding system and certain changes would offer advantages and disadvantages, most people held the competitive CoC process in a favorable light and feared that changes might reverse many of the successes of the current approach. Others were more open to certain changes, given specific conditions.

Considering the fact that our 25 communities represent many of the higher-ranking CoCs, and usually receive considerably more than their pro-rata share, almost all expressed concern that a change to a guaranteed but lower fixed amount of funding would not be desirable. Fewer federal dollars would in turn lead to gaps within the local homeless assistance system, as many projects currently addressing local needs would be de-funded if such a switch occurred. On the other hand, some respondents pointed out that the current CoC application process requires extensive and costly administrative duties and creates a sense of financial insecurity each year for the agencies with renewal applications. With a change to a guaranteed amount, many respondents pointed out that, even if dollar amounts were lower, they would be known in advance, the application process could be significantly less complicated, and agencies would be more certain about their federal funding from year to year. Still, this does not answer

the question of how funding decisions would be made within each community, and therein lie many of our respondents' concerns about such a change.

Currently, the federal guidelines ensure a degree of inclusiveness and integration in the planning process. That is, many current planning models are grassroots in nature, involving service providers, local officials and city staff, business and foundation affiliates, and advocates of homelessness and related issues. If CoC dollars were distributed to a pre-designated government agency along civil jurisdiction boundaries, respondents feared that funding decisions could be made vulnerable to local politics.

In communities where respondents had limited faith in the local and/or state political process, we heard greater apprehension about the possibility of pre-designating a government agency as recipient of the CoC funds. Respondents in one community stated they believed their state lacked the capacity and experience to administer the CoC funds in an effective manner. In fact, many communities mentioned the limited understanding of and differing levels of interest in homeless issues on behalf of the state or city government, in comparison to the diverse planning bodies currently in place. More specifically, many were concerned that service providers would be shut out of the decision making process and current system-flexibility would be curtailed. Another stated concern was that the changes in local political administrations could have a major impact on the homeless system, as new politicians enter or leave office, bringing or taking different visions of homeless assistance with them.

Positive responses were more often heard from representatives of agencies that would be the likely recipient of CoC funds distributed in this way, including respondents in one community who mentioned the possibility of consolidating homeless funding streams. Still, even in a community where the authorities have already consolidated the various funding streams, many people felt that there would be greater pressures on politicians to fund programs that the CoC planning body has felt were either not performing adequately or did not fill a niche deemed important in the system.

Already there is concern that smaller and newer homeless service providers are being slowly pushed out of the CoC process. Many respondents pointed out that politicizing the process might possibly ensure federal support only for those agencies with political connections. In other words, they feared that many good programs might be left outside of the CoC funding stream.

Another very serious concern raised about a guarantee of a particular amount of funding was that the benefits reaped by the competitive process would be lost. Because CoC funding is not now guaranteed, participants in community planning processes feel some motivation to do a good job of planning, and to try to make their own systems coherent and sensible to an outside observer. One result has been that their systems have become more coherent and sensible to themselves as well, as they have talked through their needs and come to know each other's capabilities. Without the incentive contained in the current competitive system, there would be less motivation to invest the time on a regular basis to consider system improvements.

An additional concern is what would happen to CoCs and their programs if funding were restricted to the larger population centers. Especially with HUD's push in recent years to stimulate states and rural regions to develop CoCs, some of the newest and most fragile CoCs

would lose a great deal if this were to happen. Current high ranking projects in rural areas could lose funding if most CoC dollars were sent to cities and urban counties.

Beyond concerns about the potential to politicize decisions about which programs would be funded, respondents felt that certain changes might jeopardize the diversity of planning efforts that have evolved since 1995. The CoC application's requirements related to inclusiveness and integration have helped pave the way for regional efforts and inter-jurisdictional programs in a number of our communities. A CoC application may and often does include any number of municipalities, counties, or even an entire state. HUD's pressure for everyone in a locality to work together has legitimized local efforts to pull varied political perspectives and interests to the planning table. For example, respondents from multi-jurisdictional CoCs stated that involving the variety of political constituencies with urban, suburban, and rural needs represents a strength and success of the current process. Along those same lines, many respondents felt the turf wars of the past to be less intense as a result of the requirements of the current CoC application process.

If dollars were to be distributed initially to a pre-designated government agency and/or restricted only to cities and counties, several respondents thought that regional planning efforts and inter-jurisdictional projects and services would become increasingly difficult to sustain and fewer would occur. In fact, as many service providers and planning coordinators mentioned, such changes would offer few if any incentives, and might entail disincentives, for program collaboration across local government lines. The initial funding and renewal processes for regional efforts could potentially become too complicated to make such projects worthwhile from the administrative point of view. Fear that turf battles would resurface as a divisive force accompanied apprehension about separating jurisdiction in currently collaborating CoCs.

In addition, the growing trend toward creating services throughout a larger geographic area, which allows clients to stay in their home area for services, might be thwarted. One community went so far as to say that any approach that distributed funding by civil jurisdictions rather than by locally-defined communities would undermine provider efforts to work together to form a single service delivery system or to evaluate how programs and services interact, duplicate, or fill in gaps. Ultimately, uneasiness about changes in the current planning processes and service structures were heard in most of our communities.

What all of these responses makes clear is that there is no single favored public agency or government level (state versus local—municipal versus county) that would be an acceptable pre-designated recipient. The advantage of the current process is that communities are able to decide for themselves which will be the most effective decision-making body. Most respondents said they were happy with the federal role, and many respondents went so far as to say that the CoC process has been one of the best ideas to have come from HUD in a long time.

Implications

The most salient finding relating to the history of homelessness planning in these 25 communities is also the most intuitive: the level of planning that existed before HUD introduced the current CoC funding process has had a great deal to do with subsequent planning for homelessness as well as the application to HUD. More specifically, communities that did significant, system-wide planning for homelessness prior to the HUD CoC requirements have

not only had an easier time meeting those requirements, but also tend to have more comprehensive homeless programs and services, more stable planning structures, and more participants satisfied with the planning process and its outcomes.

As would be expected, the communities that had undertaken little or no planning before the HUD CoC opportunity experienced the greatest difficulty planning for the application and tend to have more gaps in services across their homeless system. However, the CoC requirements have also had the greatest impact on these jurisdictions, as virtually all improvements to the homeless service systems were attributed directly to the requirements from HUD. The same can also be said for those communities that have been in danger of losing funding or that have lost funding at some point since the first application. The reactions observed among these communities and the changes made to the planning structures seem to indicate that the prospect of losing funding is a powerful incentive to establish more cooperative planning structures that incorporate planning for the entire continuum of services. Any change of funding mechanism that would guarantee the funds regardless of the community's performance would eliminate these incentives to better system planning and execution.

As for the current status of these CoCs, almost all communities point to affordable housing as the most significant challenge they face. Otherwise, challenges and goals depend largely on the sophistication of the process currently in place. Communities that have less advanced services and planning structures tend to identify short-term service gaps or flaws in these planning structures as the most prominent issues, while those with more advanced structures and services tend to identify long-term solutions such as prevention, permanent housing options, and ending homelessness.

Beyond these basic findings, the histories of these communities offer few hints as to which models provide the best chance of a successful planning process or continuum of services, though there is one broad pattern identifiable from these communities that seems to have at least a limited capacity to predict success. Those jurisdictions with stable leadership and firmly entrenched planning structures tend to be more successful in establishing comprehensive, system-wide planning for the application and in providing a reasonably well-coordinated and full continuum of programs and services.

It can also be said that most of the communities in this study that exhibited such stability were communities with planning processes facilitated by or with the support of local or state government, with certain exceptions. These include communities for which an independent entity was set up specifically to plan for and administer the CoC process. The clearest reason for the stability enjoyed by many of these communities seems to be the resources and staffing capacity held by many of these local governments, especially in relation to that of traditional nonprofit service providers. The corollary to this finding is that planning systems that lack sufficient resources or staffing (often those that do not have government support for the lead entity) have trouble engaging in broad planning for homelessness and tend to focus almost exclusively on getting HUD CoC funding.

CHAPTER 8: DATA SYSTEMS

Ideally, every community receiving CoC funding would have in place a system to collect data about homeless people and services on an ongoing basis. Such an information system would enhance the efficient and effective delivery of assistance to homeless individuals and families; provide accurate, unduplicated homeless counts; help in the analysis of gaps between needs and resources; assist in the measurement of performance; and provide information to policymakers. At this stage in the ongoing development of CoC systems, there is a long way to go before most communities reach this ideal. This is not due to lack of recognition of the potential benefits of Homeless Management Information Systems (HMIS), but is rather the result of significant barriers to their implementation and use that will be discussed later in this chapter.

HMISs in the Most Advanced Communities

Of the 25 communities visited, the eight that are furthest along on the road to a fully functioning HMIS are Boston; Balance of Cook County, Illinois; Columbus/Franklin County, Ohio; Memphis/Shelby County, Tennessee; Montgomery County, Maryland; Rhode Island; Washington, DC; and Shreveport, Louisiana and nine surrounding parishes. The reasons they have progressed faster than other communities vary, but with three exceptions, they each have a CoC lead agency that not only is charged with developing the CoC application, but also becomes the grantee, receiving CoC funding directly from HUD. This allows the lead agency to enforce data collection through the contracts it writes with homeless providers. The following are brief descriptions of where each of these eight communities stand in the process of implementing their HMIS systems as of spring/summer 2001.

Communities are presented in alphabetical order, thus order does not imply anything with respect to the HMIS itself. It should also be noted that while these communities may be the furthest along in developing and installing their HMIS, most still have a considerable way to go before the system is up and running as desired. Elements that may take some time, even in these advanced systems, include coverage (getting participation from all providers), timeliness (some providers may use paper rather than computers, necessitating data entry), completeness (whether or not everyone, or anyone, uses the assessment and case management components), access (solutions to confidentiality issues), and interfacing with mainstream systems.

Boston

The Center for Social Policy within the McCormack Institute of Public Affairs at the University of Massachusetts—Boston, represented Boston in the coalition of governments that piloted the ANCHoR homeless data system beginning in 1996. Because ANCHoR had technical problems and did not meet the needs of the coalition members, a new coalition, the National Human Services Data Consortium (NHSDC), was formed by 25 states/cities/counties to find a viable alternative. Through a national Request for Proposals process followed by a technical review of the software products submitted, several software programs were identified as better than the others for the purposes of the participating jurisdictions. Ten consortium

members, including Boston, have chosen to use ServicePoint, a web-based software program developed by Bowman Internet Systems.

The Center for Social Policy, which is the central server for the Massachusetts Homeless Data System, is currently assisting homeless providers in Boston to convert from ANCHoR to ServicePoint. Part of the funding to implement ServicePoint in Boston is coming from HUD CoC administrative funds. Other funding is coming from the Massachusetts Department of Transitional Assistance, the state agency that funds most shelters for single people and families throughout Massachusetts. Approximately 55 percent of Boston providers receiving McKinney Act funding are now using either ANCHoR or ServicePoint. Another 45 percent use homegrown approaches for obtaining the data that the city requires them to submit. Eventually, Boston wants all programs funded through the McKinney Act (not just those funded through the CoC application mechanism) to be on the ServicePoint system.

Columbus/Franklin County, Ohio

Columbus/Franklin County has relied on data and performance outcomes to guide the CoC application process and homeless services in general. The Community Shelter Board, Columbus/Franklin County's CoC lead agency, began a shelter tracking system almost as soon as it was formed in 1986. The shelter tracking database covers all emergency shelters and has provided unduplicated numbers and basic demographic data to guide policy. Emergency shelters were involved in the development of the system, which has been maintained under contract by a small firm. The larger shelters have their own data entry terminals, and the smaller ones send their data on paper to the firm that maintains the system. The firm enters all data and matches across programs on unique identifiers to track shelter use and unduplicate system users.

CSB had long been thinking of improving its current system, and was a member of the NHSDC that researched options. HUD's push for communities to develop a functioning HMIS within the next few years has moved CSB to begin installation of ServicePoint. ServicePoint will make a true intake/assessment/case management tool available to providers and to CSB, as well as continuing the availability of unduplicated numbers, linking them to characteristics, and extending the system to transitional housing. It is hoped that the system will ultimately be extended to cover permanent supportive housing. Many providers of this housing have their own data system, however, which in many instances is linked to one or more mainstream agency data systems. Thus issues of integration will need to be worked out.

Balance of Cook County, Illinois

The Balance of Cook County CoC is developing an HMIS called the Management and Reporting of Statistics on Homelessness system, which is to be a major information-networking tool. In 1997, the South region of the CoC received CDBG funding to begin developing an HMIS. Developers first created a universal intake form, which became a software prototype designed to gather demographic information and track service delivery. In 1999, the same group received a second CDBG award to allow the project to go continuum-wide, and partnered with Governors State University to create an Internet-based system that is expected to connect 134 providers within the CoC. The group also received grants from the state Human Services

Department to purchase computers, develop a directory of homeless services within the CoC, and allow the system to be expanded by connecting several smaller providers. At the time of our visit the project was preparing to enter Phase I implementation, with a dedicated server, newly designed software, and 25 active agency participants. It is also preparing to open an on-site training facility to support the addition of a minimum of 15 new participants in the coming year.

The system will allow access to case management and intake and assessment resources available in each participating agency. Instead of having to go to a central intake facility, those seeking help need only to go to the closest “portal agency” or homeless assistance provider organization. Using the universal intake system, each portal agency will complete a local assessment process and be able to tap into a ‘real-time’ bank of available resources within the continuum. Each client will have a unique identifier and be given an electronic referral and directions to his or her program of choice to complete the placement process. When fully implemented, this HMIS project will connect not only the 134 homeless assistance agencies, but also libraries, police, and other government facilities in 125 communities. Provision is also made for agencies that require a higher level of confidentiality than that required by the originating agency.

Objectives include producing an accurate, unduplicated count of homeless people who seek services, the location of their previous residence, demographic information on the homeless population, reasons for becoming homeless, frequency of services requested, services currently or previously obtained, longitudinal tracking of services provided to an individual, and patterns clients follow along the continuum of care. It will also be used for gaps analysis, needs assessments (as determined by homeless persons themselves), a directory of services available in the community, email links among agencies, the ability to conduct point-prevalence counts on a regular basis as well as to produce annual and longer period prevalence statistics, and linkages among agencies, organizations, and individuals.

Promoters of this HMIS are very enthusiastic about it, but convincing providers of its utility to them has been difficult. There are indications of a long road ahead before it becomes the universal system that developers have in mind. Some organizations, such as Catholic Charities, that have their own systems or are concerned about confidentiality or information sharing are pessimistic about the likelihood that such a system will ever take hold county-wide. Promoters appear to be counting on HUD to maintain pressure to move in this direction.

Memphis/Shelby County, Tennessee

Memphis/Shelby County is another locality that attempted to use ANCHoR as its HMIS. After the decision was made to try another approach, an intake data system was developed. Intake data includes type of facility, demographics, frequency of use, who has openings and who does not, number turned away, number taken in. At the time of the site visit, 29 of the 43 area providers were participating in the intake system, and another six had pledged to join it. Memphis/Shelby County has made it a requirement that programs receiving city funds must participate in the intake system. Service providers collect information (mostly electronically except for some small providers who keep paper forms) and submit it on disk to Partners for the Homeless, the organization that coordinates development of the CoC. Partners checks for people who may be entered more than once, and produces unduplicated counts and

demographic descriptions. Memphis/Shelby County has focused on ensuring broad participation by providers and on obtaining accurate aggregate numbers but will be implementing a more complete HMIS in the near future.

Montgomery County, Maryland

Montgomery County DHHS has been in the process of developing a centralized homeless management information system since 1996, when the county went through a reorganization and combined several smaller departments into DHHS. DHHS has struggled to develop an HMIS, ending its investment in the ANCHoR system in 1999 when it decided to invest in creating an in-house system. Programming for the new system has been completed and the first phase of implementation is underway. As of the date of the site visit (February 2001), DHHS had been piloting the system for four months, and was bringing two providers on-line to continue testing (a men's emergency shelter and a community-based shelter). Once the piloting phase is over, they expect to be able to deploy the system in 8 to 10 months.

The development process was very iterative. Providers reviewed each screen as it was developed and offered input on how it could be improved. DHHS found that it was not hard to sell the data system to providers, as service providers recognized the need for a tracking system from the outset. Additionally, the county gave all service providers computers (with a promise to upgrade every 2 years or so).

DHHS has hired an automated system manager to act as the liaison between the service providers and the computer developer. She provides training to the service providers and works with them to ensure that the data being tracked will meet their needs. Training sessions have been provided in a computer lab on how to use the system, but on-site training has proven to be more effective. The HMIS manager has developed a manual and an abbreviated guide on how to use the system. She also troubleshoots for providers and regularly discusses their data tracking needs with them.

The current plan is that intake staff will enter most of the data as consumers enter the system. Service providers will then simply update the data as clients are referred to them, needs are identified, and services are provided. When clients provide information to the initial intake person, they will be asked whether they are willing to release information to a list of providers. The computer program allows information to be blocked by individual organizations (i.e., if a client does not want information to be released to certain providers, the computer system will block the release of this information to those specified organizations). The system also allows individuals control over which specific screens can be shared.

Rhode Island

In 1988, the Rhode Island Emergency Food and Shelter Board, with the support of the local United Way and the Rhode Island Department of Human Services, implemented a statewide Emergency Shelter Information Project. The goal was to determine the size and profile of the population using the state's shelter services. Fifteen emergency shelters, six domestic violence shelters, and two voucher providers contributed to the formation of this database. As of December 2000, the state's emergency shelters and domestic violence

shelters had a total of approximately 629 beds. Demographic information on shelter clients is based on forms filled out by shelter staff the first time each client visits their shelter. Additional data come from monthly report forms that detail the number of shelter nights per client per month.

The CoC Services Committee has been planning for the last two years to implement an HMIS system for the state that would serve all providers of transitional housing, permanent supportive housing, and supportive services, as well as providers of emergency shelter. However, respondents indicated the strong local feeling that the critical need for permanent housing has made it difficult to justify the cost of implementing an HMIS. With the recent change in Supportive Housing Program eligibility making spending on HMIS systems eligible, a proposed project was included in Rhode Island's 2001 CoC application to purchase software and partially implement an HMIS system. The long-term goals of the system are to increase the CoC's capacity to serve homeless people; give providers a system to produce accurate reports and track client outcomes; identify resources based on individual client data; and recommend policies based on trends.

Shreveport, Louisiana and Nine Surrounding Parishes

Over forty local homeless providers in Shreveport, Louisiana and nine surrounding parishes have adopted ServicePoint and are using it to track clients from intake through assessment, referral, and follow-up. In addition, major mainstream service providers, such as the local Veterans Administration Hospital and Office of Mental Health, have pledged to provide information on their homeless clients to the system. Besides client tracking, the system documents met and unmet need and facilitates the connection of clients to services and housing.

Shreveport, Louisiana and nine surrounding parishes: Data Systems

The Shreveport, Louisiana and nine surrounding parishes CoC envisions a homeless service system "guided by collaboration, enhanced by technology, and fostered by commitment." Its reliance on collaboration and desire to use technology to better serve homeless persons can be seen in its systemwide approach to electronic data sharing. Covering nine parishes in the northwest portion of Louisiana, the CoC crosses multiple urban, suburban, and rural jurisdictions. Although a diverse homeless service system, it has a central intake and referral agency for the homeless, Centerpoint, and a common intake form across agencies. In 1997, this common intake became the basis for an intranet module in the ServicePoint software system.

The developer of ServicePoint, Bowman Internet Systems, is based in northwest Louisiana and created its homeless information management system in response to the needs of the local CoC. Currently, a significant number of local homeless providers have adopted the system and are tracking clients from intake through assessment, referral and follow-up. In addition, major mainstream service providers, such as the local Veterans Administration Hospital and Office of Mental Health, have pledged to provide information on their homeless clients to the system. Besides client tracking, the system documents met and unmet need and facilitates the connection of clients to services and housing. Important local tools, such as Centerpoint's comprehensive directory of services (featuring over 1,500 local resources) can be easily

accessed and updated via the intranet. The 2000 annual report from the State's Interagency Action Council for the Homeless states that "the region is now seeing benefits through renewed energy visible from providers as they realize it [the data system] can be used as their MIS system as well as a case management tool." Local leaders hope this new technology will result in both more successful outcomes for homeless persons and more reliable information on gaps in the service system.

ServicePoint grew out of collaboration between the NW Louisiana Homeless, Housing and Service Development Corporation (the nonprofit lead agency for the NW Louisiana CoC that is called "the Coalition"), Centerpoint, and Bowman Internet Systems, which is based in Northwest Louisiana. Centerpoint is the central intake and referral agency for homeless people in the region, and its standard intake form became the basis for a module in the ServicePoint system. In developing ServicePoint, staff from Bowman Internet Systems worked with leaders at the Coalition to learn what other needs could be met by an intranet-based service management system. Bowman staff attended Coalition meetings and talked to many providers of homeless and mainstream services.

The Coalition's leadership includes top administrators of mainstream agencies. A former head of the Coalition is the director of the local community mental health center. Before participating in the system, his office had to overcome confidentiality issues, which it did by instituting two forms—an affiliation agreement and an individual release. The affiliation agreement helped the mental health center select the agencies with whom it would be appropriate to share data. The individual release is a document signed by individual clients about the information they are willing to share and which organizations they are willing to allow to see the information. The ability of ServicePoint to customize access to individual files was a major contributor to overcoming confidentiality obstacles.

Washington, DC

Washington, DC has a reporting system that allows it to track shelter usage among shelters that receive funds through TCP, the lead agency, create an average daily figure, know the number of unduplicated people that use a particular facility, and also approximate an annual unduplicated count of shelter/housing users across all relevant programs. TCP had considered the idea of adopting ANCHoR, but did not. TCP was involved in the NHSDC, and served as its fiscal agent. The District is now in the process of adopting ServicePoint. The new HMIS will ultimately use three of the ServicePoint component systems: ServicePoint, ClientPoint, and ShelterPoint, all in real time and on-line. Among other capabilities, Client Point records client demographics and client assessments, Service Point records the services the person is receiving, and Shelter Point checks shelter availability.

The District will work on Client Point and Service Point first. TCP has distributed the hardware and software to all relevant providers, and is providing training. TCP anticipates that from start to finish it will take about a year of implementation/start-up time before the system begins to give them the advantages they expect from it. They have not yet worked out arrangements for sharing information across agencies and systems. At first, they will have

information available only within the agency that collected it, plus sending it to TCP with appropriate privacy safeguards.

Status of HMISs in Other Communities

The six communities that are least advanced toward having a functioning HMIS tend to be those where the CoC lead agency neither controls CoC funds nor enters into contracts with homeless providers, and consequently, lacks enforcement power. Only one of these six has the power to require homeless service agencies to collect data and take part in a data system. None has taken any steps toward implementing an HMIS, and such a step is clearly a long way off in these communities if it is viable at all.

Southwestern Pennsylvania: Cross-County Collaboration Yields Weekly Data On Shelter Usage

In 1996 the state of Pennsylvania began to mobilize its rural counties to take advantage of HUD's SuperNOFA funding opportunity. Prior to then, few such counties applied, or were successful in their individual applications, for funding. For that matter, homeless assistance providers in one county rarely had contact with their counterparts in other counties, and most had little "hard" information about the extent to which homeless assistance was being provided within their own or nearby counties. Cross-county communication on homeless issues was the exception.

The state established a Steering Committee to give policy guidance and technical assistance to four (initially five) geographically proximate Regional Homeless Assistance Boards (RHABs) on issues related to the submission of Continuum of Care applications. It devised uniform schedules, forms, procedures, and rating criteria for the ranking of projects submitted to HUD. It also facilitated the annual collection of point-in-time data on the number of homeless beds/units available and being used on a county-by-county basis across the entire state.

The five-county Southwest Pennsylvania RHAB carried the idea of cross-county data collection a step further by instituting its own Monday Night Shelter Count. Such a count had previously been done in only one of the five counties and in nearby Allegheny County, but not across multiple counties using a uniform protocol and reporting format. Data are assembled on a weekly basis from all homeless assistance providers within the continuum. Enumerated are the number of emergency (including voucher), domestic violence, and transitional beds used and the number of persons turned away in the region as a whole and on a county-by-county and provider-by-provider basis—by gender and household composition. Weekly reports display these counts and changes over time. The data are used for the CoC application gaps analyses and for prioritization and ranking purposes, as well as generally to inform interested persons about homeless assistance usage and trends.

Implementing a coordinated weekly count covering all providers in the five-county region was, at first, quite difficult, and keeping the count going continues to be time consuming for those involved. When CoC members first saw the results, however, many were surprised by the numbers and quickly realized the value of having such a systematic database. The Monday Night Count is, and is perceived to be, a major advance over previous information availability, and is

quite useful for all parties. It gives each county otherwise unavailable information about its own homeless assistance provision levels as well as those of nearby counties. Because the counties within the continuum are geographically disparate and not well connected by public transportation, sharing of services is not common, but this now-routine information sharing is considered a genuine spin-off benefit of having a regional continuum. Although not specifically required by HUD, the Monday Night Count is a direct result of the SuperNOFA application process and CoC members hope it would continue even in the absence of a such a process.

With regard to the remaining 11 communities in this study that fall in the middle of the spectrum, two are in the very early stages of implementing an HMIS, three have applied for HMIS funding in the 2001 CoC competition, and four are examining HMIS possibilities. Of the remaining two, one is in a state that has applied for funding in the 2001 CoC for a statewide HMIS system, and one has issued an RFP requesting recommendations for an HMIS system. Eight of the eleven have lead agencies that control CoC funds and enter into contracts with homeless providers. They therefore are in a strong position to enforce data collection if they decide to go ahead with it.

What all of these communities need now is direction from HUD as to which fields will be required, which desired, and so on. A number of respondents voiced the opinion that they, and the agencies that will be investing the most time to develop and install a system, do not want to invest in something and then find out later that they have not included some important pieces of information they are now being required to submit. As some communities will not make significant strides toward an HMIS until they have some assurance that they will not be wasting time and money (and "points" with providers), HUD would be well-advised to produce some guidance as soon as possible.

Barriers to Development and Implementation

The barriers to developing, installing, and systematically using an HMIS system throughout a CoC are quite numerous and intimidating. They include issues of power; cost; time; confidentiality; compatibility of different data systems; collecting, updating, and sharing case management information; and the daily realities of caseworker jobs. Case managers we interviewed are particularly consistent in their concerns about sharing case management information among service providers, and many are also skeptical about the utility of an HMIS for their own casework purposes. Collecting and aggregating data to provide accurate, unduplicated homeless counts, help in the analysis of gaps between needs and resources, and supply policymakers with information are less controversial HMIS goals.

Lack of Power to Collect Data

One barrier to HMIS implementation appears to be the lack of power to enforce data gathering in cases where the lead agency for the CoC application does not control CoC funds and does not enter into contracts with homeless providers. In these circumstances, the homeless providers are individual grantees with direct financial and reporting connections to HUD. CoC coordinators in several communities indicated that they feel they do not have

leverage to induce providers to participate in data collection and information sharing. Moreover, these lead agencies do not have responsibility for monitoring the performance of homeless assistance providers, and therefore they have little incentive to develop a HMIS that could help gauge performance.

Even where communities have the power to enforce data collection, they may not be able to obtain data from homeless providers who do not receive CoC funding. As CoC funding is increasingly used for project renewals, less incentive exists for providers who have not received CoC funding to participate in CoC activities, including data collection.

Cost

Many persons interviewed are concerned about the cost of implementing and operating an HMIS. Such costs include software and hardware purchase and installation, initial training of current homeless provider staff, the salary of a data systems manager, software and hardware upgrades and installation, subsequent training of new homeless provider staff, and ongoing technical assistance as problems arise or specific accommodations are needed. Costs may also include added staff time to enter data, and the intangible cost of staff who feel overwhelmed by paperwork. Many respondents realize that CoC supportive services funds now can be used for an HMIS, subject to the supportive services match requirement. However, given the major impact of project renewals in most of the communities visited, there are competing pressures for funding of renewal projects, new permanent housing, and any other new project, including an HMIS project. As was stated in one locality, it is hard to balance the critical need for permanent housing with the cost of implementing and operating a data system. Some persons interviewed described the 2001 HUD Appropriation requirement that every jurisdiction report client-level HMIS data within three years as an unfunded mandate, given the project renewal situation and the reduced size of the grants awarded to their CoCs in recent years.

Time

In most of the communities visited, paid staff support for CoC activities is minimal. In at least one of the communities, all CoC work is done by volunteers. Most staff time is spent on the many steps that must precede the annual submission of the CoC application. In general, there is little time for staff to spend on taking the many actions that are needed to implement and maintain an HMIS. Realistically, either additional staff will need to be hired or contractors will need to be brought in to assist in getting HMIS systems off the ground and keeping them operational.

Another time issue involves inputting data into the system. For basic intake data, intake staff can be trained to enter data directly on electronic intake screens. Alternatively, data from paper intake forms can be entered into the electronic HMIS as a second step. To the extent that the HMIS captures ongoing case management information, many case managers are concerned about the time needed to input hand-written notes into the electronic data systems. They believe that clients would be much more reluctant to provide information if the case manager is sitting in front of a computer screen entering data as the client speaks. Moreover, case managers often write case notes while they are away from their offices and computers.

Any procedures that involve data entry from paper originals double the paperwork burden within the system, whether borne by case managers or by data entry personnel. They also reduce any expected benefits of learning about service openings/opportunities through the system in real time.

Confidentiality

Many persons interviewed brought up concerns about confidentiality of client data. These concerns center mainly on sharing client information among provider agencies. Some advocates fear that shared client information could be used to exclude a person who was asked to leave one shelter from gaining admittance to any other shelter, or reduce the likelihood that someone who has already used a particular service (e.g., detox) will be accepted for another time. Confidentiality is especially a concern with regard to homeless persons with HIV/AIDS or mental illness.

In the communities visited that have some manner of HMIS, the systems at this point generally do not involve sharing information among provider agencies. Instead, they mostly involve basic intake data from providers being aggregated and unduplicated by a central server. In these basic systems, confidentiality concerns have been overcome by using unique identifiers that allow the central server to match persons across programs without revealing to Program A that the person already participates in Program B, or prevent even the central server from knowing the identification of clients at all and/or use information release forms signed by clients.

To some degree, the confidentiality issue may be a convenient excuse to hold off implementation of an HMIS. In the experience of some of the authors of this report, communities that want to implement an HMIS, or any other type of data sharing, for homeless populations and people with other problems as well, manage to develop approaches that respect confidentiality and still get clients the services they need. More clients are likely to suffer from an inability to get needed services because their case managers do not know enough about them than are likely to suffer because information they have placed in a database is being used to exclude them. Further, an electronic database that uses unique identifiers and has controlled access may be a better safeguard of confidentiality than a paper record in a file drawer.

Compatibility of Different Data Systems

Another barrier to sharing data among homeless assistance providers is the likelihood that some mainstream providers will be using different data systems than the one adopted for CoC purposes. For example, mental health, training and employment, and veteran agencies may already be operating management information systems to meet other federal or state data requirements. In addition to cases of incompatibility with mainstream data systems, there are also instances where large homeless provider agencies already have their own management information systems that will not be compatible with the HMIS adopted for CoC purposes. Further complications arise when large provider agencies receive funding from mainstream agencies and are tied into their data system. This situation exists in several of the communities in this study, involving at least public mental health, substance abuse, welfare, and veteran agencies. Given the time and training needed to feed one data system, it is unlikely that these

mainstream agencies and large homeless providers will readily agree to abandon their current systems or feed a second data systems. To make an HMIS work under these complex circumstances, an interface or translator function will be required.

Sharing Case Management Information

As already mentioned, most case managers interviewed for this study are concerned about the time that would be needed to enter case notes into an electronic data system and the potential loss of client confidentiality. Some also expressed doubts about the advantages of a single intake that is shared electronically among case managers at different agencies. They pointed out that case managers want to interact with the client personally and get to know him or her. The intake process is the starting point for that interaction and for building trust between case manager and client. Others emphasized that clients who are not open with some case managers will talk much more freely with others. Some case managers believe that other case managers put everything they are told by the client into the assessment, rather than probing for veracity. The point was also made that circumstances change over time and that intake information may be misleading unless it has been updated, a process that involves case managers in data collection and entry even when an initial assessment has been done centrally. Other concerns mentioned were the unfamiliarity of many case managers with computers and the likelihood of data entry burnout among case managers.

Status of Performance Measurement Systems

We found little evidence of well-developed performance measurement systems among the 25 communities visited. The three communities that appear to have the most developed systems are Boston, Columbus/Franklin County, Ohio, and Washington, DC (again listed in alphabetical order). The following are brief descriptions of these systems.

Boston

Assessing outcomes for homeless people is now part of the process for selecting projects for renewal funding. Boston's Department of Neighborhood Development and the Emergency Shelter Commission conduct site visits, review files, and complete site visit evaluation forms to gather information about actual performance. The McKinney Score Sheet used by Boston to rate projects for its 2000 CoC application included three rating criteria with a maximum score of 100 points. More than half (55) of the 100 points are for Performance, split as Occupancy (10 points), Achievement of Outcomes (15 points), Case Management (10 points), and Program Administration and Operations (20 points). Occupancy looks at how well the program maintains full occupancy. Achievement of Outcomes considers the rate of achievement of the three most meaningful performance objectives previously established by the provider for the project (e.g., proportion achieving employment, proportion maintaining sobriety). Case Management looks at whether case files are complete, demonstrating service plan, services delivered, and client outcomes. Program Administration and Operations looks into four areas, one of which is how well the program is managed, including tracking systems to monitor outcomes.

Because of CoC emphasis on performance measures and outcomes, coupled with the need for renewal funding, project managers are reportedly paying more attention to performance and outcomes. Some are adding the issue of cost to their calculations, examining their program's cost-effectiveness (i.e., how much does each placement in permanent housing cost, each one-year retention in housing cost). Both performance level and unit cost information has helped some communities in this study make decisions about future directions, changes needed in specific programs, and the wisest use of the next dollar.

Columbus/Franklin County, Ohio

CSB has insisted that providers be held accountable for results. Providers themselves are invited to propose performance criteria and levels, which at the time of our visit (several years later) were fairly standardized. They include proportions obtaining, and retaining for six months, permanent housing; proportions obtaining, and retaining for six months, employment; movement into transitional housing if appropriate; and some specialized outcome criteria depending on the program involved. Providers propose their own goal levels, but CSB has occasionally prompted agencies to increase their goals, based on the ability of the provider community as a whole to achieve higher performance. Poor performers have been held to one- rather than three-year renewals, with a requirement that they submit a mid-year report showing that they are improving their performance on whatever the criterion is they need to fix, if they want to be recommended for continued funding the next year. If, after two or three years, their performance has not improved, they are not recommended for refunding.

Washington, DC

TCP also requires providers to propose performance standards for themselves, and then tracks fulfillment of that performance through monthly reports. Each provider proposes its own measures, depending on the types of service it offers. Each provider also proposes the level of success it commits to achieving on a measure (e.g., 65 percent will be placed in permanent housing; of those placed in permanent housing, 90 percent will still be there one year later). However, other providers of similar services get a chance to comment on both the performance indicators themselves and the proposed level of achievement, and critique or challenge them if appropriate. Over the years, expectations for adequate performance have emerged (e.g., 85 to 90 percent retention in housing). If a provider proposes something significantly lower than expectations, it is challenged to justify the low level of goal setting. Usually a challenge results in a commitment to a higher standard, unless the provider can justify its goal level to fellow providers based on client difficulty or some other criterion.

Washington, DC: "Common Standards" for Homeless Services

In December 1998, The Community Partnership, Washington's Continuum of Care planning organization, began conversations with providers and other interested stakeholders about quality and standard practices for the District's homeless services system. The goal was to develop a set of common standards to promote and stimulate *at least* a minimum level of quality throughout the various levels of the Continuum of Care as well as within other organizations that serve the District's homeless populations. The nine-month process that ensued was open to anyone interested in contributing, and involved approximately 35 people representing 24 organizations. After a draft that included a "Key Terms and Definitions" section to clarify the use

and intention of terms and promote consistency and understanding of the specific standards, the current version of the Common Standards was adopted on September 1, 2000.

The “Common Standards” are meant to ensure that homeless families and individuals being served in the District can expect to receive *at least* this common care and practices *regardless* of the provider delivering the service. They include general standards that apply to all providers regardless of the service, and specific standards for different levels of the Continuum of Care including emergency shelter, transitional services, stand-alone day programs and drop-in centers, and outreach services. In addition, key service-related areas include confidentiality, client rights and responsibilities, case management, and follow-up services. General standards cover cleanliness and sanitation; meeting all health, fire, building, and zoning codes; adherence to non-discriminatory guidelines and making services accessible regardless of language, culture, or disabilities; written and posted client rights and responsibilities, house rules and grievance procedures; client assessment, collaboration and coordination with other service providers to meet program participants’ needs; help in getting various benefits; mechanisms for receiving client input and feedback; and no required religious practice for organizations receiving federal or District funding.

Compliance with the “Common Standards” became a requirement for all Community Partnership contracts beginning in fiscal year 2000, however all District homeless service system providers are being encouraged to adopt the “Common Standards” for their organizations as well. Address any questions about the standards to the Community Partnership’s Program Monitor at (202) 543-5298 or psanders@community-partnership.org.

TCP has considerable leverage for obtaining performance data, as payment hinges on their receipt. Monthly reports must be in by the 15th of every month in order to be paid by the end of the month for services delivered. Providers have a month’s grace period (i.e., they can submit data up to a month late) but they will not get paid until the data are in. The monthly report contains progress information on whatever performance goals the provider gave itself in its contract statement of work, which are similar to the goals and levels used in Columbus/Franklin County.

Other Types of Data Collection and Limits of an HMIS

This chapter has focused on HMIS prospects and realities, because that was a major interest of HUD’s. But many communities in this study invested in other types of data collection as well, and used them in a number of ways to inform their decisions. The most common activity was a periodic count or census of homeless people, done quarterly, annually, or biannually. Many of these are simple shelter counts on a designated night, but some involve more elaborate street searches and/or cover some institutions such as jails, detox, and psychiatric inpatient facilities, or even mainstream poverty and welfare organizations. Some communities also conduct periodic or one-time special studies that include in-depth client interviews. These are used to determine client needs, or perhaps to learn much more about

particular subgroups among homeless populations. Surveys of providers to identify levels of demand and perceptions of client need are also common.

Given the difficulties attendant on getting an HMIS up and running, many communities are likely to continue to rely on these various information sources for some years to come. Further, in reality most HMISs will limit themselves to shelter users. Some communities talk about extending coverage to various types of nonresidential homeless assistance services such as soup kitchens or health care programs, and even to mainstream services, but it is a rare community that has done so. Given this reality, most HMISs will never be able to answer certain questions of importance to HUD, such as whether CoCs reach “all” homeless people. Some of the other types of data collection just described are better suited to answer this question, especially when coupled with HMIS information. Therefore it would be good for Congress and HUD to think through the combinations of data types that would be most informative, and not try to put all its eggs (or pressures) into the one basket of an HMIS.

Implications

The quest for “good data” is usually propelled from the top of a system, while the people at the “bottom” are the ones who have to change their behavior if the system is to work. Too often, system administrators and funders ask for data without giving sufficient thought to the working lives of the people who will have to supply it. For the most part, unless data systems satisfy some important needs of the people being relied on to enter data into them, the data themselves will be late, incomplete, and often wrong. In this final section we try to summarize some of the concerns we heard about HMISs and suggest the boundaries of realistic expectations.

Prospects for Functioning Data Systems

Prospects for functioning data systems vary greatly among the communities visited. In communities where providers voluntarily work together on the CoC application but then sign individual contracts with HUD as grantees, the prospects for a CoC-wide HMIS are doubtful because there is little power or incentive for the lead agency to induce providers to implement such an HMIS. However, it appears that in communities where the lead agency for the CoC application also controls CoC funds and writes contracts with homeless providers, the prospects for implementing a data system are greater.

The prospects are also much better over the next several years for limited HMIS systems that concentrate on obtaining basic data for aggregation and analysis. For the reasons described in this chapter, prospects are currently poor for HMIS systems that aim at shared case management information among homeless provider agencies.

While functioning data systems are the ultimate goal for CoCs around the country, communities are finding implementation difficult. The prospects of HMIS systems solving any problems or fulfilling the hopes placed on them in many communities will require funding support from local and federal sources, independent of CoC dollars, as well as coordination among providers and administrators regardless of the type of CoC that currently exists. The success of the data efforts will depend, at least in part, upon improved data collection systems

and training at the housing provider level. Incentives such as earmarked sources of funding for improving data collection could potentially advance the timetable for communities to implement functioning data systems.

HMIS Implementation

To provide Congress with the information it seeks on the magnitude and nature of homelessness nationwide and on homeless program performance, consideration should be given to separate funding for HMIS implementation and operation. As many providers indicated, HMIS systems often are in competition with renewal projects and new permanent housing projects during the ranking process. While guidance on how to implement an HMIS may be provided through technical assistance contracts, implementing HMIS systems locally requires funding that many communities currently cannot provide with the limited resources that exist. In most communities, local needs for housing and services often trump data needs.

In implementing an HMIS system, HUD must resolve the disconnect between federal government and local community data needs in order to avoid wasted resources and time by those involved in implementation. Identifying the needed HMIS data elements for client-level data, notifying CoC lead agencies promptly, communities can begin to design plans (or adjust current plans) to meet the 2004 congressional deadline. In the short term, HUD should consider focusing on client intake data, leaving client outcome data for a later deadline. Careful consideration should be given to data elements for emergency shelter, recognizing the added difficulty of obtaining data from persons who are not participating in ongoing services but are only seeking a bed for the night.

A key element in implementation is to advise CoC lead agencies that the use of HMIS systems for sharing case management information among provider agencies is optional. Once several HMIS systems show the benefit from successfully sharing this type of case management information among provider agencies, publicizing those systems can serve as models and inducements for others.

Use of Performance Information in Funding Decisions

Any efforts in the direction of making funding decisions on the basis of performance and cost, assuming that quality does not suffer, are to be applauded, especially given that homeless assistance programs often operate on a shoestring, and are perpetually engaged in a search for additional support. Some McKinney Act technical assistance money has been used to help projects develop performance measurements. HUD hired a contractor to help provide performance measurement assistance, and some CoC administration money has been used as well. The value of performance information should become increasingly clear as decisions about which programs to fund with scarce resources become harder to make.

CHAPTER 9: SUMMARY AND IMPLICATIONS

This chapter briefly summarizes the major findings of this study with respect to the research questions with which it began. It ends by addressing broader implications that emerge when one considers general patterns in the 25 communities studied and concerns raised by the people we interviewed.

Question 1: Local Homeless Assistance Networks—Programs and Functioning

The consistent message we received through interviews and observations in the communities we visited is that more people get more services and participate in more programs as a consequence of the CoC approach than was true before it began. Since the new approach to CoC application requirements happened simultaneously with increased federal appropriations for homeless programs, we asked specifically about perceived effects of the CoC approach, as distinct from just receiving more money. Respondents attributed changes to the requirement for a community-wide process, plan, and application, not to increased funding. Further support for this as the change mechanism comes from reports that the changes were true not just for homeless-specific programs and services, but also for services and benefits offered by mainstream programs.

Even among these 25 highly ranked CoCs, however, we found great variation in system structures and coverage. It goes without saying that no system, even the most developed, has “enough” of every system component. A few have very well-developed homeless-specific programs in all or most components (except permanent affordable housing). Many have one or more underdeveloped components, for various reasons. Which components will be best or least developed in a particular community depends at least as much on local idiosyncrasies as on planning and intentions.

Most of the communities we visited had evolved or were evolving more or less sophisticated methods of helping clients learn about and obtain the services they needed. Their success in actually getting the services depended not so much on the homeless-specific system’s efforts as on bureaucratic requirements of mainstream programs and the availability of slots in homeless-specific programs. The assistance of case managers was essential for assuring access; homeless people usually encountered frustration after frustration if they tried on their own to get mainstream services or benefits, except for basics such as food and clothing.

We have no way of knowing whether these CoCs reach all homeless people. To know this we would need an independent source of information about all homeless people, which we could compare to records of service use. To the best of our knowledge these two pieces of the puzzle do not exist together in any of our communities. Respondents in some of the communities in this study felt that their networks reached all homeless people *who wanted services*, but could not say whether the system knew about homeless people who did not want services. In communities with good outreach coverage, outreach workers felt they knew everyone in their territories, and had at least attempted to offer assistance. But communities varied greatly in the extent to which their outreach efforts extended throughout their boundaries. Good publicity and a good homeless grapevine help homeless people know where to start and

which access points are the most user-friendly, assuming they want to connect. Homeless people interviewed for focus groups usually said that they knew about basic services (food, shelter, and clothing) and knew where to get them if they wanted them. Helplines, centralized intake, and/or systematized referral processes also increase the likelihood that people will get needed assistance. In the future, homeless management information systems may be able to provide data saying how well people who have contacted the system have been served. But even a community with an excellent computerized data system will not be able to show that its homeless assistance network reaches all homeless people unless it can compare that count of homeless people served to the total number of people homeless in a community derived from an independent survey or count.

It was also true that most communities in this study were not able to accommodate the needs of one or more subpopulations among homeless people. Sometimes these were people with substance abuse problems and/or mental illnesses, who were among the subgroups most commonly identified as hard to serve. But the experiences of other communities where the appropriate mainstream agencies were actively involved demonstrate that these populations can be well-served, and will respond enthusiastically to well-designed programs. Chronically homeless people with severe mental illnesses have been housed successfully, and have maintained that housing, when they have appropriate case management and supportive and medications services from mental health agencies coupled with housing itself and housing services. The same is true for chronically homeless substance abusers when they have housing and housing services coupled with appropriate services from mainstream substance abuse agencies.

Families usually receive a lot of attention and resources in our 25 communities, but not in all of them. The more active the mainstream involvement, the fewer people are left without specialized resources. To be their most effective, homeless-specific programs really need to be fully integrated into both planning and service delivery structures serving all poor people. This includes development of housing resources for poor households—a “Consolidated Plan” that goes beyond lip service.

Question 2: Inclusiveness of CoC Planning, Coordination, and Program Support

Most communities in this study had very broad representation of homeless-specific interests at the planning table, at least for the early activities of the CoC process (identifying gaps and prioritizing needs). Over the years since 1996, participation in planning has in most instances led to greatly increased cross-program knowledge of service offerings, trust, and cross-referrals. Often it has also led to revised procedures for accessing services (e.g., pre-screening, pre-authorization, more efficient use of program slots), joint activities (e.g., multi-agency teamings to assure coordinated services on a case-by-case basis), and even jointly run programs. These aspects of program and service coordination were widely cited as a major contribution of the CoC process.

However, we also heard that in some communities it was hard to keep people involved if they were not getting CoC money, and that planning tended to devolve to a small group of “interested parties.” CoC leadership needs to do everything it can to make it worth the while of those not getting CoC funding to participate. The only meaningful way to do this is to have something going on that is broader than the CoC application. Issues of prevention, outreach,

and emergency shelter should be included in the overall planning process, preferably with the funding and other resources for these programs being planned and coordinated in the same process that covers the system's transitional and permanent supportive housing components. It is also important to make sure that most people do not have to sit through the final throes of putting the CoC application together.

Question 3: Integration with Mainstream Programs and Services

Our 25 communities included the whole range of mainstream involvement, from none at all to sustained and significant involvement of the most important agencies. However, the norm was fewer rather than more. A couple of communities had major commitments from three important mainstream agencies (e.g., housing, mental health, and substance abuse; or mental health, substance abuse, and veterans). These took the form of funding for new housing with supportive services, new substance abuse or HIV/AIDS or mental health treatment, as well as coordination to improve access to existing services. Several more communities enjoyed the involvement and investment of two mainstream systems, and a few more communities had one major agency on board. But nine communities had essentially no investment by mainstream agencies, even when a few received a bit of help to write the CoC application.

A community's definition of a CoC and its goals for its homeless assistance network make a big difference for mainstream involvement. The communities that are beginning to take seriously the goal of eliminating homelessness recognize that the goal will never be reached if the only involvement comes from homeless-specific programs and advocates. In pursuit of their goal, they have become the communities with the best integration of homeless and mainstream programs and services.

Question 4: Role of Data and Statistics in Planning

Good planning relies on good information about demand and supply—demand, or need, for specific programs and services, and their availability. Mismatch between demand and supply should then trigger efforts to increase supply or reduce demand. In the homeless assistance arena, many communities take the attitude that demand so far exceeds supply that they need more of everything and do not need data to prove it. Others take the attitude that good data are essential for ending arguments about the nature and size of the problem and focusing attention on what needs to be done about it. A few of the 25 communities in this study have long taken the latter attitude, and more are moving in that direction. But some—more than a few but less than half—still feel that need so far exceeds their ability to meet it that service development is the only thing worth doing.

For the few communities that have the best data, their information comes from a variety of sources. These include special counts, special surveys, shelter tracking databases for counts and basic characteristics (but not services, yet), and manual approximations to shelter tracking databases. They also have performance reports from providers. The communities that have these data have gone to considerable lengths to get them, and they use them in a variety of ways. These include examining (1) whether capacity and specialization match needs (i.e., do we have enough low demand emergency shelter to accommodate people being referred from outreach, enough capacity to accommodate people coming out of detox so they do not have to

go back to the streets); (2) whether funds are being spent in the most efficient and effective manner; and (3) whether people placed in permanent housing are retaining it or coming back into the system, among other issues.

Question 5: Effects of HUD's Application Requirements

Respondents in all but a few communities in this study agreed that the structure of HUD's application from 1996 onward, requiring a coordinated community-wide approach, has had major effects on their homeless assistance network. The few communities experiencing relatively little change due to HUD were those that already had a high level of planning and coordination before 1996 (these communities have changed in other ways, however). Respondents reported increased capacity, increased diversity, and increased coordination of their homeless-specific programs and services. Most reported a far greater shared knowledge of each other's capabilities and expertise, and as a result, a greater ability to get their clients needed services. Less widespread is significant involvement of mainstream agencies, as providers of case management, other services, and permanent housing, but most of what exists now is a major increase over what existed before 1996. Finally, a few communities had made major investments in developing data systems without pressure from HUD, but many more are now examining their options or have taken their first steps as a consequence of HUD's pressure and HUD's willingness to fund HMIS development with CoC dollars.

Question 6: Success in Ending or Reducing Homelessness

At one level, we were not able to address the question of how successful CoCs have been at ending or reducing homelessness because the necessary data do not exist. At another level, however, we need to break this question into two parts—better exits, and fewer entries. The first part—better exits—asks how well existing homeless assistance programs are able to place their users in permanent housing, with or without supportive services, and whether those users are able to retain their housing for a significant period (e.g., at least one year). Most communities do not have this information for any program, but a few have it for all or most of their programs. As communities focus more on performance data and more communities begin making decisions related to such performance, future research will perhaps be able to address this question more successfully than could be done for this project.

The second part—fewer entries—is an entirely different matter. With possibly one or two exceptions, none of the communities we visited appears to have reduced the entry of newly homeless people into the system, or the overall volume of homeless people served by the system. To do so will require addressing the two ends of the CoC, prevention and affordable housing, neither of which can be done without significant involvement of mainstream agencies and strong support from the wider community.

Impressions and Implications

Some implications of this project's findings can be clearly understood once the reader has the information on a specific topic. These implications have been included at the end of chapters 2 through 8. We have saved the presentation of other implications to discuss in this

final chapter because they follow from many aspects of our findings rather than the contents of any one chapter.

Lack of Affordable Housing

In every community we visited, respondents told us that lack of affordable housing was the basic fact of life. Many respondents reported vacancy rates of 1 percent or less, average rents 15 to 25 percent above Fair Market Rents, people unable to find an apartment for which they could use their Section 8 voucher, landlords figuring out ways to avoid people with Section 8 vouchers, zoning and other legal restrictions on SRO and other low-income housing development, loss of public housing units, and lots of NIMBY attitudes. These communities faced a generally impossible rental housing market for many households with several earners, let alone homeless people. Ultimately homelessness will not end unless this country produces more housing and makes it affordable to very poor people, including single people with disabilities.

Steps, Stages, or Levels

Some implications of research findings in a project such as this one are obvious; others emerge from impressions, speculations, and musings across the range of experiences accumulating as one amasses more time in the field. What follows is in the latter category.

Even these 25 communities with very high CoC application ratings can be arrayed according to their (approximate) location in a series of steps, stages, or levels of CoC development (hereafter, “steps”). We hesitate to use even these words, because they imply a linear progression that may not be the case. Communities can start in the middle, start at “the beginning” and skip steps, regress, and get “stuck.” Nevertheless, the more inclusive and sophisticated steps are so much closer to HUD’s ideal of a CoC, and also appear to be so much more likely to address the ultimate goal of ending or reducing homelessness, that it seems worth presenting our impressions. We do so in the spirit of providing food for thought, and without wanting to be held to any expectation that we could or would classify each community in one and only one step.

- **Step 1:** Community planning, and perhaps also coordination, activities cover only the homeless-specific programs and services that HUD will fund through the CoC application. Little if any participation occurs from non-homeless programs, or even from emergency shelter and prevention providers.
- **Step 2:** Community planning and coordination extend to all homeless-specific programs and services, including emergency shelter, outreach, and prevention, incorporating planning for Emergency Shelter Grant monies and perhaps also Emergency Food and Shelter Program funds in the same process.
- **Step 3:** Significant involvement of mainstream agencies for service delivery to people involved with homeless-specific programs and services. These mainstream representatives may include agencies with responsibilities for services related to alcohol, drug, and mental health problems; public health; employment and training; public schools; welfare and cash

benefits; public housing; and Veteran Affairs. They may be public or private nonprofit agencies, but usually are public, or at least publicly funded.

- **Step 4:** Once communities achieve Step 3, which is no small feat, and experience its benefits for several years, they may take a deep breath and ask themselves whether even this level of cooperation and coordination is getting them closer to the ultimate goal of reducing or ending homelessness. Once they do this the answer is usually “no.” Just as many people are coming into the system as ever. They may then rethink their approach. When they do so, the results are usually an even greater involvement of mainstream agencies, this time geared to prevention and expanding the availability of affordable housing. The prevention aspect usually focuses on mental health, substance abuse, and even corrections agencies doing a better job of assuring that people released from their facilities have stable housing and any supportive services that are needed to prevent them from ending up homeless. In addition, resources to avert eviction, pay rent or utility arrearages, do some financial counseling, and otherwise handle situations of imminent homelessness, usually for families, often play a significant role on the prevention side. The affordable housing aspect means doing something serious about the often impossibly tight, and expensive, housing market facing homeless and other very poor people, and requires a very long-term vision and commitment.

Importance of the Local Environment

Several aspects of the local environment stood out as having important consequences for homeless assistance systems.

Different Levels of Local Investment. With the best will in the world, communities will not be able to progress much beyond Steps 1 and 2, as just described, without the support of mainstream agencies, local (and sometimes state) governments, and the local business community and other power brokers. Ending homelessness requires permanent affordable housing, and it requires resources for prevention. Neither can come from HUD CoC funding. The support available to the 25 CoCs in this study for helping homeless people and also for ending homelessness ranged from incredibly strong to indifferent to nonexistent—and these are 25 CoCs with very highly ranked applications. Some communities we visited invested a considerable amount of state and/or local government and private resources in their homeless assistance networks, in addition to what they received from federal sources. In other communities, if federal sources would not pay for a service or program, it did not happen, and of course there were communities between these two extremes.

Local, state, and regional attitudes toward public responsibilities also make a huge difference, as does the basic level of resources. Some of our 25 communities are located in states that have many resources and are committed to use them. Others are in states that have (or could have) reasonable levels of resources but are opposed to both taxation and public action. Still others are in states with few resources but a willingness to use whatever they have. It should be clear that communities in states of the second sort will get no help from outside, while those in states of the first and even the third sort have distinct advantages. Further, it was not only the poorest communities that failed to invest in homeless assistance efforts. Nor was it necessarily the richest ones that chose to do so. Local leadership in the most generous

communities strongly supported taking action to end homelessness and reduce its debilitating effects.

Relationship to surrounding jurisdictions and institutions. Not only do these CoC communities differ dramatically in the financial and moral support they receive locally and at the state level, but some of them also face circumstances beyond their control that affect the number and nature of the homeless people who seek their help. Some of the communities we visited were “little fish in big ponds.” They did not have much ability to influence how homeless people (and sometimes also services and programs) arrived from the surrounding areas or disappeared from within the community (e.g., a welfare office being moved out of the community, or neighboring cities sending homeless people into the jurisdiction). Others were “big fish in little ponds,” with the ability, and willingness, to help surrounding jurisdictions develop better services and integrate them to some extent across jurisdictions.

Another important factor in some communities was the presence of major social institutions (e.g., prisons, mental hospitals), that could either be a part of the problem (releasing people from their custody without adequate aftercare plans) or a part of the solution (developing adequate post-release services and supports). Having a state prison or mental hospital in your community will increase certain subgroups among the homeless. Usually, neither the institutions themselves nor the communities from which prisoners or patients came contribute adequate resources to address their housing needs, leaving local homeless service networks to do the best they can. When parole officers actually instruct felons upon release to “report” to the local shelter and stay there for six months as a condition of parole, as happens in one of the communities we visited, the local homeless system has a problem. In contrast, the local homeless system has a huge advantage when local businessmen or the public substance abuse agency invest resources to create their own program to increase the odds that people once in the system or completing basic treatment get the help they need to continue on toward leaving homelessness,

A “hometown” versus an “absentee” attitude of people and institutions with significant resources. In some communities we visited, business and corporate interests were locally based, important executives were from the locality, and they cared that it functioned well and took care of its citizens. In others, the corporate presence was indifferent or hostile; corporate headquarters were elsewhere, executives cycled through and had no roots in the community, and investment in homeless services and advocacy was not high on their agenda. Communities with significant local civic leadership pertaining to homelessness tended to be those that made the greatest local investments in their CoC.

Also important for homeless assistance networks is the “homegrown” or “imported” character of the homeless people they are called upon to serve. Some of our communities are reasonably self-contained. Of course people come into and leave the community, but the community itself is not a major draw for people at high risk of homelessness or already homeless. Nor is it a big place to which smaller neighboring communities send the people they do not want to deal with, or a small place bearing the burden of bordering a large jurisdiction whose issues dominate the whole region. The move of some of our communities toward creating region-wide service structures is one answer to the problem of “dumping” or “Greyhound therapy” (buying people a bus ticket to somewhere else). If “sending” communities can be helped to recognize their home-generated homelessness and deal with it at home, the burden of “receiving” communities will be lessened. However, our 25 communities include

some that are such magnets for currently or incipiently homeless people that without substantial outside resources they are not likely to end homelessness within their borders.

Importance of Philosophy about Homelessness

Even with strong mainstream agency support and the local power structure on board, it makes a huge difference what a community is trying to do. A few of our communities are very well organized and have strong local support, but focus their energies primarily on helping people who are already homeless. A few others have spent a number of years in that situation and have now taken the plunge toward Step 4 (described above). They have seen that they need to do something more, or different, than treating homeless people with respect and getting them the services they need, or they will still be doing that for decades to come. Their focus has shifted toward stopping the flow into homelessness, creating permanent supportive housing for the chronically homeless people in their community, and addressing the desperate need to create more permanent affordable housing for all very poor people. For these goals they need mainstream support, political support, and financial resources in totally new ways.

Philosophy also matters for individual programs. Even soup kitchens and day centers can move people out of homelessness if that is their true working goal. If it is, they will set themselves up to try to achieve it, and they will succeed with many people. The ability of no/low barrier permanent supportive housing programs to create stable housing environments for chronically homeless people taken right off the streets suggests that policy-makers should be paying more attention to how this works where it succeeds, and worrying less about theories of rehabilitation and recovery. Research could aid in discovering successful program elements.

Evolving Views of Appropriate Programs and Services

As communities gain more experience in planning homeless assistance networks and carrying out those plans, they also have the opportunity every year to reflect on what they have accomplished, how well particular approaches and programs are working, and how they could accomplish more. These opportunities for reflection have given rise to changing views of the value of certain network and program structures. Some communities have decided to reduce their investment in transitional housing programs, offering more intensive services in emergency shelters and then transitional supports once people obtain permanent housing. Others are expanding transitional housing because their clients cannot find permanent units. Some CoCs have invested in whole parallel continuums of no/low barrier programs, while others have opted to maintain or even increase requirements to participate in programs. Individual programs also differ, even more than whole continuums, in their approach to clients and their goals for clients.

The research evidence is clear with respect to no/low barrier permanent housing—it can be done, and done successfully, even with the most chronic, most disabled, street homeless (Culhane, Metraux, and Hadley, 2001; Shern et al., 1997; Shinn and Baumohl, 1999; and the experiences of several communities in this study). All it takes is the investment in housing, the right program structures, and the right mix of supportive services. It would be extremely helpful to have the same level of certainty about transitional housing programs. Opinions abound as to its utility, or inutility, for everyone, or for particular types of people.

Substance abusers just out of detoxification programs are the group most commonly mentioned as needing transitional housing. That is, they need to live in a program that keeps them out of “the old neighborhood” and helps them stabilize their recovery until they have confidence in their ability to manage on their own without returning to addiction or to homelessness. Families are the group most often mentioned as not needing transitional programs. Rather, families are seen as needing as few disruptions as possible for both parent(s) and children, so placement in permanent units coupled with ongoing supportive services are proposed as the answer. However, other providers working with families with multiple barriers (e.g., recovering from substance abuse and also having learning disabilities, persistent mental illness, and/or some degree of developmental disability) believe that these families also do much better when they live in a facility rather than in scattered site apartments. All of this is opinion. It would be nice to have some evidence from research.

Whatever the research answers about transitional housing, it also seems reasonable for HUD to allow programs to offer clients up to 24 months of transitional supportive services, regardless of where they live. At present, clients entering a transitional housing facility may stay there up to 24 months, and then get 6 months of follow-up services—30 months in total. Clients entering a transitional program that places them in permanent units from the beginning may receive 24 months of supportive services. But most clients using transitional housing programs enter a facility, stay an average of 6 months, and then are eligible for only 6 months of follow-up once they move to a permanent unit—12 months total. Providers and case managers are unanimous that the 6-month follow-up period is not long enough for clients in the last of these situations. HUD could use its administrative authority to eliminate these inconsistencies.

Effects of CoC Funding Structure on Cooperation and Coordination

There was little question among most of our 25 communities that the CoC funding structure has moved them toward significantly greater planning. Further, that planning has come over the years to encompass a broader scope, and in many communities to involve more players. Where community respondents felt the CoC structure had not made much difference, they were already very well organized and comprehensive before 1996.

Even more important than coherent planning have been the results with respect to increased knowledge of local service options among homeless-specific and mainstream providers, and increased coordination and access for homeless people as a result of that knowledge. In addition, new joint projects, collaborations, and creative programming arrangements are routine results of the planning process. Finally, the borders of many CoC communities look quite different than the borders of entitlement jurisdictions, or than the original borders of today’s CoC applicants. Whole states and substate regions have been encouraged to apply, by HUD and by their own state interest in receiving federal resources. Only six of our 25 communities, the single cities, include only one entitlement jurisdiction, and one civil jurisdiction of any type. Seven have two entitlement jurisdictions (six city/county combinations and one state), all but one of which include additional civil jurisdictions with influence over housing matters. These CoCs join authorities that do not always see eye-to-eye on every issue but have agreed to work together on homelessness. Half of our communities include more than two entitlement jurisdictions, and tens or hundreds of civil jurisdictions. Many of these collaborations would not exist without the CoC funding structure. Any potential federal program

changes should be examined very carefully before being installed, to assure that they do nothing detrimental to this trend toward cooperation.

Community Differences and Need for More Information on Rural CoCs

Among the 25 communities in this study we have seen great differences in structure, resources, comprehensiveness, approach, and results. But we have not been able to give sufficient attention to issues in truly rural communities (those beyond easy access to a major metropolitan area). Nor have we been able to explore the issues in large states of the complexities added to the negotiating and planning process by regional and state levels of government, or indeed the issues involved in determining appropriate regional membership for application to HUD, who does the organizing, and so on. We know, informally, that some states have been very active in creating, motivating, and supporting regional applicants with technical and other assistance, but we do not know much about how they do it, the decisions they face, and the ways they resolve them. These issues would make a good focus for a follow-up research project similar to the present one.

Possible HUD Actions Suggested by Respondents

Respondents in many communities expressed their desire for certain actions by HUD, and others had suggestions that we thought would be valuable for people in many CoCs. These do not really fit into any of the categories of this report, so we include them here.

1. It would be helpful if HUD established a listserv mechanism so people from one CoC could post queries to other CoCs and receive responses directly (i.e., without going through a technical assistance firm). These are questions such as “Does anyone know good examples of how to do X?” or “Has anyone tried to do Y, and what happened?” People could also post to the listserv any programs, approaches, or activities they thought would be interesting/valuable to others.
2. A great deal more information, clearer and more accurate, is needed on how to gain flexibility when faced with many renewal projects. Techniques such as amendments, use of performance information, how to substitute mainstream agency funding while retaining all of one’s renewal funding, all need description and dissemination.
3. More information is needed about best practices for involving and then working with mainstream agencies.
4. Communities need clear indications of what HUD’s requirements will be for the data to be derived from HMIS systems, since many will not make the investment in data systems until they are sure the system they adopt will meet HUD’s requirements.
5. HUD could be asking for better, and certainly more meaningful, data than are contained in the current gaps analysis chart. Communities should be asked what data would really be helpful to them, and the application requirements revised accordingly. Among other data elements, information about the past performance and accomplishments of projects asking for renewal funding should be mandatory. Communities should be made aware of which parts of the application were designed to help communities with their own

planning, and which parts are those to which HUD gives the greatest attention as it rates applications.

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ACRONYMS

General:

ACCESS	Access to Community Care and Effective Services and Supports, a competitive grant program funded by SAMHSA
AFDC	Aid to Families with Dependent Children, the pre-1996 federal-state welfare program that was replaced by TANF
CAP	Community Action Program (or Agency), what remains of the War on Poverty
CDBG	Community Development Block Grant
CoC	Continuum of Care
DHHS	U.S. Department of Health and Human Services
EA	Emergency Assistance (originally available through AFDC, if states opted for it; now local option under TANF or other mechanism)
ESG	Emergency Shelter Grants
HOPWA	Housing Opportunities for People with AIDS
HMIS	Homeless Management Information System
HUD	U.S. Department of Housing and Urban Development
NHSDC	National Human Services Data Consortium, the group of jurisdictions that researched HMIS options
NIMBY	Not In My Back Yard (meaning, don't put that program in my neighborhood)
PATH	Projects for Assistance in Transition from Homelessness, a formula grant program funded through SAMHSA to states and thence to localities
SAMHSA	Substance Abuse and Mental Health Services Administration, part of U.S. DHHS
SHP	Supportive Housing Program, the official source of the CoC dollars
SNAPS	Office of Special Needs Assistance Programs, the HUD office that processes the CoC applications
SRO	Single Room Occupancy; in this report, SRO usually refers to the Section 8 Moderate Rehabilitation SRO Program
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
TANF	Temporary Assistance for Needy Families, federal welfare program that replaced AFDC

Site-specific:

Boston, Massachusetts

DTA	Department of Transitional Assistance, Massachusetts' TANF agency
SHPG	Strategic Homeless Planning Group

Broward County, Florida

BPHI	Broward Partnership for the Homeless, Inc.
HAC	Homeless Assistance Center
HIP	Homeless Initiative Partnership

DHS Department of Human Services

Chicago, Illinois

CDHS Chicago Department of Human Services

Columbus/Franklin County, Ohio

ADAMH Alcohol, Drug Abuse, and Mental Health Board of Franklin County

CSB Community Shelter Board

Long Beach, California

HSAC Homeless Services Advisory Committee

HSAP Homeless Services Agency Partnership

HD Department of Health and Human Services (referred to as the Health Department)

MSC Multi-Service Center

Montgomery County, Maryland

DHHS Department of Health and Human Services

HPDC Homeless Policy Development Committee

Orlando/Orange County, Florida

HSN Homeless Services Network

San Francisco, California

CATS Community Awareness and Treatment Services, Inc.

MAP Mobile Assistance Patrol

Washington, DC

BID Business Improvement District

DHCD Department of Housing and Community Development

DHS Department of Human Services

TCP The Community Partnership for the Prevention of Homelessness

APPENDIX A: MOST COMMON SOURCES OF FUNDING FOR HOMELESS ASSISTANCE PROGRAMS FROM THE U. S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

1. Emergency Shelter Grant Program
2. Supported Housing Program
3. Shelter Plus Care Program
4. Single Room Occupancy Program
5. Housing Opportunities for People with AIDS

Emergency Shelter Grant Program (ESG)²

Purpose: ESG awards grants for the rehabilitation or conversion of buildings into homeless shelters. It also funds certain related social services, operating expenses, homeless prevention activities, and administrative costs. ESG supplements state, local, and private efforts to improve the quality and number of emergency homeless shelters. By funding emergency shelter and related social services, ESG provides a foundation for homeless people to begin moving to independent living.

Eligible Applicants: HUD allocates ESG funds annually based on the formula used for the Community Development Block Grant (CDBG). ESG provides funds to states, territories, and cities and counties that qualify for CDBG. Beginning October 1, 1998, Indian Tribes are no longer eligible for ESG funds, but may carry out these activities using the new [Native American Housing Block Grant](#). States and territories that receive ESG must distribute the funds to local governments or private nonprofit organizations. Local governments may administer all of the grant themselves or distribute the funds to private nonprofit organizations. They must also match ESG grants dollar-for-dollar from non-ESG sources. States and territories do not need to match the first \$100,000 of a grant.

Eligible Activities: Grantees may use ESG for the conversion, major rehabilitation, or renovation of buildings as emergency shelters. They may also use ESG for shelter operating expenses, essential services (supportive services concerned with employment, health, drug abuse, and education), or homelessness prevention activities. Grantees may use up to 30 percent of a grant for essential services and homelessness prevention activities. They may request a waiver on the cap on essential services. With the exception of homelessness prevention activities, grantees must use the property as a homeless shelter for a specific period.

Eligible Customers: A person must be homeless (or at great risk of becoming immediately homeless) to receive help from ESG projects.

² Source: <http://www.hud.gov/offices/cpd/homeless/programs/esg/esgqfacts.cfm>. Accessed October 16, 2001.

Supportive Housing Program (SHP)³

Purpose: The SHP is designed to promote, as part of a local Continuum of Care strategy, the development of supportive housing and supportive services to assist homeless persons in the transition from homelessness and to enable them to live as independently as possible.

Eligible Applicants: states, units of local government, other governmental entities such as PHAs, and private nonprofit organizations, and community mental health associations that are public nonprofit organizations.

Eligible Activities: SHP funds supportive housing projects that include: (1) transitional housing (generally used for 24 months or less as a stepping stone to permanent housing); (2) permanent housing for homeless people with disabilities; (3) supportive services for homeless people not living in supportive housing; and (4) other types of innovative supportive housing for homeless people. Supportive services include child care, employment assistance, outpatient health services, case management, help in getting permanent housing, nutritional counseling, security arrangements, and help in obtaining other assistance. SHP provides funding for new projects and for the renewal of projects currently receiving SHP funds. Providers may choose among a variety of activities: to *acquire* a homeless facility; to *build, rehabilitate, or lease* a homeless facility; to pay for *new or increased supportive services* to homeless people; and to meet some of the day-to-day *operating expenses* of homeless facilities. Finally, they may use SHP to pay limited administrative expenses.

Eligible Customers: A person must be homeless to receive help from SHP projects.

Shelter Plus Care Program (S+C)⁴

Purpose: Shelter Plus Care (S+C) is a program designed to provide housing and supportive services on a long-term basis for homeless persons with disabilities, (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families who are living in places not intended for human habitation (e.g., streets) or in emergency shelters. The program allows for a variety of housing choices, and a range of supportive services funded by other sources, in response to the needs of the hard-to-reach homeless population with disabilities.

Program grants are used for the provision of rental assistance payments through four components:

1. Tenant-based Rental Assistance (TRA);
2. Sponsor-based Rental Assistance (SRA);

³ Source: <http://www.hud.gov/offices/cpd/homeless/programs/shp/shpqfacts.cfm>. Accessed October 16, 2001.

⁴ Source: <http://www.hud.gov/offices/cpd/homeless/programs/splusc/index.cfm>. Accessed October 16, 2001.

3. Project-based Rental Assistance with (PRAW) or without rehabilitation (PRA); and
4. Section 8 Moderate Rehabilitation Program for Single Room Occupancy Dwellings (SRO).

The supportive services may be funded by other federal, state, or local sources, as well as private sources.

Eligible Applicants, Activities, and Customers: Differ among the four components. The following chart gives the details.

Element	TRA	SRA	PRA	SRO
ELIGIBLE APPLICANTS	States; units of general local government (uglgs) Indian tribes; PHAs	States; uglgs; Indian tribes; PHAs	States; uglgs; Indian tribes; PHAs	States; uglgs; Indian tribes; PHAs
ELIGIBLE ACTIVITY	Rental Assistance	Rental Assistance	Rental Assistance	Rental Assistance
ENTITY ADMINISTERING RENTAL ASSISTANCE	Recipient or other entity recipient	Nonprofit sponsor(s), or other entity	Recipient or other entity	PHA
TYPE OF HOUSING	Variety of types ranging from group homes to independent living units	Variety of types ranging from group homes to independent living units	Variety of types ranging from group homes to independent living units	SRO dwelling units
LIVING REQUIREMENTS	Participants choose; recipient may require participant to live in a particular structure in first year and within a particular area in all years	Must live in structure owned or leased by sponsor	Must live in unit in particular property that is assisted	Must live in SRO structure
ELIGIBLE PARTICIPANTS	Homeless adults with disabilities and their families, if any	Homeless adults with disabilities and their families, if any	Homeless adults with disabilities and their families, if any	Homeless adults with disabilities

Single-Room Occupancy Program (SRO)⁵

Purpose, Eligible Applicants, and Eligible Activities: Under the Single Room Occupancy (SRO) program, HUD enters into Annual Contributions Contracts with public housing agencies (PHAs) in connection with the moderate rehabilitation of residential properties that, when rehabilitation is completed, will contain multiple single room dwelling units. These PHAs make Section 8 rental assistance payments to participating owners (i.e., landlords) on behalf of homeless individuals who rent the rehabilitated dwellings. The rental assistance payments cover the difference between a portion of the tenant's income (normally 30 percent) and the unit's rent, which must be within the fair market rent (FMR) established by HUD.

Rental assistance for SRO units is provided for a period of 10 years. Owners are compensated for the cost of some of the rehabilitation (as well as the other costs of owning and maintaining the property) through the rental assistance payments. To be eligible for assistance, a unit must receive a minimum of \$3,000 of rehabilitation, including its prorated share of work to be accomplished on common areas or systems, to meet housing quality standards (HQS).

Assistance provided under the SRO program is designed to bring more standard SRO units into the local housing supply and to use these units to assist homeless persons. The SRO units might be in a rundown hotel, a YMCA, an old school, or even in a large abandoned home.

Eligible Customers: The McKinney Act requires that first priority for occupancy of SRO units be given to homeless individuals. However, HUD will also provide rental assistance for homeless individuals currently residing in units who are eligible for Section 8 assistance.

Additionally, at least 25 percent of the units proposed for assistance must be vacant at the time of application so that a significant portion of those served are homeless individuals. An application that has a vacancy rate lower than 25 percent will be rejected. Finally, when current occupants vacate assisted units, these units must be filled with homeless individuals identified through the recipient or owner's continuing outreach effort.

Housing Opportunities for People with AIDS (HOPWA)⁶

Purpose. To fund projects for low-income persons with HIV/AIDS and their families under two categories of assistance, including (1) grants for Special Projects of National Significance (SPNS) that, due to their innovative nature or their potential for replication, are likely to serve as effective models in addressing the housing and related supportive service needs of eligible persons; and (2) grants for projects that are part of Long-Term Comprehensive Strategies for providing housing and related supportive services for eligible persons in areas that are not eligible for HOPWA formula allocations.

Eligible Applicants: Under Housing of Persons With AIDS (HOPWA) Program, federal funds are granted to jurisdictions that have reached a threshold of 1,500 AIDS cases. These grants can be used by the recipient jurisdictions or distributed by them to community

⁵ Source: <http://www.hud.gov/offices/cpd/homeless/programs/sro/index.cfm>. Accessed October 16, 2001.

⁶ Source: <http://www.hud.gov/nofa/suprnofa/suprnofa3/4364sec3.cfm>. Accessed October 16, 2001.

organizations to provide housing and supportive services to people living with AIDS. Eligible jurisdictions include (1) states, units of general local government, and nonprofit organizations may apply for grants for Special Projects of National Significance; (2) certain states and units of general local government may apply for grants for projects under the Long-Term category of grants, if the proposed activities will serve areas that were not eligible to receive HOPWA formula allocations in fiscal year 1998.

Eligible Activities: (1) Housing information services (including fair housing counseling);

(2) project-based or tenant-based rental assistance; (3) new construction of a community residence or SRO dwelling, (4) acquisition, rehabilitation, conversion, lease or repair of facilities to provide housing and services; (5) operating costs for housing; (6) short-term rent, mortgage and utility payments to prevent homelessness; (7) supportive services; (8) administrative expenses; and (9) resource identification and technical assistance.

Eligible Customers: Low-income persons with HIV/AIDS and their families. Need not be homeless.

APPENDIX B: DESCRIPTIONS OF THE COMMUNITIES VISITED

This appendix describes each of the 25 CoC communities visited as part of this project. They are ordered by region, Northwest, South, Midwest, and West.

NORTHEAST

Delaware

Delaware is 96 miles long and 35 miles across at its widest point. Over half of the state's 750,000 people live in the north with 72,000 in the Wilmington, the state's largest city. Its relatively small population coupled with the small land area influenced Delaware to develop one Continuum of Care for the entire state. Although one CoC, Delaware residents think of the state as two distinct regions, "Upstate" and "Downstate." Upstate (the northernmost county of New Castle) is home to the bulk of Delaware's population (over 450,000 people) and includes the cities of Wilmington, Newark, and Claymont. This region is regarded as more urban while areas Downstate are more suburban and rural and include the capital of Dover.

Although a small city, Wilmington is the "big city" of Delaware. The majority of the population (52 percent) is African American and a comparatively low median income. Most of the long time homeless service providers are located in Wilmington, and embedded in a longstanding social service community. The interior area of downstate Delaware is less densely populated and is bordered by a coast peppered by beach communities. The service provider community in this region is spread across several towns.

The lead organization for the CoC is the Homeless Planning Council of Delaware (The Council). Recently incorporated as a nonprofit organization, the Council grew out of an informal steering committee started in 1998. Membership covers a wide range of people and organizations with significant participation from the homeless service provider community. The Council currently has no paid staff but is hoping to employ one person in the coming year to facilitate the process and oversee the development of a homeless management information system. Working with the University of Delaware and funds from the City of Wilmington, the Council hires a consultant to write Exhibit 1 of the CoC application.

The Council is divided into two committees: (1) Gaps and Assessment, and (2) Resource Development. The Gaps Committee is co-chaired by two members who are not providers and do not receive funds through Council activities. The Resource Development committee is chaired by one service provider and one non-service provider from the private business community.

Rhode Island

Rhode Island has a population of one million residents living within a small geographic area no more than 60 miles across at any point. Because of this compact geography, Rhode Islanders move readily between small cities and towns to accomplish activities of daily living.

Geographic areas encompassed in the Continuum of Care include the counties of Bristol, Kent, Newport, Providence, and Washington and the cities of Cranston, East Providence, Pawtucket, Providence, Warwick, and Woonsocket. Rhode Island has no county governments.

Rhode Island is experiencing a housing crisis, familiar to many states in the country. A Rhode Island Housing rent survey conducted in the first quarter of 2001 found average rents for a two bedroom apartment in Providence to be \$743 per month despite the official FY'01 Fair Market Rent of \$628 per month. Over 4,466 families and individuals lived at homeless shelters at some time during the period July 1, 1999 – June 30, 2000.

Historically, service planning and coordination took place through the work of the Rhode Island Interagency Council on Homelessness and Affordable Housing, the Rhode Island Coalition for the Homeless, and the Emergency Food and Shelter Board/United Way of Southeastern New England. In 1995, Rhode Island submitted its first CoC application, and responsibility for CoC membership and planning was assumed by the Rhode Island Interagency Council on Homelessness and Affordable Housing.

In 1998, the Rhode Island Housing Resources Commission (HRC) was established to examine housing issues and policies, and make recommendations to the General Assembly and Governor. The HRC is governed by a board of 27 Commissioners and examines housing issues, and policies and makes recommendations to the General Assembly and Governor for further action. Under the HRC are five offices, including the Office of Homelessness Services and Emergency Assistance (OHSEA) is now the action arm on homeless issues and leads the CoC process. It took over that responsibility from the Rhode Island Interagency Council on Homelessness and Affordable Housing, which no longer exists. The Rhode Island Housing and Mortgage Finance Corporation, a self-supporting nonprofit corporation that helps low and moderate income Rhode Islanders buy homes, facilitates the CoC process in Rhode Island. Rhode Island Housing serves as a technical advisor and applicant on behalf of the State of Rhode Island for CoC funds, and coordinates the application process.

All of the providers of homeless-specific services in Rhode Island are private, nonprofit entities, and state and local governments have played relatively minor supporting, funding, and technical assistance roles. After application approval, HUD provides grant funds to Rhode Island Housing, which enters into contracts with providers and oversees their operations.

Southwestern Pennsylvania

The Southwest Pennsylvania regional CoC consists of five rural counties, three of which are not contiguous to the other two. Butler, Armstrong, and Indiana counties are located north of the urban CDBG entitlement counties of Allegheny, Beaver, Washington, and Westmoreland and the city of Pittsburgh (as well as other CDBG entitlement cities), and Green and Fayette counties are located south of them. This is the smallest of four such regional rural homeless continua in Pennsylvania.

The five counties are separated not only by distance but also by Allegheny Mountain topography. There is little or no public transportation connecting the counties or within them. At one time coal mining and steel/heavy industries dominated the area but, today, these are declining areas with long-term population losses, low median incomes, and high unemployment

rates, as well as recent plant closings and layoffs. In 1997, 19 percent of the population in Fayette County was estimated to be in poverty; its median household income was \$25,878. The southern portions of Greene and Fayette counties border on West Virginia.

The counties within the CoC vary as to the kinds and quantity of homeless assistance services provided—as well as to how proactive they are with respect to providing homeless assistance. But, they all have in common what is described as the “rural mind-set” of “we take care of our own.” Also, while there are urban counties/cities in the region that have more services than these rural counties, there are two problems related to accessing such services: transportation, and a “mental barrier” regarding going to “distant” or “urban” places.

Each county has at most three or four providers of homeless services; usually the CAP agency is the largest provider. While CAP agencies furnish a broad range of assistance (including meals and other services), specialized homeless services are currently disparate. Fayette County, for example, has a full range of homeless services and its providers are aggressive grant writers (to the state, foundations, etc.), while some of the others have fewer services. Some of them have no emergency shelter facilities but, instead, rely on a limited number of hotel vouchers for very short-term stays—and, then, only for local people who can demonstrate that they have some type of longer-term plan to get themselves out of homelessness.

Historically, homeless assistance has been available in some counties more than in others, and resources tended to be concentrated in the larger towns. One of the five counties is totally rural and has very few resources. As stated in their 2000 application, therefore, a primary objective of the CoC is to “ensure that at least an adequate level of service is provided along the homeless Continuum of Care in each county and that providers throughout the Region collaborate with each other to maximize the availability of services to the homeless throughout the Region.” Considerable energy is spent within the CoC to ensure that all of the counties get a fair shake in the application process. In addition, CoC members have focused their efforts on identifying and measuring needs throughout the region, considering how to assess outcomes, and trying generally to devise more efficient and effective homeless assistance systems.

Boston

The jurisdiction of this CoC includes only the City of Boston. Boston is quite small and its population of about 590,000 is densely settled. Boston is 69th in physical size among U.S. cities, but has the 6th highest population density. This compactness, in combination with an excellent public transportation system, gives Boston a decided advantage in operating its CoC system.

Significant homelessness planning in Boston began under Governor Dukakis in 1983. Emphasis was on overnight emergency shelters and day programs. Boston’s Emergency Shelter Commission was established at that time to offer referrals to emergency shelter and other services for homeless persons. The state took on the role as the primary source of funding emergency homeless assistance.

Boston's CoC receives strong funding support from both the state and city governments. The city also provides substantial staff support for CoC planning, technical assistance, and oversight.

Mayor Menino created the Homeless Planning Committee (HPC) in 1994 to lead Boston's CoC planning process. It is a representative policy body made up of 21 stakeholders nominated by the community. Two-thirds of the representatives are from service providers and other nonprofit organizations. Two city agencies—the Emergency Shelter Commission (ESC) and the Department of Neighborhood Development (DND)—provide staff to assist the HPC. Both agencies play a major role in developing and writing the CoC applications, with some assistance from a consultant. The DND controls the CoC dollars and writes the contracts, and both DND and ESC provide technical assistance and oversee approved projects.

The HPC now oversees and coordinates the activities of the Strategic Homeless Planning Group (SHPG)—an entity with broader representation than the HPC—that was created in 1998 because homeless advocates, service providers, and city officials recognized that it would not be possible to adequately address the problem of homelessness with homeless-targeted resources alone. They wanted a more comprehensive community-wide planning process to look beyond McKinney funds to mainstream resources and other funding opportunities, and to determine the need for policy and programmatic changes. Mayor Menino issued the Boston Strategic Homeless Planning Group's five-year strategic plan in November 2000.

The homeless system consists of 3,706 ES beds, 2,117 TH beds, 1,942 PSH beds, and extensive services of all types provided in conjunction with these residential options. In addition, there are a variety of programs aimed at increasing permanent housing opportunities for homeless persons.

Despite Boston's success in moving large numbers of homeless individuals and families out of homelessness, the number of homeless persons is continuing to increase. Boston has been conducting an annual homeless census since at least 1986. According to the SHPG's Summary Report, the number of homeless persons in shelters and on the street increased from 3,830 in 1989 to 5,820 in 1999, a 52 percent increase.

Some of the reasons that local respondents suggested for this increase are: the tight housing market that has been squeezing out affordable housing for homeless and low-income households; welfare reform statewide end of rent control; changes in federal housing policies, a 37 percent decrease in federal homeless McKinney Act funds for Boston since and State human services policies, especially those related to discharge planning from institutions.

Washington, DC

The District of Columbia is unique among U.S. political entities in being the nation's capital, having no national voting rights, and having less than total control over its own budget in terms of amount, focus, and taxing authority. It is probably not unique in the historical (and to a large extent present) difficulties besetting its city agencies, or in its highly disparate income structure (many high, and many very low). It has also just emerged from the major fiscal crisis that led to its being placed by Congress under the aegis of a Fiscal Control Board. The city of

Washington, DC, the applicant jurisdiction, has a population of about 570,000, and up until the last year or two had been losing population steadily for a couple of decades. The fact that well-off people have been moving back to downtown is not helping the cause of affordable housing in DC.

The Community Partnership for the Prevention of Homelessness (TCP) is the lead agency for the CoC application, which it writes. It also organizes and facilitates the planning process for the application. For many years TCP was also the lead/only agency orchestrating most other homeless planning in DC, as the District government had ceded this responsibility when HUD negotiated funding for the DC Initiative, an early "showcase" of the CoC idea. The District government also has contributed significantly less funding to support homeless services than it spent on homelessness (mostly through emergency shelters and motels) before DCI began.

TCP is a private nonprofit agency that does not offer any homeless services on its own. ESG, CoC, transferred federal funds (e.g., TANF, CDBG), and some city dollars for homeless services from the Department of Human Services (DHS) flow through it and are disbursed to providers through formal contracts. This gives TCP a considerable amount of leverage over providers in terms of setting common standards for service delivery and receiving data (counts, descriptive characteristics and needs, and performance indicators). Both evolved gradually and obligations to meet/provide standards/data are written into contracts.

With the advent of the Williams mayoral administration and the hiring of a new deputy mayor for human services, the city has taken some steps to re-involve itself in homeless policy making. Together with TCP, it convened a Homeless Services Strategic Planning Group (HSSPG) whose formal mission is stated as "articulating the vision, mission, design, and priorities for the post-DCI CoC." HSSPG has created a number of workgroups to address specific issues. Four address several very specific problems (1) what to do about the CCNV (Federal City Shelter) building and its remaining programs; (2) what to do about the trailers that serve as 12-hour emergency shelters and by implication the old school properties where they are located; (3) developing a new multi-service center with residential space as well as an employment center and a commercial kitchen; and (4) changing local laws to grant legal authority to the ways that money is actually being spent. Two are more general (what transitional and permanent supportive housing capacity is needed and what it should look like, and what standards of service should be for homeless programs in terms of moving people to maximum independence). In addition, the legislative work group is developing recommendations for eligibility standards at all levels of the CoC, client responsibilities, and due process and confidentiality protections for all clients in the public system. Other issues on the table are protocols to guide police and case manager cooperation to handle individuals with severe mental illness who, while on the streets, may be a danger to themselves or others. The last work group is supposed to pull everything together, get all the relevant District government agencies to work together, develop an integrated cross-agency "homelessness budget" for 2003 and be the voice of homelessness within DC policy making.

Of the District's approximately 8,400 "homeless" beds, about 5,500 are "public" beds connected by contract to TCP. TCP administers about \$30.8 million a year to support homeless services (which translates into only about \$18/night/person served). Programs themselves also do significant amounts of fundraising from private sources, so the overall system probably spends close to \$50 million a year.

Essex County, New Jersey

With over 793,000 residents, Essex County is located in northeastern New Jersey and one of the most densely populated counties in the United States. With an area of only 127 square miles, it is geographically the second smallest county in New Jersey. The jurisdiction for the CoC includes Essex County and the cities of East Orange, Bloomfield, Irvington and Newark.

Ten percent of NJ's population resides in Essex County, although a disproportionate of the state's poor reside in this county. 33 percent of the state's TANF population and Emergency assistance population reside in Essex County. Newark's unemployment rate is twice that of the state of New Jersey. One in four Newark residents earn less than a poverty-level income, with more than 40 percent of all low-income renters paying more than half their income in rent. Shelters throughout Essex County have seen an increase in the numbers of working poor needing services because of their inability to make rent payments. According to Essex County, shelters have seen a 40 percent increase in the number of working people in shelters. The fair market rent for a two-bedroom apartment in Essex County is \$846. The average income for people coming off welfare is approximately \$795 (net).

In 1995, the Comprehensive Emergency Assistance System (CEAS), a state mandated committee of the County's Human Services Advisory Council, was created. In New Jersey each county has a CEAS committee responsible for planning and overseeing human services and homeless services for state and county governments. The County's Human Services Advisory Council is appointed by the County Government to review county level human services activities and to serve as the primary vehicle for making local recommendations to the New Jersey Department of Human Services.

The CEAS committee is the major decision making body for the CoC process. CEAS membership is very broad and includes government officials, faith based groups, service providers and business community representatives. The Department of Housing and Community Development for Essex County is responsible for compiling the HUD application. As the application states and others confirmed, almost all major planning decisions are made at the open monthly meetings and decisions are made by the entire group. Additional key players include several county and statewide departments and the Homeless Taskforce, an advocacy group made up of providers.

Montgomery County, Maryland

Montgomery County, Maryland is an urban and suburban jurisdiction located between Baltimore and Washington, D.C. With a total land area of 496 square miles and a population of 873,341, Montgomery County is Maryland's most populous jurisdiction. With only 5.6 percent of its population living below the poverty line, it is also Maryland's most affluent jurisdiction. Nearly 65 percent of Montgomery County's population is white, 15 percent African American, and just over 11 percent Asian. In addition, approximately 11 percent of the county's population are of Hispanic or Latino origin.

The Homeless Policy Development Committee (HPCD) is the lead entity for Montgomery County's Continuum of Care. Established by the County in 1991, HPCD is a public-private

consortium of program and agency executives charged with setting policy for homeless assistance in the county. HPCD, which is co-chaired by the Montgomery County Department of Health and Human Services, accomplishes its work with input from the following groups:

- Data Committee—designs CoC data collection strategies.
- Community Development Advisory Committee—approves county’s Consolidated Plan.
- Unmet Needs Committee—recommends service enhancements to the CoC system.
- Adult Teaming Group—ensures single homeless adults progress through the system.
- Service Provider Team—ensures homeless families progress through the system.
- Emergency Shelter Committee—designs and recommends emergency shelter model.
- Health Care for the Homeless—coordinates health care for the homeless.
- Emergency Assistance Coalition—coordinates nonprofit emergency assistance provision.
- HMIS Committee—develops and implements homeless tracking system.
- Regional Services Team—establishes priorities in six geographic areas of the county.

Membership is open to all agencies that provide homeless services. In addition to participating in the HPCD subcommittees, each member also serves on one or more of three councils that guide key aspects of Montgomery County’s homeless service delivery system:

- The Montgomery County Coalition for the Homeless. A nonprofit advocacy organization founded in 1982 to marshal and coordinate resources within the county to ameliorate homelessness.
- The CoC Prioritization Panel. Establishes CoC Priorities and reviews/ranks proposals submitted by local applicants in Montgomery County’s Associated Application.
- The Local Board on Homelessness. Serves as the formal vehicle linking state government with countywide strategic planning and decision making.

The CoC in Montgomery County is defined by an array of services from prevention through permanent supportive housing, with efforts made to have all stages available and accessible. Entry into the system is streamlined through a 24-hour Crisis Center, where masters’ level therapists are on staff to conduct intake and assessment. Designed to facilitate

and expedite clients' referral to the most appropriate services, it minimizes a prolonged and misdirected search for emergency shelter and services.

In the early 1990s, Montgomery County developed a tiered system to address the county's homelessness problem. The tiered system, like the Continuum of Care approach, includes emergency shelters, the Community Based Shelter (which is emergency in nature, but services are more intensive and clients must be willing to work with a case manager), transitional housing, and permanent supportive housing. The goal of the community-based shelter is to move an individual to a tier two (transitional) facility within 30 days of entering. Montgomery County also has low/no barrier emergency shelters for individuals not willing to work with a case manager.

After an emergency shelter or the Community-Based Shelter, clients who need it move to transitional housing. Transitional housing is designed to prepare individuals for permanent housing and is generally organized by issue – mental illness, substance abuse recovery, and work readiness. There are also four safe havens in the county. While acknowledging that there is a role for transitional housing, the county is moving away from transitional housing and toward permanent housing with transitional services.

The continuum functions a bit differently for families, who often enter the system through one of three regional DHHS Crisis Intervention Units. The Crisis Intervention Units provide an array of prevention services, including assistance with past-due rent, utility turnoffs, security deposits, and eviction mediation or legal representation. If housing is not preservable, families work with Emergency Services social workers to avert placement in an emergency shelter. The goal is generally to place families back in permanent housing as soon as possible.

SOUTH

Shreveport, Louisiana and nine surrounding parishes

The Northwest Louisiana Continuum of Care covers nine predominantly rural parishes (counties) including the cities of Shreveport and Bossier where most services are located. The local economy experienced a significant slump in the 1980s during the downturn in the oil industry but is currently growing as new, large casinos dominate the skyline and marketplace. The community is small and close-knit with service providers knowing of each other. Mainstream providers (particularly VA, mental health, and substance abuse) are very involved in the operation of the homeless system.

The CoC planning and application processes are facilitated by the Northwest Louisiana Homeless, Housing and Service Development Corporation ("the Coalition") as the lead entity. The Coalition is an incorporated nonprofit with all CoC operations conducted by volunteers from the member organizations and the CoC application written by members of the leadership board after all applicant projects have been reviewed and ranked by the entire Coalition membership. The main business of the Coalition is conducted through committees with significant involvement from homeless service providers, mainstream service providers, and government agencies.

The Coalition has been involved in three-year strategic planning for homeless services in the nine-parish region. The nine parish region comes from, and corresponds to, the state's Planning Region VII. The Coalition is the homeless planning entity for Region VII and worked with the Louisiana Interagency Action Council for the Homeless (LIACH) to provide information in the state's annual homeless report. The Coalition also works with the appropriate state and entitlement agencies to provide the homeless information in the Consolidated Plan.

Data is a major focus of the CoC in Shreveport, with the Coalition and a local software developer teaming together to develop a central client tracking system (ServicePoint). The client tracking system grew out of a central intake system (Centerpoint) which offers intake, referral, and case management services to homeless persons.

Fort Lauderdale/Broward County, Florida

Broward County is situated on the southeast coast of Florida between Miami-Dade and Palm Beach Counties. With a total land area of 1,197 square miles, 30 municipalities, and a population of approximately 1.6 million people, it is the second largest county in Florida. Over 70 percent of the county's population is white, while approximately 20 percent is African American and just under 17 percent is of Hispanic or Latino origin (Hispanic may be of any race). More than one of every ten Broward residents (11.7 percent) lives below the poverty line.

Broward County's Continuum of Care is a collaborative effort among public, private, and nonprofit organizations. The lead entity for the County's homeless planning process is the Homeless Initiative Partnership (HIP) Advisory Board. The HIP Board was created in 1993 by the Broward County Board of County Commissioners after determining that there were more than 5,000 homeless people in the area and only one general population homeless shelter. An immediate goal was established to create full service Homeless Assistance Centers (HACs) as points of entry into a CoC system. The County instituted a \$.01 gas tax to help pay for the emergency phase. The gas tax now raises approximately \$6.5 million annually.

The HIP Board has 18 members appointed by the Board of County Commissioners, including a County Commissioner and ex-officio memberships of the Broward Coalition for the Homeless (BCH), the Broward Partnership for the Homeless, Inc. (BPHI), and the Broward Outreach Center (BOC). BCH represents over 500 organizational and individual service providers in the county, and plays a large role in conducting the gaps analysis and organizing the community planning and prioritization workshops. BPHI is an organization that represents major business community funding partners that raised almost \$4 million for and operates the central region HAC. The Broward Outreach Center is the southern HAC, located in Hollywood.

The HIP Advisory Board is staffed by the "HIP Administrator," a position located within the Broward County Department of Human Services. The HIP Advisory Board serves in an advisory capacity to the Board of County Commissioners, making recommendations regarding the development, implementation, and coordination of homeless assistance programs within Broward County. Ultimate authority, however, rests with the Board of County Commissioners. The Board of Commissioners is the recipient of the HUD funding and is the entity that writes the contracts with provider agencies for projects supported under the CoC application.

Broward's homeless service system assists an estimated 7,000 sheltered and unsheltered homeless individuals and persons in families. It features two (soon to be three) regional full service Homeless Assistance Centers as entry points to transitional and permanent supportive housing. The County has also attempted to streamline entry into the system through 524-BEDS, a telephone hotline service operated by BCH from 8:00 a.m. to 6:00 p.m., seven days per week. BCH also conducts outreach to the hard-to-reach homeless population through the teaming of a police officer and a formerly homeless staff person. This outreach team brought 1,800 placements into shelters over a two-year period.

Movement of homeless persons within the system is accomplished through well-established linkages among community providers. Contracts and written agreements define and ensure service delivery from provider to provider. All county contracts for homeless services require shelters in one phase to identify shelters or housing with the next or preceding continuum phase from which they will accept referrals and make placements, and the specific number of referrals that will be accepted from or placed at that shelter, on an annual basis. The components are also linked through collaborative case management, including meetings, case management consultation, record sharing, and direct client transport.

Orlando/Orange County, Florida

Orlando's Continuum of Care originally included the city of Orlando (population 164,693) and Orange County (population 896,344) only. In 2000, the CoC jurisdiction expanded to include two neighboring counties, Seminole (population 365,196), and Osceola (population 172,493). The Homeless Services Network of Central Florida, Inc. (HSN) is the lead entity for the continuum of care planning process in the three counties. HSN is responsible for coordinating advocacy efforts, managing the gap analysis and CoC application process, administering contracts, coordinating service delivery, and tracking progress towards goals.

In 1988, the state of Florida mandated that five key government agencies jointly plan the delivery of services to the homeless to eliminate the duplication of services and maximize the use of limited resources. As a result of this mandate, the District VII Coalition on the Hungry and the Homeless, which encompassed Orange, Osceola, Seminole, and Brevard counties, began meeting. A 1993 report issued by a Coalition subcommittee, which detailed resources and gaps in services for the homeless, resulted in the incorporation of HSN.

Today, no Orange County government agency takes a lead role on the issue of homelessness. As a result, HSN is the only entity in the tri-county area dedicated to coordinating services for the homeless. HSN attempts to involve as many stakeholders as possible, but is ultimately responsible for guiding the planning process and coordinating service delivery. The membership of HSN, which has grown from 11 agencies to over 58 agencies, meet on a monthly basis to coordinate services in the tri-county area. HSN is managed by an 11-member Board of Directors elected from the membership on an annual basis (with a minimum of one currently or formerly homeless member).

While the Coalition formed well before the inception of the CoC process, the CoC process proved to be the main impetus for coordination amongst HSN's member organizations. In 1995, when this jurisdiction received its first round of CoC funding, participating service providers were given the option of receiving \$100,000 - \$200,000 each, which was far less than

the amount each provider requested, or turning the entire amount over to HSN. The providers agreed to give the funds to HSN. This decision making process had a significant impact on the level of coordination among providers and on their approach toward addressing homelessness as a community.

In the early years of the CoC's development, the primary focus was on homeless families as little funding was available for other types of services. In the past few years, however, Orlando's focus has shifted to homeless persons with substance abuse problems and severe mental illness.

Nonetheless, because of continued resource limitations and/or strict program requirements, many providers feel that these groups remain largely excluded from the system. Funding for mental health services is severely underfunded in Florida, and Orlando, in particular, has not been successful in obtaining funds. In addition, because HSN is a nonprofit organization and operates outside of the local government structure, it has had difficulty involving mainstream agencies into planning and service delivery.

Memphis/Shelby County, Tennessee

The Memphis Continuum stretches to the borders of Shelby County and includes metropolitan, suburban, and rural areas. The City of Memphis is predominantly African American (66 percent nonwhite) and is surrounded by the more white and affluent Shelby County (19 percent nonwhite). The area is strained economically, with few entry-level jobs that pay a living wage and offer benefits. It also has the nation's highest per capita bankruptcy rate (Tennessee — mostly in Shelby County). Both contribute to homelessness. Public housing is hard to access as four developments have been demolished in recent years under HOPE VI and the City's Section 8 waiting list has been closed for 3 years.

While the City of Memphis is the lead agency (Department of Housing and Community Development) for the CoC, the department uses CDBG funds to contract with two local nonprofit organizations to facilitate the system: Partners for the Homeless (Partners) and The Greater Memphis Interagency Coalition for the Homeless (GMICH). The city is the sole funder of GMICH while Partners is a public/private partnership and receives about a quarter of its funding from the city.

Partners coordinates the Continuum of Care application to HUD, collects/analyzes intake information provided by agencies for Partners' Intake Database System, provides data to organizations funding homeless services, identifies gaps in services and housing, and works with local agencies to help fill those gaps. GMICH is the convening organization for service providers, provides educational and technical assistance programs on topics of interest to providers, and produces the annual directory of services. Partners and GMICH collaborate closely on development of the planning process, in the point-in-time count, and in implementation of Quality Standards of Care.

The Memphis CoC benefits from another public-private partnership funded by the city, county and local foundations, the Grant Center, which provides grant writing advice, training, and information on resources to local nonprofits. All service providers who seek CoC funding

are strongly encouraged to work with the Grant Center in developing their project applications to ensure clarity, accuracy, and competitiveness.

The city and county recently established the Mayors' Task Force on Homelessness, consisting of senior-level public-private policy/ grantmakers to oversee development and implementation of a "blueprint" to break the cycle of homelessness and prevent future homelessness in Memphis/Shelby County. The Task Force is expected to be helpful in efforts to integrate and coordinate mainstream resources with homeless-specific programs. Partners provides administrative support to the Mayors' Task Force on Homelessness.

The February 2001 point-in-time street and shelter count reported a total of 2,021 homeless people—225 on the streets, 363 in emergency shelters, 242 in quasi-emergency programs, 1,141 in transitional housing, and 50 turnaways. However, the Intake Database System analysis reflected that 4,281 unduplicated men, women and children were sheltered/housed in 2000, with an additional 6,399 persons turned away

Winston-Salem/Forsyth County, North Carolina

The Winston-Salem/Forsyth County Council on Services for the Homeless (Council) leads a CoC system that covers Winston-Salem and Forsyth County, a relatively small area with an urban and suburban population of 306,067 persons, based on the 2000 census. Winston-Salem has a population of approximately 187,000. Because of the availability of shelter services, the system attracts homeless persons from other areas, particularly more rural areas of northwestern North Carolina.

The CoC Committee of the Council, comprised of both project sponsors and non-sponsors, oversees the CoC process, including gaps analysis and prioritization and ranking of proposed projects. The Council includes local government, shelter providers, mainstream service providers, faith-based ministries, homeless persons, the Department of Veteran Affairs, and others.

The CoC's Task Group, with membership of approximately 15 persons, conducts the CoC process, although other Council standing committees conduct CoC business throughout the year. Other Council committees include Operations, Advocacy, Housing Production, Shelter Providers and Basic Needs, Public Relations/Education, and the Executive Committee. The chair of the Council and the chairs of the committees comprise the Executive Committee. Membership on the standing committees is open and voluntary. Every Council member is encouraged to join one or more committees. The city of Winston-Salem provides staff for the Council (minutes, meeting notices, etc.) and oversees the CoC grant-writing process. The city also funds a professional facilitator for parts of the CoC process, as well as a consultant to assist project sponsors with development of proposals.

The homeless services and shelters are somewhat concentrated in a small geographic area of Winston-Salem. On average, 500 persons without homes are receiving homeless services at any point in time. Of the population served by the CoC, 25 percent are persons in families and 75 percent are singles. The sub-populations served by the CoC include approximately 30 percent with mental illness, 35 percent with substance abuse problems, 40

percent with a criminal history, 10 percent victims of domestic violence, and 8 percent with HIV/AIDS (some have more than one condition).

Winston-Salem has a fairly extensive Emergency Assistance (EA) system in place. Four local agencies provide emergency financial assistance to individuals and families to help prevent events that could lead to homelessness. Funding can be used for such things as rent, utility bills, and health care bills. Funded through a combination of federal and private/foundation dollars, \$1.95 million was provided to assist 9,263 cases in 2000.

The Winston-Salem homeless service system has also benefited from the efforts of some mainstream agencies to address their clients' housing needs. As a result of these efforts, the Department of Veteran Affairs and the Division of Mental Health are well integrated into the homeless service system. Winston-Salem is one of the communities in which the VA conducted a pilot study on homeless outreach. North Carolina's Division of Mental Health created a new position at each of its area programs called Housing Development Specialist in an effort to address housing issues for its mentally ill clients. The Housing Development Specialist is responsible for coordinating all the resources available within the community to develop affordable, supportive permanent housing.

MIDWEST

Chicago, Illinois

Located in the eastern portion of Cook County, Chicago's land area consists of 228 square miles (comprising about one-third of the county's land area), and has a 29-mile eastern shoreline bordering on Lake Michigan. With a population close to 2.9 million persons, Chicago is the nation's third largest city.

About 55 percent of the total Cook County population (of almost 5.2 million persons) and 35 percent of the total nine-county metropolitan area population (of 8 million persons) resides in Chicago. Although the population of both the county and city showed a modest net gain during the last decade, reversing the previous decade's trend, the population in the surrounding counties increased at rates between 10 to 30 times that of Cook County—according University of Illinois at Chicago researchers.

Chicago's population is about 45 percent white, 39 percent African American, and 4 percent Asian/Pacific Islander. The city is home to scores of ethnic groups, and 20 percent of the population is Hispanic. Cook County and, especially, the city of Chicago continue to have the greatest number and proportion of residents within the region who are African American, Hispanic, and Asian and Pacific Islander, while the number of nonwhite persons remains relatively small in the other counties.

At present, the city's lead agency for its Continuum of Care for the Homeless is the Family Support Services Division of the Chicago Department of Human Services. Both the city government and private organizations within the city have been funding and providing a range of homeless assistance services over the last quarter century. Priorities and emphases have changed over time, however, as administrations and the local context in which homeless issues

are handled have changed. Even before HUD began funding supported housing through the SuperNOFA—which emphasizes the development of complete continuums of care—the number and variety of entities involved in Chicago's homeless service provision system as well as the services provided simulated a full continuum, although it was not formally characterized or planned for as such. Nevertheless, the sheer size of the system, multiplicity of funding sources, variety of participants, and location of services resulted in a structure that was relatively unorganized and uncoordinated on a city-wide basis.

More recently, significant efforts are underway to improve Chicago's continuum of care, and the system is currently in transition. Participants and stakeholders have been engaging in a new strategic planning process, a new project review and performance scheme has been developed, and the continuum may be moving toward greater inclusiveness and less city-government dominance. The city is also a participant in a regional roundtable that, in the short term, is generating information about homeless services and needs on an area-wide basis. In the long term, the roundtable process may lead to more inter-jurisdictional information sharing and collaboration. It is very early in the transition process, however, so the extent to which the potential for an improved and better-coordinated city- and region-wide homeless service system will be realized will be a matter of great future interest.

Balance of Cook County, Illinois

Cook County is a 709 square mile urban county that includes and surrounds the city of Chicago on its south, west, and north sides, as well as the city of Evanston. It consists of 125 municipalities, 28 townships, and 800 government taxing bodies. It is the Nation's second most populace county, with over 5 million residents—about 2.2 million of whom live outside of the city limits of Chicago and Evanston.

The region is served by a "radial" highway system and mass transit network designed to move people in and out of downtown Chicago but not to link the municipalities that are located away from the various radii. According to the County's 2001 CoC application, the communities that blossomed along the highway and mass transit corridors following World War II were typical "bedroom" communities, and the radial transit concept allowed the County's governmental social service programs to focus on the population of the central city. As such, local and township governments were left with the responsibility of identifying and addressing the growing social service needs of burgeoning communities with radically different social, economic, and demographic compositions. The inability of the many municipalities and townships to address these growing needs led to the advent of private, not-for-profit social service agencies, beginning in the older suburban communities with the greatest need.

Homeless persons in suburban Cook County are characterized in the county's CoC application as an indigenous suburbanite population with a strong community identity and a fear of unfamiliar (even if neighboring) communities. To deal with the size and configuration of the county as well as this sense of community identity, social service organizations tend to cluster into three distinct sub-regions—north, west, and south. Even so, however, attempts to develop centralized homeless services, including within each of the three sub-regions, have not been successful. Therefore, while the 9 entitlement and 2 metropolitan cities (exclusive of Chicago and Evanston) and the remainder of the county apply for SuperNOFA funding as a single continuum, the CoC has evolved as a very decentralized support system. The idea is that

services are brought to people instead of "herding people to the services." The CoC strategy is one of "entry-point portals" in which each of the 134 homeless provider organizations acts as a portal agency to connect with persons in need of services, assess that need, and refer such persons to appropriate providers.

Lake County, Illinois

Lake County, with 644,356 people in 2000, is located north of Chicago and Cook County in Illinois. Lake County has Lake Michigan as its eastern border and Wisconsin as its northern border. Lake County submits its own CoC Application, like many counties in Illinois. According to 2000 U.S. Census data, Lake County is 80 percent white; 7 percent African American; 4 percent Asian; and 9 percent other. About 14 percent of residents in Lake County are Hispanic or Latino.

Lake County is one of the wealthiest counties in the United States with a median household income of \$63,354, over \$20,000 greater than Illinois in 1997 and over \$25,000 more than the U.S in 1997.⁷ Lake County is largely rural in its western half, leaving homeless services primarily concentrated in the eastern entitlement jurisdictions of Waukegan and North Chicago. Shields Township, located just south of Waukegan, is home to a regional Veteran Affairs Facility and the County's largest emergency shelter provider.

Responsibility for coordinating the overall Continuum of Care process and organizing the county's application resides with the Advisory Planning Group (APG). The APG is in its fourth year of operation and is comprised of homeless providers, community organizations, local governments and other stakeholders. The APG was originally convened in January 1998 to oversee the county's Continuum of Care process under the auspices of the Community Development Commission (CDC) and the Lake County Board. The APG functions as an advisory arm of the CDC, keeping the CDC informed about ongoing activities, and bringing pivotal decisions back to them for input and approval.

As facilitator of the APG and staff to the County Board, the Lake County Planning, Building, and Development Department (known as the Planning Department) plays an integral role in the local CoC. Specifically, the Planning Department

- Coordinated the development of the 1995-2001 CoC applications and administers the CoC funds;
- Prepares the county's Consolidated Plan;
- Allocates and administers the county's ESG, CDBG, and HOME Grant funds; and
- Participates in the Homeless Coalition.

⁷ 1997 model-based estimate using U.S. Census data.

The Lake County Homeless Coalition (HC) was formed in 1988 and is incorporated as a nonprofit organization. The HC is a consortium of community organizations and individuals whose mission is to “eliminate homelessness in Lake County through the provision of leadership in the areas of assessment, advocacy, and community education.” Currently, its membership includes nonprofit organizations, government representatives, people who are formerly homeless, and other concerned citizens as well as most APG members. The Coalition meets every other month, and serves as a clearinghouse for information, helps the APG, and provides balancing perspectives. Some respondents said that in recent years, there is an increasing overlap between the membership of APG and the HC and that it is increasingly difficult to distinguish between the two groups. Therefore, the two groups coordinated meeting schedules and began meeting at the same time every other month, with the Homeless Coalition Meeting in odd months and the APG meeting in even months.

Madison/Dane County, Wisconsin

Dane County, with 426,526 people in 2000, is the second largest county in Wisconsin—after Milwaukee County. Located 72 miles west of Milwaukee and 122 miles northwest of Chicago, Dane County submits its own Continuum of Care Application—one of three jurisdictions in Wisconsin in addition to the state itself that does so.⁸ Dane County is 89 percent white; 4 percent African American; 3.5 percent Asian; and 3.5 percent other race. Just over 3 percent of residents in Dane County are Hispanic or Latino. Dane County has a median household income of \$47,607, over \$10,000 more than the U.S. in 1997.⁹ Madison is the state capital and, with 208,000 people, has nearly half of Dane County’s population. All of the homeless service providers, advocates, local public agencies, and other funders we visited were located in Madison.

The Homeless Services Consortium (HSC) acts as the lead agency for the Continuum of Care application and planning process. HSC is a group of 30-40 people that meets monthly to discuss priorities, service needs, and duplication, and to coordinate homeless services. HSC is comprised of service providers, advocates, local public agency representatives (e.g., police, social worker(s) from Madison Metropolitan School District), other funders (e.g., state and CDBG representatives), and state and county officials (e.g., Dane County Department of Human Services (DCDHS) and State Division of Housing). While not the focal point of the HSC meetings, Continuum of Care funding and funding from other sources may be discussed at HSC meetings.

A smaller group of homeless service providers, informally called the Continuum of Care Writing Group, meet to discuss the Continuum of Care funding and application revision and writing process. The membership of this group varies from year to year but includes providers

⁸ The other two jurisdictions submitting Continuum of Care Applications besides the State of Wisconsin and Dane County are Milwaukee City and County, and the City and County of Racine.

⁹ 1997 model-based estimate using U.S. Census data.

who receive Continuum of Care funding, and others may participate occasionally. This smaller group presents the plans for the Continuum of Care Application to the larger HSC. HSC decides on the final ranking of projects and service providers for the Continuum of Care Application. DCDHS provides advisory input and signs the application before it is submitted.

Washtenaw County/Ann Arbor, Michigan

Primarily known for housing the University of Michigan, Washtenaw County (W.C.) includes not only Ann Arbor but also the City of Ypsilanti, along with other smaller towns throughout the county. The Continuum of Care is a joint plan including Washtenaw County and the city of Ann Arbor. Ann Arbor is currently the only entitlement community, although Washtenaw County is expected to become an entitlement jurisdiction based on the new Census figures. Within the jurisdiction is the city of Ypsilanti, which has not been actively involved in the CoC process to this point. The CoC Board is currently seeking to include a representative from Ypsilanti in the process.

The planning process is currently led by Washtenaw County Government, and is facilitated by staff from the Department of Community Development. The CoC Board is the primary planning entity, composed of providers, advocates, county staff, city of Ann Arbor representatives, state agency representatives, and other members of the community. Two consultants hired by the county have also been helping to facilitate the process for the past two years.

The CoC Board has undergone dramatic changes since its inception in the mid-1990s. Originally it was dominated by providers who, by all accounts, did not work together effectively. Many participants complained about the political nature of the previous CoC Board, and all were dissatisfied with the process. In 1998 the CoC Board was disbanded by the County and restructured without any providers. Consultants were brought in to help facilitate the process. This structure lasted about a year before providers successfully petitioned to regain representation on the CoC Board. Gradually, more and more providers have been allowed back on the CoC Board, again becoming a presence in the planning process.

Columbus/Franklin County, Ohio

The jurisdiction of this CoC includes the city of Columbus, Franklin County, and all of the smaller towns within Franklin County. 700,000 of the county's 1.3 million people live in Columbus, and it is not easy to tell where Columbus stops and surrounding towns begin, as the county is relatively small physically. The Community Shelter Board (CSB) is the lead agency for the homeless service system. Either its staff write the application (2001) or it hires a consultant to do so (during the previous five years). It also manages and facilitates all activities relating to the CoC application and associated programs. CSB is an independent entity that is neither an original source of money nor a direct provider of services. It is a nonprovider, nongovernment independent nonprofit agency.

The CSB was founded in 1986 by a group of business leaders, city and county government agencies, corporate and foundation funders, the United Way, and other players to do all the planning, managing, supervising, and strategic thinking about what homeless services

should look like in Columbus/Franklin County. It enjoys the strong support of corporate and civic leaders, and mainstream agencies, who also actively participate and provide funds. This availability of local backing and local resources makes Columbus unusual in being able to act on its vision for preventing and eliminating homelessness.

From the beginning, all foundation, United Way, city, county, state, and some federal funds supporting homeless services flowed through the CSB. Federal funds such as CoC dollars that do not flow directly through CSB are nevertheless greatly influenced by it through the CoC process and before that, by strong support for individual agencies making CoC applications. CSB writes the contracts with provider agencies for emergency shelter and some transitional and permanent supportive housing. However, programs that received HUD funding for the latter before the CoC application process began participate in the CoC application as associated applications, and receive funding/contracts directly from HUD. This difference gives CSB somewhat less control over these projects than it might otherwise have, but probably does not create many problems because of the general level of cooperation among the elements of the Columbus system.

Its control of money gives CSB considerable leverage over service providers. It used this leverage early in its existence to impose a rudimentary data system on the emergency shelter system, and is orchestrating the change during 2001 to Service Point. There was some concern, however, with respect to implementing ServicePoint throughout the system, arising from the noncontractual relationships between CSB and HUD-funded transitional and permanent supportive housing programs. CSB also imposed performance monitoring and outcomes evaluation, which have become increasingly sophisticated in the last year or two and are being used to make funding decisions.

A dramatic recent change of direction is CSB's shift from "making homelessness comfortable" by expanding emergency shelter and transitional housing capacity and amenities toward eliminating homelessness through prevention/diversion and major investments in permanent supportive housing.

The system has a total of almost 4,000 specifically "homeless" beds, plus a variety of other permanent housing programs through the Columbus Metropolitan Housing Authority, and extensive mental health, substance abuse, and other services connecting these residential facilities/options. It has a central intake mechanism for families that also has the resources to divert/prevent homelessness for about 40 percent of families who contact the system. It has a commitment from major financial sources to develop 800 units of permanent supportive housing for chronically homeless people with disabilities (substance abuse, mental illness and other disabilities), of which about 175 are either in operation or about to be, and the rest are in development.

St. Paul/Ramsey County, Minnesota

The St. Paul/Ramsey County Continuum of Care serves an urban and suburban population of 511,035. A staff person from the Ramsey County Department of Human Services, with assistance from a CoC Planning Committee, takes the lead in coordinating the planning process and preparing the application. The Planning Committee includes representatives from agencies providing emergency shelter, transitional housing, permanent supportive housing, and

supportive services. The Planning Committee also includes a formerly homeless individual who now works for the St. Paul Area Coalition for the Homeless. However, the county has been less successful at engaging mainstream agencies and private sector representatives in the planning process.

In Ramsey County, homeless service planning revolves heavily around the CoC application process. The Planning Committee, although open to anyone, is generally small and narrow in composition. And because there are no paid staff, the process of putting together the CoC application typically overwhelms efforts around broader strategic planning. After application approval by HUD, CoC funding flows directly from HUD to the nonprofits, and it is the nonprofits who sign contracts.

The effort to build a Continuum of Care for Ramsey County began in 1985 with the *More than Shelter Plan* developed by the Family Housing Fund. The process eventually evolved through the development of the *St. Paul/Ramsey County 5-Year Low Income Housing and Homeless Services Report and Plan*, which was officially endorsed and adopted by the St. Paul City Council and the Ramsey County Board of Commissioners in 1999. The Five-Year Plan serves as the main source of data and goals for CoC planning efforts, but is not itself a product of the CoC process.

In April 2000, Ramsey County convened a Funders Council to oversee implementation of the Five-Year Plan. The Funders Council consists of representatives from the city of St. Paul, Ramsey County, the United Way, the St. Paul PHA, the Metropolitan Council, the Minnesota Housing Finance Agency, the Minnesota State Department of Human Services, the Wilder Foundation, the Corporation for Supportive Housing, and the Family Housing Fund. The scope of the Funder's Council is much broader than homeless- or CoC-related projects. In actuality, it has no role in or authority over what types of projects are approved, but instead tries to package funding for projects, identifies who might meet gap financing needs, and tracks the status of projects through completion.

City/county financial support for homeless assistance is limited, amounting to roughly \$1,000,000 per year. The state provides \$500,000 per year to support the Family Homeless Prevention and Assistance Program, and also funds the Bridges Program, which provides rental assistance for (approximately 90) homeless persons with mental illness until they can secure Section 8 vouchers.

Situated directly next to the city of Minneapolis/Hennepin County, there has been little effort to date to coordinate planning or service delivery. While clients undoubtedly move back and forth between jurisdictions, the cities operate two separate continuums. In fact, many providers in Ramsey County have instituted residency requirements as eligibility criteria for their programs. While there is currently little coordination, they are looking toward regional planning in the future through establishment of the Metro-wide Engagement for Shelter and Housing (MESH) Committee. Through MESH, they are attempting to develop a web-based electronic information system that will link all emergency shelters and transitional housing providers in the seven-county metro area. It is hoped that the group will lead to a more coordinated emergency shelter policy throughout the metro area, the end result being a more consistent and accessible system.

The Minneapolis/St. Paul region has struggled with the issue of affordable housing in recent years. Ramsey County's vacancy rate was less than 2 percent at the time of the site visit, and one county official cited a need of over 100,000 units of affordable rental housing in the metropolitan region. This affordable housing crisis can be attributed to a couple of factors. First, Ramsey County is geographically the smallest and most densely populated county in Minnesota, and it is nearly fully developed. The few available land parcels that exist are often polluted brownfields, adding enormously to the cost and complexity of development. In addition, exclusionary zoning (e.g., requirements for 2- and 3-car garages, large minimum lot sizes, maximum densities, minimum set-backs, etc.) and "Not In My Back Yard" (NIMBY) attitudes have added to the struggle over affordable housing.

The lack of affordable housing has led to an increase in homelessness among people who have jobs. According to a county official, the Minneapolis-St. Paul region had, on an affordability scale, the highest per capita housing costs in the country as of June 2001. One provider offered the example that an individual needs to be making \$16 per hour to rent a two-bedroom apartment in the area, but 70 percent of jobs pay less than this. Data from 2001 indicated that 26 percent of people living in area shelters were working full time, while 42 percent were working at least part-time.

WEST

Alameda County, California

Alameda County is a large and diverse county. It spans an area of more than 812 square miles and ranges from highly urban (Oakland, Berkeley) and newer cities (Hayward, Fremont, San Leandro) to suburbs (Pleasanton, Castro Valley) and semi-rural areas (Livermore, Sunol). Approximately 1.4 million people reside in Alameda County, which is located about 15 miles from San Francisco on the other side of the Bay.

On any given night approximately 12,000 people are homeless in Alameda County, with approximately 69 percent of the county's homeless residing in Berkeley and Oakland. Of those who are homeless, 60 percent are single individuals and 40 percent are families with children. Approximately 11.8 percent of the county's residents are below poverty (1997 Census estimate).

For the past two decades, formally and informally, cities in Alameda County, nonprofits, faith-based institutions, businesses in Alameda and other community members have worked to address the needs of the homeless. These efforts have brought together service providers, funders, and governments to address needs through coordinated planning and organizing. Responses initially included food, clothing, transportation, shelter, and health-related services.

Prior to the emergence of wide-spread homelessness in the 1980s, most services for low-income people were fragmented and lack of coordination drove the homeless providers to begin to work together. The first networking occurred under the Emergency Services Network. This networking body evolved as the issues did, serving primarily to address emergency needs of families and individuals in crisis. The network soon began discussing transitional and permanent housing issues, and finally worked with the county to develop the current CoC

system and Council. The Base Closure Initiative also sparked discussions on community-wide planning and facilitated the development of the current planning Council.

The CoC in Alameda County is comprised of a Continuum of Care Council, which serves as the planning body for all homeless issues in Alameda County. Each year the Council reviews the Continuum of Care plan and develops a yearly workplan. The Alameda County Department of Housing and Community Development assists in the compilation of the CoC application. CoC dollars flow directly from HUD to providers, who sign the contracts and submit APRs directly to HUD.

In Alameda County there are 15 jurisdictions, including 14 cities and the County, most of which invest some portion of their locally-controlled resources in homeless services and housing.

Denver, Colorado and five surrounding counties

The Denver area Continuum of Care covers six counties (Adams, Arapahoe, Boulder, Denver, Douglas, and Jefferson) and includes 28 municipal jurisdictions. The geography covered by the CoC is extensive and includes over 8 million people in urban, suburban, and rural areas. The most active areas include the city and county of Denver, city and county of Boulder, Arapahoe County, Jefferson County, and the cities of Arvada, Aurora, Lakewood, Longmont, and Westminster.

In 1994, the Metropolitan Denver Homeless Initiative (MDHI) was formed to be the lead agency in the Denver area CoC. The State Department of Human Services is a key player in the CoC and provides technical assistance and support services to MDHI. Until recently, MDHI had a part time Executive Director on loan from a local bank. He resigned to return to the bank full time and CoC activities are currently run by a temporary administrator from the State Department of Human Services. This person facilitates the CoC process (including consolidating the various agency Continuum applications and preparing Exhibit 1) but the official lead entity for the CoC planning process is the Metropolitan Denver Homeless Initiative (MDHI). The temporary administrator works with the membership of MDHI through its Governance Board and network of committees and subcommittees. No other funds originate from, or flow through, MDHI and the group provides no services. However, with the dearth of homeless resources in the local system, the CoC funding is an important driver of the homeless service system. The planning process is driven by the CoC requirements and targeted toward CoC activities. Much of the work undertaken by the organization is conducted by volunteers serving on the committees and subcommittees of MDHI (mainly homeless service providers augmented by local government and mainstream service representatives).

The system is resource poor with few to no local public dollars. Several of the major service providers are solely or primarily funded by private donations. Providers lamented the lack of emergency, transitional, and permanent beds for all population groups, particularly families. Some services exist for most groups (e.g., alcohol and drug abusers, persons with AIDS, youth, and mentally ill persons) but many providers are overwhelmed with requests. Available emergency and transitional beds are quite low compared to population; interviewees had a very difficult time identifying gaps in service or the most pressing needs because they could see significant need in most areas.

The state Department of Human Services is spearheading a data collection effort, CHIRP. The state Department of Human Services also runs a Shelter Helpline that provides a single point of contact for information on available shelter beds. The information is gathered through daily calls to shelter providers.

San Francisco, California

With one of the highest rental markets in the nation, San Francisco, California faces many issues related to affordable housing. Both a city and a county, spanning only 49 square miles, San Francisco currently boasts a population of 776,733 people. This progressive city is home to approximately 11,000-14,000 men, women and children who have no where to go on any given night. San Francisco currently provides shelter for about 15 percent of their total homeless population.

The principle community challenge is the citywide housing crisis. Despite a fixed land supply that was almost completely developed by 1960, the City has continued to grow in population and add to its housing stock. Neighborhoods have become denser, and areas that were previously industrial have been infused with residential development---and yet housing demand continues to outweigh supply.

The loss of SRO housing, a source of stability for many poor people, has also had a dramatic impact on the overall housing market. With some of the nation's highest housing prices and rental housing that is barely affordable or available for middle-income people, low-income and homeless individuals are finding themselves locked out of the current housing market. The competition for housing in the face of skyrocketing rents in San Francisco drives the price of housing beyond the reach of low-income renters, with shelters increasingly becoming destinations, rather than the emergency accommodations they were created to be.

Feeding the housing frenzy is a dramatic shift in San Francisco's employment landscape. San Francisco has also experience dramatic changes with regard to housing and the job market. Nearby Silicon Valley has driven a new wave of economic prosperity in San Francisco and the Bay Area. While issues of housing and homelessness have always existed, economic growth in the region has added to the pressure on the limited housing stock that is affecting many income groups. The concentration of job growth since 1990 in the services sector has meant an increase in relatively low paying retail and hotel/restaurant jobs, accompanied by a loss of blue-collar jobs in industry, warehouses and manufacturing. This change has been paralleled by rapid growth of high-paying positions in sectors such as telecommunications and biotechnology.

The California Budget Project shows that a two-income family of four in the Bay Area requires an income of \$53,736 per year to maintain a modest standard of living. This figure is 324 percent greater than the poverty level for a family of four (CoC Plan 2001-2006). San Francisco's median income has increased from \$33,482 in 1990 to \$50,753 in 1999. Based on the 1998 poverty threshold of \$16,660 and population projections, it is estimated that at least 14.5 percent of the City's population lives in poverty.

San Francisco's vision for their Continuum is to build a "continuum of services whose ultimate goal is to prevent and eradicate homelessness in San Francisco." San Francisco's

vision is based on 13 guiding principles including to have a unified strategy, integrated, coordinated and flexible system, and to promote permanent solutions. San Francisco publishes a CoC plan every five years, recently updated for 2001-2006.

The lead entity for San Francisco's CoC planning process is the Local Homeless Coordinating Board (Local Board), a 34 member body comprised of homeless advocates, formerly homeless persons, representatives of service providers, nonprofit housing organizations, neighborhoods, education and training, labor, business and foundations, as well as key City departments. The Mayor appoints 16 of the non-City members of the Local Board, and the Board of Supervisors appoint 10. The Department of Human Services (DHS) plays a particularly large role in assisting the Local Board and managing contracts. DHS contracts with a private consultant to write the CoC application. HUD sends most of the grant money to DHS and DHS writes a majority of the contracts.

Long Beach, California

Long Beach, with about 460,000 people, is the fifth largest city in California. However, located as it is in Los Angeles County about 27 miles south of central Los Angeles, the attention it gets is very different from the focus on downtown Los Angeles homelessness. Although Los Angeles County has somewhere between 60 and 80 entitlement jurisdictions, only Long Beach, Glendale, and Pasadena have chosen to submit their own CoC application rather than be part of the Los Angeles County application. Long Beach has recently been named "the most diverse" city in the country, based on 2000 census data, and is home to approximately equal numbers of whites, Hispanics, African Americans, and Cambodians, plus smaller populations of many other ethnic/cultural groups.

The city suffered significant economic problems in the early 1990s when the Navy closed a major base there, defense spending was reduced drastically, and McDonnell-Douglas reduced its Long Beach operations after merging with Boeing. Long Beach undertook the task of rebuilding the economy, largely around tourism and technology. With economic recovery, the City is attempting to address the sources of poverty, and significant progress has been made on developing homeless services.

The city's Department of Health and Human Services (HD) is the lead CoC agency, funding a homeless coordinator position and providing staff support to write the CoC application. The current occupant of that position, who has held it three years, plays an essential role in bringing and holding things together. HD also is the recipient of the HUD money, and writes the contracts with provider agencies for projects supported under the CoC application. Three committees/groups—HSAC, HSAP, and the Coalition—work together to promote homeless services and programs.

HSAC (the Homeless Services Advisory Committee) grew out of an earlier Mayor's Task Force on Homelessness, and is the decision-making entity prioritizing and ranking CoC applications. Two of its members are appointed by the mayor, with the remainder appointed by City Council members to represent particular councilmanic districts. None of the present group had any significant association with homeless issues before being appointed, but all have various other areas of relevant expertise and have invested time in being educated about homeless issues and taking their responsibilities seriously. HSAP (Homeless Service Agency

Partnership) is an organization of service providers working on service development, coordination, and advocacy. Although it existed in years past it did not do much. New leadership in the past year or two has made it an active force. The Coalition is an advocacy group whose members include providers, homeless and formerly homeless people, members of the general public, and anyone else who wants to join. Membership in HSAP and the Coalition overlaps considerably. All three groups work together on the CoC and larger planning process. In addition, members of the Coalition are helping to develop a local branch of Los Angeles' Community Action Network, a self-help organization of homeless people.

Homeless services in Long Beach are developing, but major sectors are quite weak. Emergency shelter for men appears to be the worst. Family and women's shelters also report many requests for emergency shelter that they cannot meet within the city itself. Many homeless people are referred to facilities beyond the city for emergency shelter, or are given hotel/motel vouchers. Transitional housing capacity is growing; permanent supportive housing is also a weak component of the system. City ordinances prevent development of SRO housing. Despite weaknesses in some parts of the CoC, Long Beach has developed two remarkable collaborations, the Multi-Service Center and the Villages at Cabrillo. It is also home to an internationally acclaimed program for people with severe and persistent mental illness—the Village—that has a major component of homeless outreach and supportive services.

Phoenix/Maricopa County, Arizona

Within the state of Arizona (population 5,130,632) exist three Continuum of Care jurisdictions: Tucson/Pima County, Phoenix/Maricopa County, and the Balance of State. Maricopa County, one of the largest counties in the US, covers 9,200 square miles and is home to 3,072,149, people (Census 2000). Since 1990, over 1 million people have moved to the county, an increase of over 44 percent. While the county encompasses almost thirty cities, towns, and Indian Tribes, most of the county's population lives in the city of Phoenix (1.3 million); neighboring cities of Mesa and Tempe include populations of 400,000 and 200,000, respectively. The Phoenix metropolitan area spreads across a desert valley surrounded by low mountains. Temperatures in this dry region can top 110 degrees Fahrenheit in the summer; winter temperatures average between 44 and 68 degrees Fahrenheit.

Within the boundaries of the Continuum—currently and historically defined as the county lines—live an estimated 14,000 homeless persons. Much of the system's services are located in the city of Phoenix; more specifically, emergency shelters and services are concentrated in the downtown area. Still, facilities do exist throughout the county. The system has a total of almost 8,000 beds, distributed as 1,823 emergency shelter beds (992 for singles and 831 for families, +465 winter overflow beds), 4,163 transitional housing beds (1,854 for singles and 2,309 for families), and 2,008 permanent supportive housing beds (1,436 for singles and 572 for families). There is no central intake mechanism, though many enter the system using the shelter helpline (CONTACTs) or receive rental, mortgage, or utility assistance (among other services) through one of 18 area Community Action Program offices (which provided assistance to over 12,000 households last year). Permanent supportive housing represents one of the

Continuum's highest priorities in that affordable housing is becoming increasingly hard to find, particularly with the advent of Crime Free Housing.¹⁰

The last two years have brought drastic changes to the Continuum's planning infrastructure, and the 2000 application brought an award of over \$18 million, almost three times the pro-rata share. Service providers remember a time of divisiveness and severe "turfism." Previously, Phoenix held the role of lead agency in the Maricopa Continuum (in collaboration with the city of Mesa and Maricopa County). However, both the city and the Continuum community saw a conflict of interest in this structure and, with the help of HUD-Arizona in 1999, decided upon a new structure. The Phoenix City Council agreed that the Maricopa Association of Governments (MAG)—a public, nonprofit, planning nongovernmental agency—not only had the experience in homeless planning the role required, but also the regional membership that provided both inclusiveness and legitimacy to their taking on the role. MAG's condition in accepting the role was that the process be funded, making it possible for MAG to dedicate significant staff time, hire a part-time consultant for the Continuum process, and ensure a smooth transition with fast results. New and continued financial support for planning from the local foundation community as well as city and state CDBG resources shows a growing interest and increasing buy-in to the Continuum process. In addition, the Arizona Department of Commerce has played a long-time role in the planning process, in terms of providing both leadership and planning dollars, and has promised to continue to do so. The business community has expressed interest in Maricopa County's proposal to create a gateway campus of emergency services (with an estimated cost of \$25 million) in the downtown area, indicating future private-sector support and private-public collaborations.

Despite its successes, the Maricopa Continuum faces numerous challenges. A lack of state spending on social services (ranked 48th in the nation) has created major gaps and needs in the homeless system. In 1989, the 8-year battle against the state of *Arnold vs. Sarn* came to a close with an affirmation of the right for severely mentally ill to receive adequate treatment. Over 10 years later the Arizona Legislature passed a bill devoting \$30 million for severely mentally ill; the Governor vetoed the bill until it was later reduced to \$10 million. Nevertheless, studies show a need for \$529 million for the state to comply with the lawsuit, demonstrating the magnitude of the matter and the extent of the inadequacies of the behavioral health system. With such gaps in services for what typically characterizes a chronic homeless person, the Maricopa Continuum has a lot of catching up to do, particularly for severely mentally ill persons and persons with alcohol and drug problems.

Though responsible for Exhibit 1 of the application and the facilitating the planning process, MAG does not maintain fiscal responsibilities. Grantees include the city of Phoenix, the Department of Commerce, and a number of direct service providers and housing developers. Completing this partnership model is the Valley of the Sun United Way, which is responsible for managing and facilitating the ranking process. The planning structure is composed of a Regional Committee and several subcommittees, where most of the work is done for approval by the Regional (or Steering) Committee. An inclusive group, the Regional

¹⁰ Under the lead of their Police Departments, both the City of Mesa and Phoenix have passed an ordinance stating that any developer receiving HOME or CDBG funds must include on the property deed that they are building a "crime-free zone." That is, these new multi-family complexes will not allow any ex-offenders or families of ex-offenders to become tenants (or employees) until 10 years after the release from prison.

Committee is co-led by a retired Supreme Court Justice and the current chair of the County Board of Supervisors. In addition to other appointed and elected officials, their participation has kept the issue of homelessness at the forefront of public discussions and created pressures when necessary to get certain agencies to the planning table. The disadvantage of this political nature is that innovation is sometimes stifled and those less viable issues receive less attention.

Today, more and more municipalities, government agencies, political and business representatives, and service providers are at the planning table. Services are beginning to appear throughout the county rather than being concentrated within the Phoenix city limits. And the various players are thinking of the system's needs and goals as regional in nature. This past year the Maricopa Continuum community has begun to feel it has reached a fair and inclusive process, though everyone admits there is always room to grow.

Tacoma/Pierce County, Washington

Situated on the edge of Puget Sound in the state of Washington, Pierce County (P.C.) has a population of just over 700,000 and borders King County and Seattle to the north. The Pierce County Continuum of Care (CoC) covers the entire county, including the cities of Tacoma and Lakewood, Washington, both entitlement jurisdictions.

In 1995, the Pierce County CoC was formed as a committee of the Pierce County Coalition for the Homeless, a group composed of providers, advocates and other members of the community. The Coalition led the process at that time. When the CoC grant concept emerged, the city of Tacoma and Pierce County came to the Coalition and proposed collaborating on an application for HUD funding. It became apparent that one entity would have to take over the lead role, as the Coalition was focused on issues other than the CoC and could not devote itself to a year-round planning process. The city of Tacoma, which was the only entitlement jurisdiction at the time, deferred to the county, and Pierce County Department of Community Services, Housing Programs, took over. Gradually, the Coalition came to play less of a role as the group focused on other issues. Currently staff from the county facilitate the planning process and are responsible for implementation of the plan and programs, while working closely in partnership with the CoC Committee.

Pierce County faces several major challenges in confronting homelessness. First, it is geographically diverse. Tacoma is very urban, while there are extremely rural areas located within the county, such as small communities near the base of Mt. Rainier. So there is urban poverty and rural poverty to deal with, and different approaches to each (e.g., there are problems in the rural areas that are not in the urban areas, such as the large number of methamphetamine labs). Second, state institutions in the county feed its homeless population without offering the county any substantial assistance in dealing with homeless persons. These include two state correctional facilities and one state mental institution, the latter will close a wing within the next year. Finally, the county does not have an abundance of resources. Pierce County borders King County, which tends to receive a great deal of resources from the state and garners a great deal of attention. These circumstances contribute to the difficulties that are already present in every homeless service system, and make it that much more challenging to confront homelessness in Pierce County.