



# STRATEGIES

*for Preventing Homelessness*

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

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

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The contents of this report are the views of the contractors and do not necessarily reflect the views or policies of the U.S. Department of Housing and Urban Development or the U.S. Government.

## FOREWORD

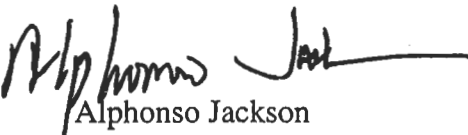
Homelessness prevention is an essential element of any effort to end homelessness either locally or nationwide. To close the front door of entry into homelessness, the central challenge of prevention is targeting our efforts toward those people that will become homeless without the intervention. Providing prevention assistance to people who would not otherwise become homeless is an inefficient use of limited homelessness dollars.

In 2003, HUD contracted with Walter R. McDonald & Associates, Inc., and its subcontractor, the Urban Institute, to conduct an exploratory study to identify communities that have implemented effective and well-targeted community-wide homelessness prevention activities. The study documents these approaches in six communities with the hope that other communities might learn how to carry out similar efforts.

This study suggests that a number of elements contribute to homelessness prevention and a number of promising prevention activities exist. The study identifies elements of community homelessness prevention strategies that seem to lead to reductions in the number of people who otherwise would become homeless. The contributing elements include targeting through control of the eligibility screening process; developing community motivation; maximizing mainstream and private resources; fostering leadership; and ensuring the availability and structure of data and information used to track progress, improve on prevention efforts, and facilitate outcome-based contracting. Evidence from the six communities studied indicates that those employing the most elements seem to be more successful at prevention and better able to document their achievements.

Within the context of the aforementioned elements, the study identified four promising homelessness prevention activities that may be used alone or in combination as part of a coherent community-wide strategy: (1) supportive services coupled with permanent housing, particularly when combined with effective discharge from institutions, especially mental hospitals; (2) mediation in Housing Courts; (3) cash assistance for rent or mortgage arrears; and (4) rapid exit from shelter.

This study provides insight into approaches that will help prevent homelessness. It is an important contribution to our understanding of how to help homeless Americans.

  
Alphonso Jackson  
Secretary

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## EXECUTIVE SUMMARY

### WHY HOMELESSNESS PREVENTION?

Every day in the United States, families and single adults who have never been homeless lose their housing and enter a shelter or find themselves on the streets. No matter how effective services are to help people leave homelessness, reducing homelessness or ending it completely requires stopping these families and individuals from becoming homeless. Policies and activities capable of preventing new cases, often described as “closing the front door” to homelessness, are as important to ending homelessness as services that help those who are already homeless to reenter housing (National Alliance to End Homelessness, 2000).

Most communities in the United States offer a range of activities to prevent homelessness. The most widespread activities provide assistance to avert housing loss for households facing eviction. Other activities focus on moments when people are particularly vulnerable to homelessness, such as at discharge from institutional settings (e.g., mental hospitals, jails, and prisons). Given that the causes and conditions of becoming homeless are often multifaceted, communities use a variety of strategies to prevent homelessness.

By definition, the intent of prevention is to stop something from happening. The worse the effects of what one is trying to prevent, the more important it is to develop effective prevention strategies, and the more one is willing to accept partial prevention if complete prevention is not possible.

Homelessness is a very undesirable condition, both for the people it affects and for society in general. The effects of homelessness on children, for example, make it easy to see why many communities offer interventions to help keep families with children in housing. Compared to poor, housed children, homeless children have worse health (more asthma, upper respiratory infections, minor skin ailments, gastrointestinal ailments, parasites, and chronic physical disorders), more developmental delays, more anxiety, depression and behavior problems, poorer school attendance and performance, and other negative conditions (Buckner, 2004; Shinn and Weitzman, 1996). There are also indications that negative effects increase the longer homelessness continues, including more health problems (possibly from living in congregate shelters or in cars and other places not meant for habitation) and more mental health symptoms of anxiety, depression, and acting out brought about by the disruptions in routines, relationships, and environments that homelessness entails (Buckner, 2004).

Even housing instability negatively impacts children. Analyses of the National Health Interview Survey show strong associations between moving three or more times and increased behavioral, emotional, and school problems (Shinn and Weitzman, 1996), even when poverty does not complicate the picture. These findings suggest that even if families receiving prevention assistance would not become literally homeless without assistance, reducing the number of times they move may be worth the investment of paying rent, mortgage, or utility arrearages.

Effects of homelessness on parents in homeless families are similar to those of their children, with the exception of school-related problems (Shinn and Weitzman, 1996). The effects of homelessness on single adults are also grim. Homeless individuals report poor health (37 percent

versus 21 percent for poor housed adults), and are more likely to have life-threatening contagious diseases such as tuberculosis and HIV/AIDS (Weinreb, Gelberg, Arangua, and Sullivan, 2004).

The risk of homelessness is relatively high among poor households in the United States. About one in 10 poor adults and children experience homelessness every year (Burt, Aron, and Lee, 2001; Culhane, Dejowski, Ibanez, Needham and Maccia, 1994; Link, Susser, Stueve, Phelan, Moore, and Struening. 1994, 1995). Homelessness exacerbates the negative effects of extreme poverty on families and individuals.

The litany of negative effects of homelessness makes it easy to see why a community would want to prevent it. But being convinced that action is needed and knowing what action to take are two different things. Despite the theoretical importance of prevention as the only intentional practice that will reduce the number of *new* cases of homelessness, public funders are often reluctant to invest in homelessness prevention strategies. In part, this reluctance stems from fear that funds could benefit people other than those likely to become homeless, thereby diluting the already limited public resources committed to homeless people, or invested in activities that have not been proven effective to prevent homelessness.

### **WHAT MAKES A GOOD PREVENTION INTERVENTION?**

To prevent something from happening, ideally one would know what causes it. The next best thing is to be able to predict in advance when, or to whom, it will happen. Knowing causes or having the ability to predict causes improves the odds of being able to design effective interventions.

The causes of some undesirable things are clear and the solutions obvious, if not always simple or inexpensive. Bacteria cause some diseases, so to prevent these diseases one must do something about the bacteria.<sup>1</sup> One can kill the bacteria in a number of ways, by washing or using antibacterial agents on one's hands, by using sterile procedures in operating rooms, or by assuring that the water in dishwashers reaches 180 degrees. Other approaches seek to prevent the bacteria from reaching people, including killing mosquitoes that carry malaria or yellow fever, fleas that carry typhus, or ticks that spread Lyme disease. Still other approaches (vaccines) make people more resistant to the bacteria.

Unfortunately, the causes of homelessness are not as clear as is true for many diseases, and prediction is thus less certain. Research has identified many antecedents of homelessness that can serve as predictors. But knowing such factors about a set of people will not predict homelessness with certainty. For example, in their groundbreaking study comparing poor housed and homeless families in New York City the best that Shinn and her colleagues were able to do was correctly

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<sup>1</sup> Even this example is not so simple, as some people will not get a disease even if infected with the relevant bacteria. As with homelessness, the presence of risk factors does not guarantee that the outcome will follow.

classify a family as homeless or not homeless 66 percent of the time (Shinn et al., 1998). The prediction equation used 10 factors, including race and ethnicity, childhood poverty, being pregnant or having an infant, being married or living with a partner, current domestic violence, childhood disruption, and four housing factors—overcrowding, doubling up, not having a housing subsidy, and frequent moves. The single factor “facing eviction” predicted homelessness only 20 percent of the time (that is, 20 percent of families facing eviction eventually became homeless).

Few communities desiring to prevent homelessness among families will be able to eliminate these risk factors, at least in the short run. That is, they cannot do the equivalent of killing the bacteria. But communities can use knowledge of these factors to increase the odds that they are delivering homeless prevention services to families who would *very likely* become homeless without it, and would be well advised to use more factors than just “threat of eviction.” Communities can use the identified predictive factors mentioned above to screen families for high homelessness risk and then target their resources toward the highest-risk families.

Factors differentiating adults who have experienced homelessness from those who have not include having an income less than 50 percent of poverty level; the presence of mental health, substance abuse, and chronic physical health problems; and a history of incarceration. Adverse childhood experiences including physical and sexual abuse and out-of-home placement also predicted the likelihood that an adult had experienced homelessness (Burt, Aron, and Lee, 2001).

### **THE CHALLENGE OF CREATING EFFECTIVE PREVENTION STRATEGIES**

This study concentrated on the *primary* prevention of homelessness—that is, on preventing *new* cases of homelessness and stopping people from *ever* becoming homeless. It also examined secondary and tertiary prevention activities, but only as part of a community’s comprehensive prevention strategy. Secondary prevention focuses on intervening early during a first spell of homelessness to help the person leave homelessness and not return. Tertiary prevention activities seek to end long-term homelessness, thus preventing continued homelessness, and were the focus of an earlier HUD study (Burt et al., 2004).

It is relatively easy to offer prevention activities but difficult to develop an effective community-wide prevention strategy. Such a prevention strategy needs to offer *effective* prevention activities and do so *efficiently*. *Effective activities* must be capable of stopping someone from becoming homeless (primary prevention) or ending their homelessness quickly (secondary prevention). An *efficient system* must target well, delivering its effective activities to people who are very likely to become homeless unless they receive help.

Inefficiency is widely considered to be the common failing of local prevention strategies and activities; they simply target too broadly. The people receiving the intervention are not uniformly at very high risk of homelessness, so relatively few would actually become homeless even without the intervention. Based on the goal of prevention, a prevention strategy is not efficient and “wastes” resources if it uses them to assist people who would not have become homeless without the service. Briefly stated, poor targeting leads to an inefficient strategy and inefficient strategies are rarely effective. This study sought evidence that particular prevention activities

were *effective*, and also sought to understand what makes a community's homelessness prevention strategy *efficient*.

*By what standard should one judge the effectiveness of a prevention activity?* The answer to this question depends on the type of prevention one attempts. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services maintains a Web site called "The Guide to Community Prevention Services" ([www.thecommunityguide.org](http://www.thecommunityguide.org)), through which it recommends activities whose effectiveness is considered proven for preventing health problems as diverse as suicide, youth violence, and smoking. Rates of change achieved by prevention activities that this guide describes as having strong evidence of effectiveness range from very low for primary prevention activities to very high for tertiary interventions. For instance, raising the price of cigarettes reduces smoking initiation by about 4 percent, and, when combined with extensive media campaigns, by about 8 percent. At the other extreme, therapeutic foster care for chronically delinquent violent youth—a tertiary intervention—produces a 70 percent reduction in violence compared to regular group home treatment.

The lesson for homelessness prevention efforts is that sometimes even relatively small percentage changes may be judged effective when the issue is primary prevention, both because the target population is so large and diverse, and therefore difficult to influence, and also because the consequences of failure are many and costly. When looking at the impacts of interventions designed for secondary and tertiary prevention, however, one should look for somewhat stronger effects because the target population is well-defined and interventions can be more precisely tailored.

## **THE FOCUS OF THIS STUDY**

To learn more about effective prevention strategies, the U.S. Department of Housing and Urban Development (HUD) contracted in 2003 with Walter R. McDonald & Associates, Inc. (WRMA) and its partner, Urban Institute (UI), to conduct this study. Specifically, the study's objectives were to:

- Identify communities that have implemented community-wide strategies to prevent homelessness and can document their effectiveness;
- Describe these strategies and their component activities for other communities and the field at large; and
- Review community data that measure achievements in preventing homelessness and provide evidence that the prevention activities were effective.

## **Common Prevention Activities**

To give the concept of "homelessness prevention" some concreteness, the study team examined Continuum of Care (CoC) applications for 2004 to identify the activities that communities

include in the prevention component of their CoCs.<sup>2</sup> One cluster of activities was found in almost every application. It included counseling and advocacy to help households connect to resources and housing, as well as budget and credit counseling. It also included in-kind emergency assistance (food, clothing, transportation vouchers, and occasionally furniture and medical care); and cash assistance with rent, mortgage, or utility payments to avert eviction.

A smaller proportion of communities also offered a second set of activities aimed at preventing homelessness. These activities included the following: legal and other assistance to retain housing; mental health, corrections, child welfare, and Temporary Assistance for Needy Families (TANF) agencies making commitments to house their clients as part of their service obligation; and strategies that involve more than one public agency working together to prevent homelessness. An example of the latter is mental health and corrections agencies collaborating to prevent homelessness at institutional release for mentally ill inmates.

### Selecting Communities to Study

Armed with a general knowledge of prevention activities and target populations (e.g., families, people leaving institutions), the study team sought communities to include in this study that represented a range of approaches and focal populations, and also met two criteria specified by HUD.

- **Community-wide strategy:** Primary prevention activities that represent a conscious commitment of the community to prevent homelessness. They go beyond the activities of a single agency to encompass the whole community in a structured and coordinated way, although they may have a specific population focus.
- **Data documenting effectiveness:** The community collects and analyzes data capable of showing that its prevention efforts do or do not prevent homelessness.

To identify appropriate communities, the study team started by contacting national experts on homelessness, who suggested 45 points of contact in 28 communities. A canvass of these communities eventually identified six communities that met both HUD criteria reasonably well. If the only criterion had been “community-wide,” more communities would have been included. However, most communities with community-wide prevention strategies did not maintain data on program effectiveness. The lead agencies in the six communities selected for further study were:

- Hennepin County Human Services Department in Minnesota;
- Montgomery County Department of Health and Human Services in Maryland;
- Mid America Assistance Coalition (MAAC) in Kansas City, Kansas and Missouri;

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<sup>2</sup> “Continuum of Care” is a concept HUD has used since 1994 to describe the full range of a community’s response to homelessness. It spans activities from prevention through emergency shelter to supportive housing and permanent affordable housing without supportive services. In applications for funding under HUD’s Supportive Housing Program, communities are asked to describe their Continuums of Care; the study team examined the prevention components of these descriptions.



- Department of Mental Health (DMH) serving the Commonwealth of Massachusetts;
- Office of Behavioral Health (OBH) in Philadelphia, Pennsylvania; and
- Urban Peak, a private nonprofit agency in Denver, Colorado.

### **Prevention Activities in the Six Study Communities**

Among these six study communities, one can find virtually every type of prevention activity, although they varied in their combinations and population focus. The first three communities were included to examine their strategies for primary homelessness prevention for families. The next two were included to examine their strategies for primary and secondary prevention with people with serious mental illness. The sixth site was selected because it served homeless youth, which is an important population to understand from a prevention perspective.

The key to understanding homelessness prevention in the study communities lies in understanding what each community was trying to do. Differences in their prevention strategies and activities flowed from differences in their target populations and goals.

The communities that aimed at primary homelessness prevention for families—Hennepin County Montgomery County and MAAC—selected families with short-term problems. Although they often discovered family issues that could not be resolved with one month of cash assistance, for primary prevention they *selected* the families whose housing problems could be resolved with the resources that were available. These communities offered families cash assistance to prevent eviction and cover rent, mortgage, or utility arrears, along with other prevention activities such as in-kind assistance and budget counseling.

The other communities—Massachusetts, Philadelphia, and Urban Peak—focused their attention on people who would need long-term help. Of course, these communities found less severely disabled people during screenings, but they *selected* the ones who needed *the most* help. The help these communities offered was generally more intense, more expensive, and longer-term than that offered by the family-focused communities, in keeping with the nature and needs of the population being served. Permanent housing and supportive services to remain in housing were key activities, and collaborations among two or more mainstream agencies to make these approaches work were common.

It is also important to recognize that some of the more intensive prevention activities serve multiple purposes. For example, Massachusetts DMH uses four interventions—mental health services, supportive services to maintain housing, rent subsidies, and permanent supportive housing—to accomplish both primary and secondary prevention and also to end chronic homelessness. Supportive and mental health services help keep never-homeless people with serious mental illness in housing and also help formerly homeless people stay in their new homes. Secondly, the same intervention can be used with different populations. For example, Hennepin County has a well-developed rapid exit program to assist families with multiple

housing barriers to leave shelter and sustain their new housing. Massachusetts DMH also has a rapid exit strategy to assist homeless people with serious mental illness to leave shelters and the streets.

## PROMISING HOMELESSNESS PREVENTION ACTIVITIES

This study identified five effective prevention activities that may be implemented at all levels of prevention: primary, secondary, and tertiary. These activities may be used alone or in combination as part of a coherent community-wide strategy.

- **Housing subsidies.** Evidence for housing subsidies as a very effective prevention activity comes from studies other than the present one. Shinn and colleagues (Shinn et al., 2001; Stojanovic et al., 1999) documented the effectiveness of housing subsidies at keeping at least 80 percent of first-time homeless families housed for a minimum of two years. Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, and Holupka (1995) demonstrated similar success (80–85 percent retention over at least 18 months) for homeless families in which a parent’s mental illness complicated housing stability. Evidence from simulations (Quigley, Raphael, and Smolensky, 2001) indicates that subsidizing housing costs for extremely low-income people has the strongest effect on lowering homelessness rates compared to several other interventions tested. Thus when used as secondary and tertiary prevention, housing subsidies help 80–85 percent of homeless families or chronically homeless single adults to achieve housing stability.
- **Supportive services coupled with permanent housing.** For people with serious mental illness, with or without co-occurring substance abuse, permanent supportive housing works to prevent initial homelessness, to rehouse people quickly if they become homeless, and to help chronically homeless people leave the streets (Burt et al., 2004; Shern et al., 1997; Tsemberis and Eisenberg, 2000). Evidence collected in Massachusetts for the present study indicates declining rates of homelessness among people with serious mental illness admitted to state psychiatric hospitals over the 10-year period during which the DMH was expanding housing with supportive services.<sup>3</sup>
- **Mediation in Housing Courts.** Evidence collected in the present study on the effectiveness of mediation under the auspices of Housing Courts shows the ability to preserve tenancy, even after the landlord has filed for eviction. Sixty-nine percent of cases filed against families in the Hennepin County Housing Court were settled without eviction and the family retained housing. Mediation preserved housing for up to 85 percent of people with serious mental illness facing eviction in the Western Massachusetts Tenancy Preservation Project and cut the proportion becoming homeless by at least one-third.

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<sup>3</sup> Some cost-conscious state corrections departments are recognizing that lack of housing and employment at release are two very strong predictors of renewed criminal activity and return to prison—two-thirds of prison inmates return within three years. These factors also predict homelessness, often within one or two months after release. These departments are experimenting with transitional housing with employment services for the highest-risk releasees, which should prevent both reincarceration and homelessness.

- **Cash assistance for rent or mortgage arrears.** This commonly used primary prevention activity for households still in housing but threatened with housing loss can be effective—the challenge is to administer it in a way that makes it well-targeted and, therefore, efficient. In the study communities, 2–5 percent of families receiving assistance became homeless during the following year, which is an improvement over the 20 percent that might have become homeless when facing eviction without the intervention.
- **Rapid exit from shelter.** These secondary prevention activities are directed toward families just entering shelter, to ensure that they quickly leave shelter and stay housed thereafter. Using this innovative strategy, Hennepin County halved the average length of shelter stay (from 60 to 30 days) and achieved an 88 percent success rate in keeping formerly homeless families from returning to shelter over the next year.

## DOCUMENTING PREVENTION EFFECTIVENESS

A community that wants to offer the most effective prevention activities in a manner that directs the most resources to those most likely to become homeless would be well advised to monitor performance. The community should establish systems to assess both the effectiveness and efficiency of its prevention efforts on a regular basis and use the resulting feedback to improve its targeting and balance among prevention activities. However, commitment to such performance monitoring is rare, as this study’s search for communities with performance data indicated.

Each of the study communities collected basic data and could describe who they served and what services they provided. Some communities had sophisticated linkages among service providers, while others had more centralized databases. For most, sharing data among various systems remained a challenge, even though most study communities had developed innovative strategies to meet these challenges. Yet the communities had taken considerable strides in developing systems that could document primary and secondary prevention of homelessness.

- **Matching against emergency shelter records.** This performance monitoring approach requires a prevention database and a shelter database, each of which should cover all or most of the relevant services. Each database must have a field or fields that permits matching a household in one database with the same household in the other database. The database containing information about which households received a prevention intervention is matched to a database such as a homeless management information system showing which households used shelter. Knowing when a household received prevention assistance, the shelter database is queried to learn whether that household used shelter at any time during the following 12 months. One database could contain all of the needed data.
- **Changes over time documented within a single database.** Evidence over time that fewer people who received homelessness prevention services are becoming homeless increases the confidence that a system is moving toward greater prevention. This movement could reflect several changes that would indicate that prevention is occurring: decreasing numbers of households are requesting shelter, only households with the most

complex problems are requesting shelter, or decreasing proportions of people are homeless at psychiatric facility intake and discharge. The study communities of Hennepin County and Massachusetts DMH documented outcomes of this type.

- **Special data collection.** Even in the absence of formal databases or the ability to match across databases, specific prevention interventions can maintain records to document prevention effectiveness. The Tenancy Preservation Project in Massachusetts is one example. It maintained records on all people assisted and tracked housing outcomes. As it had a waitlist and some people never received services, it was also able to construct a small comparison group of people similar to those receiving services, and was able to show substantial differences in outcomes between the two.<sup>4</sup>

## KEY ELEMENTS OF PREVENTION STRATEGIES

Any agency may use effective prevention activities, alone or in combination, and will probably prevent some homelessness. But prevention resources are unlikely to be used *efficiently* unless they are part of a larger structure of planning and organization that addresses the issue of targeting. A single agency can target and do it well. But to get the most from a community's prevention dollar, indications from this study are that one needs a community-wide system. The system would have a carefully articulated targeting strategy and mechanisms to assure that funds allocated to prevention are used in ways likely to reach the people at greatest risk of homelessness. The communities in this study each had some elements of such a system, and several had many. From the evidence we have, the study communities with the most elements, Hennepin County and Massachusetts, were more likely to prevent homelessness and were best able to document achievements in homelessness prevention.

The elements found in the study communities that appear to contribute to homelessness prevention all concern *community organization* of one type or another. The more comprehensive and sustained they are, the more they are likely to contribute to developing a *system* of homelessness prevention. The elements include:

- Elements affecting ability to target well:
  - Agencies and systems sharing information, through a single unifying data system or with the capacity to track clients across different data systems; and
  - A single agency or system controlling the eligibility determination process, including agreed-upon criteria combined with housing barrier screening and triage.
- Elements reflecting community motivation:
  - Community accepts an obligation to shelter one or more at-risk populations—the obligation may come as county council policy, as statutory requirement, as a governor's commitment, or through other mechanisms; and
  - Given the obligation, the jurisdiction accepts that it must provide funds to fulfill it. As these funds are usually substantial, the community is motivated to use them wisely.

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<sup>4</sup> The small numbers of the comparison group provide tentative rather than conclusive results.

- Elements that maximize resources:
  - Collaboration among public and private agencies helps stretch resources through referrals to appropriate agencies and creates new resources when two or more organizations work together to identify a need and then develop a service that did not previously exist (e.g., mediation in Housing Courts); and
  - Nonhousing mainstream agencies accepting their clients' housing stability as one of their responsibilities. For example, child welfare departments fund housing options for families in which mental illness is an issue (Philadelphia) and for youth aging out of foster care (Denver).
- Elements affecting direction, sustainability, control, and the use of data to guide future development: Leadership is essential at two levels. Agency heads and public figures must commit to developing and sustaining a community-wide prevention strategy. To make such a strategy work, it has to be someone's job to "mind the store," manage the strategy, analyze performance, promote collaboration, and all the other activities that make a system work well. Several elements are involved in making this happen, including:
  - Having a clear goal of preventing homelessness;
  - Developing a strategy to reach the goal;
  - Having mechanisms that provide feedback on progress, stimulate new thinking and innovation, identify gaps and next steps; and
  - Knowing what is needed and making sure contract agencies are committed to providing it.

With respect to organizing a community for prevention, the study team identified two overall strategies—short-term assistance and long-term support. The first strategy, most commonly applied to families threatened with housing loss, screens for short-term problems that nonetheless constitute crises for particular families, and applies short-term solutions. The latter seeks people whose disabilities or other circumstances indicate chronic problems, and applies the long-term solutions of housing with supportive services. When these solutions are made available before homelessness occurs, they have a stabilizing and preventive effect similar to what happens when they are offered to chronically homeless people with disabilities. (See Exhibit ES.1 for a complete list of organizing elements by population type.)

These two community-wide prevention strategies, focusing on populations needing short-term or long-term assistance, respectively, operate through several mechanisms that other communities could begin to develop. These include careful targeting toward populations at very high risk of homelessness, and organizing and controlling access to preventive services to maximize targeting. The best organized among the study communities reached their present situation deliberately and over time, in a process that involved leadership, analytic thinking, strategic planning, alliance building, and collaboration. Developing better data and using existing data more strategically can improve performance, identify and fill gaps, and further the development of a community's approach to homelessness prevention.

### Exhibit ES.1. Organizing for Community-Wide Homelessness Prevention

Element		Community-Wide Strategies with Families			Community-Wide Strategies with Specialized Populations		
					People with Serious Mental Illness		Homeless and Runaway Youth
		Hennepin County	Montgomery County	MAAC	Massachusetts	Philadelphia	Urban Peak
Targeting Aids	Information sharing across agencies and systems	All prevention and rapid exit agencies share a data system	Prevention and shelter services through one agency, with common database	All private agencies handling prevention funds share common database, which also tracks shelter referral and usage	Acute inpatient, shelter, DMH transitional programs share information through outreach; courts and DMH contract agencies share information through Tenancy Preservation Projects; working with Medicaid and TANF agencies	OBH shares data with child welfare, homeless system, jail/prison, and internally among its mental health and substance abuse service agencies	No
	Housing barrier screening and triage	Yes, measure via scale	Yes, though no formal measurement	No	Formally, to become DMH client (must meet diagnostic and disability criteria); informally for housing (related to level of need, absence of alternatives)	Formally, to become OBH client (must meet diagnostic and disability criteria); informally for housing (related to level of need, absence of alternatives)	No
Motivators	Public jurisdiction recognizes a legal or moral obligation to shelter	Yes, moral, from County Council	Yes, moral, from County Council	No	Yes, part of legislative and DMH commitments	Some, from city	No
	Significant mainstream resources are invested (other than Federal)	Yes, state and local	Yes, mostly local	No	Yes, mostly state	Yes, mostly local	Only from child welfare to youth leaving foster care
Maximizing Resources	Collaboration among public and private agencies	Public and private, extensive	Public and private, extensive	Private only	Public and private, extensive	Public and private	Public and private
	Nonhousing mainstream agencies accepting housing their clients as one of their responsibilities	Yes, child welfare, TANF, mental health caseworkers included in rapid exit case planning for families	Yes, child welfare, behavioral health, and domestic violence case workers coordinate housing services	No	Yes, DMH itself and to some extent corrections, for people with serious mental illness	Yes, OBH for people with serious mental illness	No

**Exhibit ES.1. Organizing for Community-Wide Homelessness Prevention (continued)**

Element	Community-Wide Strategies with Families			Community-Wide Strategies with Specialized Populations			
				People with Serious Mental Illness		People with Serious Mental Illness	
	Hennepin County	Montgomery County	MAAC	Massachusetts	Philadelphia	Urban Peak	
Direction, Sustainability, Control, and Feedback	Leadership	Yes, strong, sustained, for both prevention and rapid exit	More coordinating than leadership	Coordinating function, but not for new or developing prevention strategies	Yes, strong, sustained, for prevention, rapid exit, and community-based housing for people with serious mental illness	Just beginning for prevention, long been present for community-based housing for people with serious mental illness	Strong leadership to organize community to address youth homelessness, but no significant public role
	Clear goal of preventing homelessness among target population(s)	Yes	Yes	Yes	Yes	Just beginning	Yes
	Clear strategy with ways to track success and progress	Have strategy, track progress, use feedback to adjust system; prevention success tested against shelter database	Only beginning to develop a strategy; prevention success tested internally and against Sheriff's eviction database; have data to do more	Do not have a strategy for system development; have data to track progress but have not to date	Have strategy, track some kinds of progress, but not yet specifically for prevention	Just beginning to develop strategy and tracking	Have had strategy and some data; just beginning to use data for tracking outcomes
	Lead agency has control of funding and contracting for all or most of system	Yes	Yes	No	Yes	Yes	No
	Uses outcomes-based contracting with adjustments based on performance	Contracts specify outcomes, not process or services; contractors have been terminated or not renewed for not meeting outcome commitments	No	No	No	No	No

## **IMPLICATIONS FOR POLICY AND PRACTICE**

The implications of study findings are clear for communities desiring to mount effective and efficient homelessness prevention strategies and for funders desiring to support effective efforts.

- First, offer only prevention activities for which some research has indicated at least a minimal level of effectiveness.
- Second, recognize that the effectiveness of any activity is only as good as the efficiency with which it is targeted to the families and individuals most likely to become or remain homeless if they do not receive help.
- Third, organize the community to improve targeting, develop strong collaborations, and involve mainstream agencies.
- Fourth, develop useful data systems and use the resulting data to reflect and improve system performance. Important data elements and outcome measures were identified in the study communities.

### **The Role of Funding Agencies**

Funders considering support for homelessness prevention, including governments at any level, foundations, or even service agencies using charitable donations, should pay attention to the effectiveness of prevention activities and the likelihood that community organization is adequate to assure careful targeting before making significant investments in prevention activities. They should also consider funding the organizational capacity itself, as having staff responsible for seeing that the system works well is an important element in developing into a well-functioning system.

In addition, state and local governments and private funders may accept multiple goals for an activity, of which homelessness prevention would be one. Paying rent, mortgage, and utility arrearages or offering in-kind assistance and budget counseling may serve more than one purpose, and funder goals may include providing crisis relief to extremely poor households whether or not they face a high homelessness risk. If this is the case in a community, performance monitoring will need to reflect the success of several outcomes that an intervention is expected to achieve, not only homelessness prevention.

Federal, state, and local government resources are being used extensively to support homelessness prevention. Federal resources include the Supportive Housing Program, Emergency Shelter Grants, Emergency Food and Shelter Program, Projects for Assistance in Transition from Homelessness, and several block grants. In the case of the Supportive Housing Program, this support is for secondary and tertiary prevention. Although secondary and tertiary prevention activities are called prevention in this report, they actually involve interventions for people who are already homeless, such as rapid exit from emergency shelters and other activities that reduce the time a person spends homeless and assure that homelessness does not reoccur or act to end a person's chronic homelessness. Significant state and local commitments were obvious in several study communities. The government agencies responsible for these funding



streams emphasize community-wide strategic planning, integrated approaches to homelessness prevention, and the importance of reducing homelessness for those at greatest risk. HUD in particular can stress the need for a systematic approach to prevention in its annual CoC applications. Funding agencies should assemble and disseminate information about prevention activities, the circumstances under which they are most likely to be effective, and how they can be integrated into a community-wide strategy. Federal and possibly state agencies should make technical assistance to improve targeting and the measurement of outcomes widely available to communities to use in their strategic planning to prevent and end homelessness.

## **IMPLICATIONS FOR FUTURE RESEARCH**

This study has only scratched the surface of homelessness prevention—assembling data from a few communities that could begin to reflect the effectiveness of prevention. Other researchers (Lindblom, 1997; Shinn, Baumohl, and Hopper, 2001) have concluded that strong evidence is still lacking that homelessness prevention efforts are effective, but the bulk of their criticism has to do with targeting and inefficiency, not with the underlying effectiveness of different activities. Developing powerful evidence on the effectiveness of prevention activities requires sophisticated and usually expensive research designed to assess what would have happened if particular families or disabled people were not assisted. For this, controlled experiments or at least quasi-experimental designs are essential. Minimally, research needs to compare over time persons who receive prevention assistance with those who do not where those households are carefully assessed so that they differ only on receipt of such assistance. Federal government agencies are in the best position to support such research, as it is usually beyond the means of local actors.

## **CONCLUSIONS**

Community-wide approaches to prevent homelessness have an essential role to play in ending homelessness, as reaching this goal will require communities to stop the flow of new households into homelessness as well as assisting those already homeless to return to housing. Many communities offer a wide range of activities intended to prevent homelessness. This study found examples of promising policies and practices that could be adapted to local circumstances and applied by other communities.

This study identified two issues confronting communities desiring to prevent homelessness: knowing what prevention activities are effective and developing a system to deliver them efficiently (i.e., to the households with a very high risk of becoming homeless if they do not receive help). Many activities and interventions may succeed in preventing first-time homelessness for some, or helping newly homeless people return to and retain housing. However, many resources might be expended if such activities were offered to households that did not have a significant risk of becoming homeless. That is, the intervention might help a particular household avoid homelessness, but a *program* offering the intervention would be very inefficient if it did not take steps to assure that very high proportions of the people receiving the intervention really would have become homeless without it. In common parlance, an intervention is considered to be effective if it meets two tests—the intervention itself prevents homelessness, and it selects recipients with a very high risk of homelessness.

## **Maximizing Effectiveness**

Several effective prevention strategies were identified, including some that are most likely to be used for primary prevention and others that are more likely to be used for secondary prevention or even tertiary intervention.

For a community looking for the most effective and efficient approaches, the evidence suggests two places to concentrate:

- Intervening to promote rapid exit from shelter and prevent renewed homelessness is a secondary prevention activity. Intervention with newly homeless people should be quick, and seek to prevent lengthy or repeated homeless spells and their negative consequences. Rapid exit has the advantage of potentially being able to target very accurately, as households in shelter clearly have become homeless at least once. Screening is still necessary, however, to select for the intervention households likely to return to homelessness if they do not receive help, as even with currently homeless households, evidence suggests that about two-thirds exit homelessness and do not have additional episodes.
- People with disabilities leaving psychiatric and correctional institutions have a very high risk of homelessness if they do not receive assistance to find and keep stable housing. Their risk level for homelessness makes them an ideal target population for prevention activities, which may be primary or secondary depending on whether the people in question were ever homeless prior to institutionalization. Having or developing community-based housing and supportive services for people with serious mental illness exiting these facilities, coupled with discharge planning that links people in need with the housing and services, can be both effective and efficient, preventing both homelessness and a return to costly institutional settings.

Cash assistance to prevent housing loss is a primary prevention strategy, and as such joins primary prevention in other fields in being held to a lower standard of impact than would be expected of secondary or tertiary prevention strategies because the intervention is applied to people with a relatively broad range of risk. Communities may still be interested in offering this activity with multiple goals, of which primary homelessness prevention will be only one.

## **Planning and Organizing for Prevention**

Any homelessness prevention activities will have the greatest chance of success if they are part of a coherent, multiyear approach supported by strong leadership, adequate resources, and mainstream agency commitments, particularly for the policies involving populations with chronically disabling conditions. Communities could also begin to improve their prevention targeting and establish one or more of the innovative strategies described in this report. The CoC planning process occurring in many communities is an appropriate vehicle for implementing many of this report's suggestions. Federal and state programs, as well as national organizations that encourage community-wide, collaborative thinking and help fund such efforts, would contribute significantly to their success.



## **CHAPTER ONE**

### **INTRODUCTION**

Every day in the United States, families and single adults who have never been homeless lose their housing and enter a shelter or find themselves on the streets. No matter how effective services are to help people leave homelessness once they lose housing, reducing the level of homelessness or ending it completely requires stopping these households from becoming new cases of homelessness. Policies and activities capable of preventing new cases, described in the memorable phrase of the National Alliance to End Homelessness as “closing the front door” to homelessness, are as important to ending homelessness as are services that help those who are already homeless to reenter housing (National Alliance to End Homelessness, 2000).

Virtually every community in the United States pursues some activities that it considers homelessness prevention. The most widespread of these activities is to provide cash assistance to cover rental, mortgage, and utility payments to avert housing loss, often for households facing eviction. Other activities focus on moments when people are particularly vulnerable to homelessness, such as at discharge from institutional settings (e.g., mental hospitals, jails, and prisons). Given that the causes and conditions of becoming homeless are complex, it is not surprising that communities have developed a range of activities to prevent first-time homelessness and keep homeless spells as short as possible.

Despite the theoretical importance of prevention as the only practice that will reduce the number of new cases of homelessness, public funders are often reluctant to invest in homelessness prevention. In part, this reluctance stems from fear that funds could be used to help broader populations, losing focus on those very likely to become homeless, or be invested in activities that have not been proven to prevent homelessness. Further, the most widespread prevention strategies remain loosely organized and untested.

To learn more about effective prevention strategies, the U.S. Department of Housing and Urban Development (HUD) contracted in 2003 with Walter R. McDonald & Associates, Inc. (WRMA), and its partner, Urban Institute (UI), to conduct this study. The purpose of this study was to identify and learn from communities that had a systematic, community-wide strategy to address homelessness prevention and were able to demonstrate with data that the strategy actually prevented homelessness. Specifically, the study’s objectives were to:

- Identify communities that have implemented community-wide strategies to prevent homelessness and can document their effectiveness;
- Describe these strategies and their component activities for other communities and the field at large; and
- Review community data that measure achievements with preventing homelessness and provide evidence that the prevention activities were successful.

## UNDERSTANDING PREVENTION

The challenges involved in any attempt to document the effectiveness of prevention activities are twofold: (1) specifying what one is trying to prevent, and (2) demonstrating that one's efforts have actually stopped or reduced the occurrence of the event.

The study team adopted one of the most enduring approaches to prevention to guide the selection of prevention activities to examine for this study—the public health model (Klein & Goldston, 1977; Mace, 1983). This model identifies three types of prevention: primary, secondary, and tertiary intervention. This study concentrated on primary prevention and examined approaches to secondary and tertiary prevention only when these activities were part of a community's comprehensive prevention strategy.<sup>5</sup>

- **Primary prevention** strategies take proactive steps to keep a particular event or behavior from occurring for the first time. For purposes of this study, primary prevention refers to preventing homelessness before it occurs for the first time. Various factors may contribute to one's risk of homelessness, and several of these factors may be involved in a community's decisions about whom to target for prevention activities. These factors include income loss, release from institutions or transitions out of social service programs, family violence, and mental health or substance abuse issues.
- **Secondary prevention** efforts focus on early intervention after risks are identified, but before severe problems arise. In the case of homelessness, secondary prevention targets those who have recently become homeless to curtail the time spent homeless and assure that homelessness does not recur. The goal of secondary prevention would be to prevent first-time homelessness from becoming episodic or chronic and spanning many years.
- **Tertiary intervention** is not always considered prevention because it addresses situations in which people have had extensive experience with homelessness. Yet interventions at this advanced stage can be successful at ending chronic homelessness, thus preventing continued homelessness.

The public health framework helps to place homelessness prevention strategies and activities in a context used by practitioners and policymakers working in a number of areas, including disease prevention, drunk driving, and youth violence. This framework may also help readers to understand where the homelessness prevention activities in their own community fit in a larger conceptual framework and aid future planning. Decisions about whether to invest resources in prevention may be influenced by a clear understanding of the types of prevention that are most likely to be effective, as well as the types of prevention that a community identifies as being most important.

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<sup>5</sup> This study was deliberately oriented toward the primary end of the prevention continuum because several other HUD-sponsored studies had focused on tertiary intervention strategies (ending street homelessness, Housing First approaches to permanent housing for chronically homeless people).

## **TARGETING EFFICIENCY—THE KEY TO PREVENTION EFFECTIVENESS**

Showing that a prevention activity “works” is a challenge. Prevention targets people at risk. However, risk is not reality; the risk will only materialize for some, even without the intervention. The objective of the intervention is to reduce the probability that the risk will become reality. A common failing of many prevention efforts is that they target their interventions too broadly. Those receiving the intervention are not uniformly at very high risk, so relatively few would actually experience what the intervention is intended to prevent (in this case, homelessness) even without the intervention. Briefly stated, poor targeting leads to an inefficient program, and inefficient programs are rarely effective.

For instance, threatened eviction is a common targeting criterion for homelessness prevention programs, but by itself it is a poor predictor of becoming homeless. Analyses in New York City showed that only one in five (20 percent) welfare families facing eviction actually became homeless (Shinn, Baumohl, and Hopper, 2001). Without an intervention, 80 percent of the families were “successes.” The intervention would have to improve those odds and would attempt to do so by assisting both the 80 percent who did not need it as well as the 20 percent who did. Using only this criterion, the program would be very inefficient. Clearly, excellent targeting procedures capable of identifying the people at highest risk are necessary for prevention activities to be both efficient and effective.

In addition to good targeting, a prevention intervention also has to be able, at least in theory, to affect a person’s housing status. The link to housing retention and stability is more robust for some interventions than others. For instance, providing housing is one of the strongest interventions, but also probably the most costly and therefore, not to be used unless necessary. Instructing a family in budgeting is much less expensive, but also more tenuously linked, because the family would need to follow the budget over many months and also have the resources to pay for the budgeted items. All other circumstances being equal, one would expect stronger, more intense, and long-term interventions to be more effective in preventing homelessness.

## **WHAT “PREVENTION” LOOKS LIKE IN AMERICAN COMMUNITIES**

To give the idea of “prevention” some concreteness, the study team identified 13 Continuum of Care (CoC) applications for fiscal year 2004 through a Web search and scanned their Services Activity Chart, Ending Chronic Homelessness, and Discharge Planning sections for prevention activities.<sup>6</sup> Exhibit 1 displays the activities that various communities around the United States include in the prevention component of their CoCs. The first cluster of activities is found most commonly, described in almost every Services Activity Chart consulted. These activities include counseling and advocacy to help households connect to resources and housing. Budget and credit

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<sup>6</sup> “Continuum of Care” is a concept HUD has used since 1994 to describe the full range of a community’s response to homelessness. It spans activities from prevention through emergency shelter to supportive housing and permanent affordable housing without supportive services. In applications for funding under HUD’s Supportive Housing Program, communities are asked to describe their Continuums of Care; the study team examined the prevention components of these descriptions.

counseling is also very common, in part as a prelude to assessing whether the household should receive cash assistance with rent, mortgage, or utility payments and in part to prepare the household to avoid future financial crises. In-kind emergency assistance in the form of food, clothing, and transportation vouchers is also widespread; the offer of furniture and medical care somewhat less so, but still fairly common.

**Exhibit 1. Homelessness Prevention Activities<sup>7</sup>**

<i>I. Most Commonly Offered Activities</i>	
Counseling and advocacy	<ol style="list-style-type: none"> <li>1. Information and referral about available resources</li> <li>2. Budgeting and debt reduction, handling credit and improving credit rating/history</li> <li>3. Links to entitlements and community resources</li> <li>4. Housing search assistance</li> </ol>
In-kind emergency assistance	Food, clothing, transportation, furniture, medical care
Cash assistance to maintain or obtain housing	<ol style="list-style-type: none"> <li>1. Deposits (first month's rent, last month's rent, security)</li> <li>2. Arrearages (rent, mortgage, utilities) to prevent eviction or foreclosure</li> <li>3. Moving costs</li> </ol>
Links to more sustained help	<ol style="list-style-type: none"> <li>1. Mental health treatment</li> <li>2. Substance abuse treatment</li> <li>3. Training and employment assistance and support, job search</li> <li>4. Links to benefits: Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), food stamps, housing subsidies, local programs</li> </ol>
<i>II. Less Commonly Offered Activities</i>	
Other cash assistance	<ol style="list-style-type: none"> <li>1. Automobile loan or repair</li> <li>2. Short-term rental payments for people with disabilities while waiting for SSI</li> <li>3. Special funds associated with Memoranda of Understanding arrangements, described below</li> </ol>
Legal and other assistance to retain housing	<ol style="list-style-type: none"> <li>1. Mediation with landlords around rents, heat or utilities, repairs, hazardous conditions</li> <li>2. Arrangements through Housing Courts, including mediation, provision of counselor, fee return to landlords, special funds</li> <li>3. Supportive services to assure housing retention once families or singles move to housing (e.g., Assertive Community Treatment for people with serious mental illness)</li> </ol>
Mainstream agencies assuming prevention responsibilities for own clients, inmates, or consumers	<ol style="list-style-type: none"> <li>1. Develop specialized housing (various forms for people with serious mental illness, halfway house for corrections)</li> <li>2. Supportive services to assure housing retention</li> <li>3. Employment links and supports</li> <li>4. Discharge planning, especially linked to housing, services, and employment</li> <li>5. Specialized units, trained staff</li> </ol>
Memoranda of Understanding or other formal interagency arrangements to prevent homelessness for vulnerable populations	<p>Strategies</p> <ol style="list-style-type: none"> <li>1. Special funds for cash assistance</li> <li>2. Hotlines and other mechanisms to alert agencies to risk situations</li> <li>3. Special training and staffing</li> <li>4. Centralized resources to resolve housing emergencies</li> <li>5. Mental Health Courts (prevent people with serious mental illness cycling through jails, shelters)</li> <li>6. Planning and coordination so code enforcement (condemning or otherwise closing housing, temporarily or permanently) does not produce homelessness</li> </ol> <p>Agencies involved (with each other, public agency responsible for homeless programs, CoC, or in 10-year plan process as partner): Corrections, Mental Health, Child Welfare, TANF</p>
<i>III. Sometimes Mentioned as Deep or Long-Term Prevention Strategies</i>	
Antipoverty activities	<ol style="list-style-type: none"> <li>1. Job training, continuing education, skill development</li> <li>2. Literacy, adult basic education, English as a second language</li> <li>3. Affordable housing development</li> </ol>

<sup>7</sup> Sources: (1) Canvass of the 28 candidate communities for this study and in-depth examination of six of them; (2) Web search for “2004+application+continuum of care” and a review of 13 CoC applications: Very large—New York City, NY; Los Angeles County, CA; Medium—Bridgeport, CT, Columbus/Franklin County, OH, Dakota County Knoxville/Knox County, TN, Santa Clara County, CA, Washington, DC; Small and/or largely rural—Burlington, VT, Delaware, Frederick City and County, MD, Iowa balance-of-state, and West Memphis, AR.

The most commonly offered homelessness prevention activity, especially for families, is short-term (usually one month) cash assistance to obtain or retain housing. Two McKinney-Vento programs, the Emergency Food and Shelter Program and the Emergency Shelter Grants Program, are important funders of these activities. Local decisionmakers allocate approximately \$25–\$30 million of these funds each year for rent, mortgage, and utility cash assistance. This sum comprises about 10–15 percent of the resources in these two programs, but is swamped by the total McKinney-Vento budget of over \$1 billion per year in Federal funding for homeless services. Federal resources used for prevention are widespread. The Emergency Food and Shelter Program funds (\$153 million during the most recent year), for example, are distributed through 11,000 agencies in 2,500 jurisdictions across the country. State and local funding streams are also used, as are charitable donations. In most communities, many social service agencies have some access to these resources and offer these prevention activities. These activities may be organized into a linked network, but more often are not.

The second set of activities, identified in Exhibit 1 as “Less Commonly Offered,” include the following: legal and other assistance to retain housing; mainstream agencies such as mental health, corrections, child welfare, and Temporary Assistance for Needy Families (TANF) agencies accepting their clients’ housing stability as one of their responsibilities; and various strategies to prevent homelessness that involve more than one public agency. These activities require more organizational commitment and a longer time perspective on the part of leadership. They are most commonly undertaken by mainstream agencies, alone or in collaboration with others, whose clients risk homelessness due to institutional discharge or the periodically disruptive nature of their conditions (e.g., serious mental illness). In general, CoCs offering the second set of activities reflect a high degree of investment by mainstream agencies, as well as homeless-specific agencies, to develop effective community-wide prevention strategies.

Finally, some CoCs mention some generic, antipoverty activities that seek to give people the skills to generate incomes sufficient to afford housing as homelessness prevention. Development of affordable housing is also an obvious, if expensive, long-term anti-homelessness strategy.

There is no simple correspondence between the prevention activities in Exhibit 1 and the primary-secondary-tertiary prevention framework introduced above. Many prevention activities can serve multiple purposes. For instance, budget counseling would be relevant for never, newly, and chronically homeless people. Likewise, permanent housing with supportive services may be used to keep someone with serious mental illness from ever becoming homeless (primary), as a way to move a newly homeless person with serious mental illness out of homelessness quickly (secondary), or for ending a 20-year spell of homelessness (tertiary).

That being said, most communities perceive the following activities as contributing mostly to primary prevention: counseling and advocacy; in-kind emergency assistance; and rent, mortgage, and utility cash payments. This perception arises largely because these are the activities most common in strategies targeting families and single individuals who are still in housing, but threatened with housing loss. In addition, discharge planning involving housing, often combined with supportive services to help maintain tenancy, tends to be associated with secondary and tertiary prevention efforts.



## IDENTIFYING COMMUNITIES TO STUDY

Given the wide array of activities undertaken in the name of homelessness prevention, the study team had to narrow the field to select communities to visit. Two criteria were specified by HUD: the prevention strategy had to be community-wide and have data to document prevention effectiveness.

- **Community-wide:** Primary prevention activities represent a conscious commitment of the community to do primary prevention. They go beyond the activities of a single agency to encompass the whole community in a structured and coordinated way, although they may have a specific population focus.
- **Data documenting effectiveness:** The community collected and analyzed data capable of showing that its prevention efforts did or did not prevent homelessness.

The study team sought to include prevention strategies that represented the full range of activities, and selected some that attempted to prevent first-time homelessness among families—using primarily the first four activities in Exhibit 1—and others that attempted to prevent homelessness among populations at high risk due to mental illness or institutionalization. Finally, with knowledge based on extensive prevention research literature that appropriate targeting is the key to efficient and therefore, effective prevention, the study team looked for communities with systematic strategies to determine the homelessness risk level of the people the community might potentially serve.<sup>8</sup>

The study team's canvass to identify relevant communities began by contacting sources identified in WRMA's and UI's previous studies of homelessness, as well as national experts on homelessness, state and local agencies, and mental health and homelessness consortia. Requests for candidates stressed the requirement that the communities have data because experience indicated that requirement would be the hardest to meet. This indeed proved to be the case. The "community-wide" criterion also posed challenges, as key informants sometimes knew contacts at individual programs pursuing prevention activities but, upon further inspection, these programs were not part of community-wide efforts.

The canvassed communities were neither a comprehensive nor random sample of what communities in the United States are doing to prevent homelessness. Rather, the study team used knowledgeable people to identify potential communities to include in the study. The various key informants were able to suggest 45 points of contact at various agencies in 28 communities. More communities might have been included if the only criterion had been "community-wide," but the requirement that the community have relevant data narrowed the selection.

Contacts in all 28 communities were interviewed by phone to determine whether their communities met the study criteria. Even among these 28 that had been specifically recommended by people aware of the selection criteria:

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<sup>8</sup> For homelessness prevention, the best summary is Shinn et al., 2001.

- Nine were found to be single programs that were not part of a community-wide strategy and were dropped from further consideration;
- Ten had strategies for preventing homelessness among families;
- Nine served specialized populations, such as people with serious mental illness, ex-offenders, and youth; and
- Most communities did not have data capable of assessing effectiveness at preventing future homelessness among families and individuals receiving prevention assistance.

Among the communities with community-wide strategies, the study team selected six sites for further study. These sites had relevant data and the promise of being able to assess future homelessness among people receiving prevention aid. The lead agencies in these communities were:<sup>9</sup>

- Hennepin County Human Services Department in Minnesota;
- Montgomery County Department of Health and Human Services in Maryland;
- Mid America Assistance Coalition in Kansas City, Kansas and Missouri;
- Department of Mental Health serving the Commonwealth of Massachusetts;
- Office of Behavioral Health in Philadelphia, Pennsylvania; and
- Urban Peak, a private nonprofit agency in Denver, Colorado.<sup>10</sup>

Among these six study communities, one can find virtually every prevention activity identified in Exhibit 1, although they varied in their combinations and population focus. The first three communities listed above were included to examine their strategies for primary homelessness prevention for families. The next two were included to examine their strategies for primary and secondary prevention with people with serious mental illness. The sixth site (Urban Peak) was selected because it served homeless youth—an important population to understand from a prevention perspective. Exhibit 2 shows the sites and the types of systems they represent.

**Exhibit 2. Study Sites**

		Community-Wide Strategies with Specialized Populations	
			Homeless and Runaway Youth
Hennepin County	X		
Montgomery County	X		
Mid America Assistance Coalition	X		
Massachusetts Department of Mental Health		X	
Philadelphia		X	
Urban Peak			X

<sup>9</sup> Appendices A–F present the findings from the in-depth reviews of the six communities.

<sup>10</sup> Throughout this report, public agencies are designated by the name of the community they serve, e.g., Hennepin County ; Montgomery County; Philadelphia; and Massachusetts. The two remaining sites are referred to by their names: Mid America Assistance Coalition (MAAC) and Urban Peak.

## STUDY DOMAINS

The difficulties noted above in targeting prevention to those at highest risk—identifying and implementing effective strategies, stimulating investment in prevention, and documenting effectiveness—drove the study’s exploration of homelessness prevention in the six communities. The study team examined the following domains of inquiry, for which examples of questions posed during site visits are provided.

- How the Strategy Evolved and Why It Took the Form It Did
  - What was the context and history under which the prevention policies or programs were established?
  - If alternative strategies or activities were considered, how were the current ones decided upon?
  - How did the community define the at-risk population? Why that population and not others?
  - How much multiagency coordination was involved in developing the strategy?
  
- Who the Strategy Served and How They Were Identified
  - Who did the strategy serve? How were they found? How was risk assessed? How was eligibility restricted to those at highest risk? To what extent could the strategy successfully target its services to the at-risk population?
  - How did the community decide what prevention activities were likely to be most effective for the target population?
  - If one subset of the at-risk homeless population was targeted, were there other policies or programs to respond to the needs of other at-risk populations in the community? How did the strategy fit into the broader local effort to aid homeless people, frequently called the “Continuum of Care?”
  
- What Prevention Activities Were Offered and How They Were Organized
  - What programs, services, and activities were offered?
  - How was the strategy administered? How much multiagency cooperation was involved in implementing the strategy?
  - What changes in policy were required to establish the strategy to preventing homelessness?
  - Did the community consider any aspects of the program to be controversial?
  
- How the Strategy Was Funded
  - What funding sources were used for the strategy?
  - How was the community induced to invest resources in the prevention strategy?
  
- Available Evidence of Effectiveness
  - What outcomes were achieved?
  - Was the agency able to document these outcomes? What types of evidence were available?
  - What additional quantitative and qualitative measures might be used by community-wide homelessness prevention programs to determine their

effectiveness, and how could these measures be incorporated into the Homeless Management Information System?

The study team conducted site visits to the six communities to collect qualitative information pertaining to the above domains. Study team members interviewed the people who designed the community's strategy, supervisors, front-line staff, contract agency staff, and collaborators. Between 11 and 74 people were involved per site, depending on the complexity of the prevention strategy. Meetings with information technology staff provided specific information about the relevant data systems, the data collected, and how sites could analyze these data to assess the effectiveness of their homelessness prevention programs. Representatives at each site reviewed for accuracy what this report says about their community and its activities for preventing homelessness.

### REPORT ORGANIZATION

The four remaining chapters report the study's findings and implications:

- **Chapter Two:** A summary description of each site including how the community developed its commitment to prevention; the population served and targeting strategies; components and organization of the community strategy; data collection and use; and the strategies' relationship to the CoC and Homeless Management Information System within the jurisdiction.
- **Chapter Three:** A description of the study communities' data systems, current use of outcome measures, the outcomes the communities have been able to measure, as well as recommendations for additional data collection and analysis of homelessness prevention programs.
- **Chapter Four:** A cross-site analysis of the common themes that appear to be salient to the development and implementation of a community-wide homelessness prevention program, differences depending on the populations served and the level of prevention attempted, ways the communities developed commitments, and useful tactics.
- **Chapter Five:** The implications of these findings for local communities in terms of policy, practice, and future research.

Appendices follow, describing the six study communities' prevention strategies in detail (Appendices A–F). Each site appendix includes:

- A brief description of the jurisdiction and a list of practices of potential interest to other jurisdictions;
- The history and context of the strategy for preventing homelessness in the community and gaining organizational and funding commitments and collaborations;

- Information on the administration and organization of services and targeting strategies; and
- A description of the data collection and documentation processes. Also identified are potential future analyses.

Appendix G provides additional information on the study methods, including the initial canvass of the 28 communities. Finally, Appendix H supplies a glossary of acronyms used in the report.

## **CHAPTER TWO**

### **SUMMARY DESCRIPTIONS OF SITES**

This chapter provides a summary overview of each of the six communities selected for this study, and places their prevention activities in the context of the prevention activities identified in Exhibit 1. Each community is described in terms of five main topics:

- **Developing the Commitment to Prevention**—how the community developed its strategy and made and sustained commitments with community partners;
- **Population Served, Targeting Strategies**—how and why the community selected its target population, a description of the target population, and techniques for improving the odds of serving only those at highest risk of homelessness;
- **Components and Organization of the Community Strategy**—programs and services, and how the community organizes and administers them;
- **Data Collection and Use**—the data the community collects, by whom, and how they are used, e.g., for monitoring, feedback on goal achievement, quality control, and advocacy (examples of documentation for specific outcomes are discussed in Chapter Three); and
- **Relationship to Continuum of Care (CoC) Process and Homeless Management Information System (HMIS)**—the role that prevention plays within the larger homeless assistance system and how it is integrated into the local HMIS.

The three sites we visited to examine their homelessness prevention strategies for families are described first and include Hennepin County, Montgomery County, and the Mid America Assistance Coalition serving Kansas City. The three sites that focused on longer-term, more intensive interventions with persons who were seriously mentally ill and with homeless youth are summarized next. These sites include the Massachusetts Department of Mental Health and the Philadelphia Office of Behavioral Health, followed by Urban Peak.

Descriptions of the Hennepin County strategy for family homelessness prevention and the Massachusetts Department of Mental Health’s strategy for preventing homelessness among people who are seriously mentally ill are described at greater length than other community approaches because these two communities represent the most fully developed and systematically implemented strategies found among the six study sites. A more detailed description of each of the study sites can be found in Appendices A–F.

## **HENNEPIN COUNTY, MINNESOTA**

In Hennepin County, the Human Services Department administers the Family Homeless Prevention and Assistance Program (FHPAP), which is an umbrella program with components focused on homelessness prevention for families and adults, rapid exit from shelter for families and adults, transitional housing for families, and programs for youth. The study team focused on the components of homelessness prevention and rapid exit for families. Private nonprofit agencies, under contract to the Department, provide most of the services. Agencies may participate in any or all of the FHPAP components, depending on their areas of competence. Federal, state, and county monies fund the program, with the bulk of the money coming from the state FHPAP.

### **Developing the Commitment to Prevention**

Hennepin County has traditionally been a jurisdiction that takes seriously its responsibility “to promote the general welfare.” With respect to family homelessness, the County Board of Commissioners has a long-standing policy that the county will do what it takes to assure that no family spends the night on the streets. Several factors help explain why the county was motivated to create its current system of homelessness prevention, why families are the primary target population, and why it has succeeded to a considerable extent. These factors are:

- The county’s commitment to prevent all family “street” homelessness;
- The county’s investment in sheltering families—the county pays for this shelter through contracts with shelter providers;
- The county’s ability to shape and control the various parts of the system through contractual arrangements;
- The county’s facilitation of extensive collaborative networks of providers and inclusion of many influential stakeholders on the FHPAP Advisory Committee; and
- The county’s use of data to facilitate daily assistance to clients and to provide daily, monthly, and annual feedback to improve the system, including contract monitoring and nonrenewal of poorly performing contractors.

The first critical year for family homelessness prevention and sheltering in Hennepin County and the state as a whole was 1993. Facing the reality that the system could no longer adequately serve the increasing number of homeless families, county officials in the Human Services Department decided that they needed to do something very different. In addition to beginning to charge families for shelter, the county looked for a way to stem the tide of family homelessness. The county’s Human Services Department worked with the Minnesota Housing Finance Agency to draft creative legislation that authorized FHPAP, and the Minnesota Housing Finance Agency administers the program at the state level. The FHPAP legislation established a set of outcomes related to preventing family homelessness, including shortening lengths of stay in shelter, preventing first-time entry into shelter, and eliminating shelter re-entry. FHPAP is a statewide

program, with Hennepin County receiving the most funding because it serves about one-half the state's known homeless population.

FHPAP provides flexible outcome-based funding, which is an extremely valuable commodity. It allows grantees to do “whatever it takes” to prevent homelessness, with the exception of paying for shelters, building housing, or subsidizing housing for more than 24 months. Contractors apply for funds every biennium and are awarded funding based on outcomes accomplished, or on outcomes proposed if they are new contractors. Initially designed for families and youth, the state added single adults to the program in 1998. However, the county uses the bulk of its FHPAP funding to prevent family homelessness.

Even with FHPAP resources, the number of sheltered families did not decrease in Hennepin County and indeed began to grow. A second crisis year was 2001, during which homeless families overflowed available shelter and hundreds were placed in motels without significant services to help them leave shelter. Managers from the Human Services Department realized that they had to use their resources “smarter,” as the resources were not going to increase. To cope with not having a system that could ensure that shelter resources would be used for the families with the most barriers to housing, and who needed the most help, the county began to develop a shelter screening and admission system to control access to only those families. This process required several iterations, trying different things, assessing their effects, and revising. The resulting screening and admission system cut shelter length-of-stay by one-half (to just under 30 days, on average), reduced the number of families in shelter on any day by 63 percent, and assured that only families with serious and multiple barriers to housing receive shelter services (with the remainder receiving referral to the prevention component of FHPAP). The system is structured around two essential components, a precise and demanding screening tool and strong casework supports to help families leave shelter and keep them in housing thereafter.

### **Population Served, Targeting Practices**

This study looked at two FHPAP components, both focused on families. The first is primary prevention for families still in housing; the second is secondary prevention for families in shelter.

#### ***Homelessness Prevention***

The family homelessness prevention component of FHPAP operates through 17 nonprofit agencies that offer a variety of emergency assistance and other social services. All roads lead to one of these agencies; they are well known and highly publicized as the source of emergency assistance and receive referrals from many sources, including 211 (the local information and referral hotline), churches, schools, city and county agencies, and other nonprofit service agencies. Each agency has its own screening procedures, but criteria for receiving help paid for by FHPAP are uniform. The family must be threatened with housing loss from past failures to pay rent or other situations leading to eviction, *and* resolution of the crisis situation must be in sight. These criteria usually mean that past nonpayment of rent has been due to illness or job loss but that someone in the family will soon have an income sufficient to cover future housing costs.



In addition to assessing the amount of arrearages or danger of housing loss and the promise of future relief, FHPAP prevention agencies also examine the family's personal resources and savings, those of relatives or friends, budgets and spending habits, credit history, rental history, and other factors. This information is used to determine how desperate and lacking resources the family truly is, and what the family might be able to do for itself. It is rare that a family receives full payment from an FHPAP provider; providers insist that the family contribute something to resolve its immediate difficulties. How much the family is asked to contribute depends on the caseworker's judgment about available resources. These probes and other practices (e.g., working with the family to develop a realistic budget, including helping them move to a smaller apartment if necessary) are the FHPAP providers' way of assuring that the most resources go to the families who need them the most and who have the highest risk of homelessness if they do not receive assistance.

### ***Shelter and Rapid Exit***

Families without housing and who are seeking shelter do so through the Human Services Department Shelter Team. At first contact with a family, a Shelter Team worker probes to determine if the family has any alternatives to entering shelter, including family or friends with whom they could stay. If not, the family receives a voucher for shelter, but only for the number of days (usually one to three) that it takes for the family to meet with the rapid exit coordinator for screening. This is a very thorough screening that requires about one hour and covers a wide range of housing barriers. (This housing barrier screening is more fully described in Chapter Four.) The county has established four levels of housing barriers and tries to reserve emergency shelter only for families at the two highest levels. Since instituting rapid exit screening procedures in 2001, representation of the two lowest levels has decreased from 55 percent in 1995 and 43 percent in 1998 (before the procedures began) to 2 percent in 2003.

### **Components and Organization of the Community Strategy**

Family homelessness prevention services are organized separately from family shelter services. All are funded through county contracts and managed and monitored by the FHPAP Umbrella Program manager. The Umbrella Program is also overseen by an Advisory Committee that serves many useful functions, from reviewing proposals and contract performance, to lobbying the legislature, to participating in strategic planning for the county's FHPAP.

Seventeen nonprofit agencies run the prevention services. They are organized by geographical catchment areas, with families being served only by the agency covering the area of its current or most recent address. These agencies screen families and decide which families should receive prevention assistance, and what types of assistance they should get. Contact between FHPAP prevention providers and families around a threat of housing loss is usually relatively short (several months at the most, and usually less), although families may use other services of the same agency (e.g., food, clothing, and transportation assistance) at other times. If a family needs a service that a particular FHPAP provider does not offer (e.g., car repairs, certain types of job training, or adult basic education), the providers refer among themselves to an agency that does have that service. FHPAP providers try not to duplicate these specialized services, and each has

its specialties. In Minneapolis, FHPAP cash assistance is a grant; in the suburbs the prevention providers decided it should be a loan. Suburban families who received assistance are now repaying about \$40,000 each year to the program, and many say they are happy to be able to help other families in trouble as they once were.

All families receiving county-vouchered shelter go to one 116-unit facility in Minneapolis. The county pays this facility for sleeping accommodations and three meals a day, but not for services. All services to homeless families are contracted to nonprofit agencies offering rapid exit services. The rapid exit coordinator, who did the intensive screening, will refer the family to a rapid exit program that does all services. This structure evolved from the county's belief that it was smarter, and avoided even an apparent conflict of interest—to separate the work of providing shelter from the work of helping people leave shelter. The rapid exit agency assigns a caseworker to work with the family to develop a housing stabilization plan. The plan includes action steps and timetables; continued shelter stay is contingent on the family cooperating with the rapid exit caseworker and the plan.

The rapid exit caseworker attends mostly to the housing portion of the plan and uses community resources for additional services. Ongoing services are coordinated by a Shelter Team worker who is responsible for identifying other county services with which the family is involved (e.g., public assistance, employment services, child welfare, and services to the disabled), notifying county caseworkers that the family is in shelter and is receiving housing services, and coordinating the family's various service requirements. The rapid exit caseworker helps the family find housing, leave shelter, and stabilize and sustain housing through six months after the family leaves shelter.

All FHPAP contracts are awarded annually based on responses to a very carefully worded request for proposals (RFP). Numbers of families to serve and expected outcomes are specified. Agencies may “do what it takes” with FHPAP resources to achieve those outcomes. FHPAP does not monitor types and amounts of services delivered, only outcomes. Some agencies thrive in this environment, while others do not. The FHPAP manager uses performance data to identify successful agencies and reward them with continued contracts. Agencies that do not achieve the required outcomes receive assistance to correct their performance. If performance does not improve, the contract is not renewed. The Advisory Committee's involvement with this process helps to keep it as peaceful as possible.

### **Data Collection and Use**

The Human Services Department contracted with the Wilder Foundation, a local research organization, to develop and maintain an automated client database to meet FHPAP program needs. All FHPAP providers currently use this database. Agencies maintain current and historical data on the characteristics of the client families and the services they receive. Caseworkers can see the service history of their clients, and can also check to see if the client has received services from other FHPAP providers. FHPAP agency managers track their own agency performance for clients served, service history, resource use by funding source and month, client flow from month to month, outcomes achieved (for rapid exit providers, these include shelter exit and months of maintaining housing), and other managerial issues.

Every month, FHPAP agencies copy their databases and send them to the Wilder Foundation, where the database manager assembles them into a system-wide database. The system manager routinely uses this system-wide database to assess program performance, both overall and for each agency. She checks for possible duplication of services, funding drawdowns, and client outcomes, among other things. Each year, FHPAP data are compared to the county's records of families using emergency shelter to determine if families who received prevention or rapid exit services had a shelter episode during the 12-month period following their receipt of assistance. The system manager also uses FHPAP data to monitor if the provider agencies achieved the outcomes specified in their contracts for services.

### **Relationship to CoC Process and HMIS**

Individual FHPAP providers and the Umbrella Program manager participate in the CoC planning and application process, but another agency has the lead. The FHPAP data system was developed before the advent of HMIS. The data system contains the data elements required for HMIS, but also contains other data elements that are useful to FHPAP. The program was told to use HMIS, rather than uploading relevant data from its own system. To maintain its own operation, which depends on using its own data system, FHPAP is now doing double data entry to retain its own system while complying with HMIS demands.

### **MONTGOMERY COUNTY, MARYLAND**

For more than 20 years, Montgomery County government, in partnership with the nonprofit community, has provided funds and services to prevent evictions for those at risk of homelessness. With respect to family homelessness, the County Council has a long-standing policy (since 1987) that no family spends a night on the streets; it supports this policy by paying for shelter. The extreme pressure of housing costs in the county, and the commitment to shelter every family who applies for assistance, drives the response to families in crisis in Montgomery County. The county has a unified system for access to homelessness prevention, emergency shelter, and transitional housing for families. The lead agency is the Montgomery County Department of Health and Human Services (MCDHHS), which is also the lead agency for the county's CoC.

### **Developing the Commitment to Prevention**

Montgomery County began serving families and individuals at risk of homelessness during the early 1970s, but these services took several years to evolve into a community-wide approach to homelessness prevention. Early on, responsibilities were split between a state and a county agency. The state Department of Social Services provided eviction prevention services to help families and individuals with past due rents and utility bills, while the county's Department of Family Resources partnered with the nonprofit community to develop and provide emergency shelter. In 1987, new leadership at the Department of Social Services recognized that prevention was an essential part of a continuum of services to address the growing problem of homelessness. The local office of the Department of Social Services assumed leadership for both

the prevention services and the contractors providing emergency shelter services, but initially only for families. This was the genesis of the unified entry system for homelessness prevention, placed in the new Department of Social Services, Division of Emergency Services.

During 1995, the nonprofit community organized the Emergency Assistance Coalition. This coalition coordinates a regional network of 40 nonprofit agencies that work with the county to distribute public and private resources to prevent eviction. This public-private partnership is the basic structure of family homelessness prevention activities in Montgomery County today.

Also during 1995, another public agency reorganization occurred, bringing what had been a state agency's local office for social services together with three county human services agencies (health, mental health, and family resources) to form the MCDHHS. This move officially united homelessness and other social services, which improved the access of families and individuals to an array of important services. The move also brought together agency directors and staffs that often had their own ideas. No single leadership structure has yet emerged to make system-wide assessments of resource availability, identify the points of maximum payoff for investing those resources, and orchestrate the changes that would be needed to shape a more efficient primary and secondary prevention system.

### **Population Served, Targeting Practices**

MCDHHS provides emergency services to any family or individual who requires financial assistance to remedy an eviction, foreclosure, or utility disconnection. When the system combining family prevention and shelter began in 1987, the first and most important change involved establishing triage, screening criteria, and priorities for which families would be sheltered and which would receive prevention assistance. The county established standardized procedures to assess level of need and develop a service plan, placing the responsibility on the family to address the issues that led to its homelessness.

Screening criteria include having a verifiable county address and being in a short-term financial crisis rather than an ongoing condition. Prevention efforts focus on families or individuals whose inability to pay rent stems from a temporary illness, job loss, or other short-term problem, and for which returning to work or a new job or income source is verified. The MCDHHS Emergency Services worker determines that the family will be able to maintain housing following receipt of the cash payment and other assistance for one month. The worker assesses the precipitating factors that led to the housing crisis and reviews the family's income sources and budget to determine the feasibility of paying housing costs in the future. The family develops a service plan and agreement with the worker to resolve the housing crisis and must complete required action steps of the service plan before payment is authorized to the landlord or utility company. For example, a family member may be required to attend drug screening or treatment, obtain credit counseling, or apply for income supports and entitlements.

The screening process for access to congregate shelter services is more comprehensive than the screening process for eviction prevention assistance, to ensure that emergency shelter is offered only as a last resort to those families with the most serious barriers to housing. MCDHHS will not provide financial assistance if a client at risk of eviction or foreclosure has arrears in excess

of several thousand dollars. Further, if the client or family is involved in a recidivist situation and has never followed through on a service plan to resolve the crisis, MCDHHS may deny assistance. Households with financial crises that exceed the department's guidelines receive a referral to the nonprofit Emergency Assistance Coalition, which is a group of nonprofit agencies that may provide eviction prevention funds, utility assistance, food, clothing, transportation, and other goods and services.

### **Components and Organization of the Community Strategy**

Families must apply in person for emergency assistance or shelter at one of the three regional county centers. Social workers screen clients, determine needs, enter relevant data into the MCDHHS client database, and make the relevant referrals or service linkages. Access to homelessness prevention services is co-located with assessment for shelter services. In addition, co-locating homeless prevention services with mainstream services provides access to screening, history, and eligibility determination information not only for emergency assistance but also for mainstream resources such as Temporary Assistance for Needy Families (TANF), medical assistance, and food stamps.

Most of the actual services and supports available to families facing housing loss in Montgomery County are provided by a network of nonprofit agencies organized through the Emergency Assistance Coalition. In addition to the usual range of services, MCDHHS works extensively with landlords and with the Housing Opportunities Commission (the county's public housing authority) to negotiate accommodations on the part of both landlords and tenants to prevent eviction.

### **Data Collection and Use**

The county collects data on recipients of emergency housing assistance using three automated systems. One system tracks clients, a second distributes payments, and a third manages shelter and other contracted services. The nonprofit agencies do not have access to the county systems, but the county uses them for a variety of management functions. MCDHHS also routinely checks against the Sheriff's eviction database to see if households that received prevention assistance were able to retain their housing.

For the past five years, the department has used a manual process to track the outcomes of emergency assistance recipients. Client data are obtained from several systems to determine the outcomes for those who have used shelter. As part of this study, data sets were merged to determine the percentage of people who entered emergency shelter within 12 months following the prevention intervention.

### **Relationship to CoC Process and HMIS**

MCDHHS is the lead agency for the unified system for access to homelessness prevention, emergency shelter, and transitional housing for families and is also the lead agency for the county's CoC. The Homeless Tracking System for Montgomery County does not include data on clients receiving emergency assistance or prevention services.

### **MID AMERICA ASSISTANCE COALITION**

The Mid America Assistance Coalition (MAAC) includes more than 175 nonprofit agencies that share the goal of improving emergency assistance services for low-income and homeless individuals in the greater Kansas City metropolitan area. Each of the social service agencies associated with MAAC provides a variety of services under its own budget. All agencies provide assistance with utilities payments as the primary homelessness prevention intervention. Services are coordinated using a shared information system. The goals and prevention strategies of MAAC have remained stable over the years of its existence, with the major change being the increasing number of agencies that have joined the network. The nonprofit agencies in MAAC do not have any significant public allies in pursuing their goal of preventing homelessness.

### **Developing the Commitment to Prevention**

As early as 1974, nonprofit agencies in the Kansas City metropolitan area that were offering emergency assistance services saw the need to organize among themselves to prevent clients from bouncing among providers and to assure nonduplication and efficient use of shrinking resources. During 1975, the first alliance of 21 agencies convened, with increasing numbers joining over the years until they created a new nonprofit, the Mid America Assistance Coalition, in 1984. MAAC's goal, shared by member agencies, was to improve emergency assistance provision to low-income and homeless individuals. To this end, MAAC merged centralized client tracking and information and referral services to improve accounting for services and payments, creating the data system known as MAACLink.

Funding agencies applauded this move, which they saw as helping to avoid duplication of services and track case management and funding accountability. Agencies participated in defining data system elements and information to track as well as management outcomes to report. This data system is the heart of MAAC and also defines the scope of collaboration. The data system has been upgraded numerous times, and new agencies have joined MAAC. Both the goal and the activities offered to reach it have remained consistent over the years. MAAC, and the homelessness prevention efforts in the greater Kansas City area, have not enjoyed significant participation or leadership from any public agency.

### **Population Served, Targeting Practices**

This study concentrated on MAAC's efforts to prevent homelessness among families, although single individuals are also eligible for the services of network agencies. There is no single point of entry for MAAC clients, but neither is there any wrong door. MAACLink allows a family to walk into any agency and either receive services or a referral to another agency that can provide services.

When a client enters a MAACLink agency, a staff person conducts a standard intake of basic client demographics. The major reason for screening someone out is too high an income (usually, above 150 percent of the poverty level) or too frequent or too recent use of a service similar to what is being sought. The agency also assesses the match between need and available assistance; if a client's need is more than the rent, mortgage, or utility payment the MAAC agency is authorized to make, referrals to more sustained help may be made instead of giving cash assistance. As is the case in Hennepin County and Montgomery County, MAAC agencies are looking for families with relatively short-term and limited need, albeit also those facing a crisis such as utility shutoff or eviction for nonpayment.

### **Components and Organization of the Community Strategy**

MAAC's nonprofit social service and emergency assistance agencies operate independently but are linked through the MAACLink data system. Services offered within the system include counseling and advocacy, in-kind assistance, and cash assistance for rent, mortgage, or utility payments (the activities listed in the first four rows of Exhibit 1). Some MAAC agencies also offer emergency shelter.

In addition to using MAACLink for screening, workers also use MAACLink to identify other pertinent service agencies that can provide services (within certain confidentiality restrictions). If a family's situation is beyond prevention, agencies can check shelter availability on MAACLink and refer the family to the appropriate shelter facility. MAACLink is thus the primary form of organization for member agencies. Although member agencies occasionally participate in collective advocacy for more resources, no system-level planning or strategy development activities are a significant part of MAAC.

### **Data Collection and Use**

The MAACLink data system is MAAC's main contribution to preventing homelessness. The system's capacity for data collection and analysis is broad. Any MAAC agency can see a client's service history including rental, mortgage, or utility assistance, as well as other services such as food, transportation, case management, or bed nights at a homeless shelter. Any service provided by any MAAC agency is recorded, making it easy to determine how frequently and recently a family received assistance as well as if the family has sought help from different agencies. Other unique aspects of the system include the ability to manage eviction prevention funds across the system so that workers can accurately refer clients; and the ability to view homelessness prevention and homeless shelter use in the same data system.

MAAC produces many routine reports in two major areas: services and fund utilization. Some reports describe clients, by demographics and service use. Others describe fund utilization, by fund (MAAC agencies manage more than 20 different emergency assistance funds) and the type of services it paid for, by agency, and many other breakouts. These reports are used by program managers to monitor and control expenditures, prevent duplication of services, and report to funders. Until the study team visited this community, however, the MAACLink data had never been used to see if families receiving assistance to prevent homelessness actually stayed out of emergency shelters for the 12 months after they received aid.

### **Relationship to CoC Process and HMIS**

The Homeless Services Coalition, an organization of homeless service providers, coordinates the greater Kansas City region's response to homelessness. Each county in the region pursues its own CoC planning and application process, and all adopted the MAACLink system as its HMIS in 2002. Of the six study communities, only MAACLink tracks both prevention and homeless services in the same HMIS. Sharing these data and the interagency communication channels have become the foundation for the region's CoC planning process.

### **MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH**

The Massachusetts Department of Mental Health (DMH) has invested heavily, both directly and indirectly, in addressing homelessness among persons with serious mental illness. Elements of homelessness prevention are present throughout the department's multifaceted system of inpatient and outpatient continuing care. Most of the department's core services are relevant to homelessness associated with serious mental illness. In addition, the department sponsors various initiatives to prevent first-time homelessness, to identify and move newly homeless clients or potential clients quickly out of homelessness, and to avoid chronic homelessness. The department's prevention efforts are supported primarily with state-appropriated funds, which the department uses to leverage the U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Health and Human Services (HHS) resources in its role as the lead agency for the CoC covering all areas of the state not included in city CoCs. Many of the department's prevention efforts are conducted through contractual arrangements with nonprofit and for-profit providers.

### **Developing the Commitment to Prevention**

DMH began to focus on homelessness among its clients during the early 1990s, recognizing that people were leaving state hospitals without adequate housing arrangements. In 1991, advocates and shelter operators in the Boston area documented a surprisingly high number of people in shelter who had come directly from mental hospitals. Strong advocacy parlayed this information into the first Homeless Initiative, providing DMH with \$1 million in 1992 to "do what it takes" to prevent or end homelessness for people with serious mental illness. Advocacy, coupled with DMH leadership and positive results from DMH activities, has sustained state commitment. DMH has been rewarded with steadily increasing state appropriations for the Homeless



Initiative, reaching \$22 million in recent years. DMH has additional service resources as part of its regular budget as well as access to capital resources for housing development from state funds. The capital resources are designed to move the investments once made in state mental hospitals into the community.

The department established homelessness prevention as a legitimate and important goal, which makes it one of only a few state mental health agencies to do so. It undertakes regular staff training to reinforce the attitude that “housing is a clinical issue,” meaning that appropriate clinical treatment cannot happen when clients are homeless or insecure in their housing. Over several years, the high risk of homelessness among people with serious mental illness and the need for a coordinated and strategic prevention approach were identified as critical issues. Closings of state hospitals, the continued pressure of advocates, and ongoing negotiations among various agencies maintained the issue in the public agenda.

DMH’s strategy for homelessness prevention is multifaceted, based on the recognition that people with serious mental illness may face the risk of homelessness from various causes. Supportive services to keep people in housing, respite beds to relieve caretakers, caseworkers to monitor stability and identify problems early, and providing housing are all activities that may keep people from becoming homeless for the first time or a subsequent episode. Discharge planning, coupled with developing housing to provide discharge options, prevents homelessness for people who were homeless at hospital admission or who lost their housing while hospitalized for an extended period of time. Outreach to find homeless people with serious mental illness who are not yet DMH clients shortens homeless spells for both first-time and chronically homeless people. DMH has pursued all of these activities. Most importantly, it has systematically developed an extensive network of housing options, leaning heavily toward the independent and semi-independent living situations that clients prefer and away from group homes.

DMH has used its extensive funding and strong leadership to pursue a long-term strategy of system development that has been sustained through three commissioners, as many governors, changes of political party, and state budget crises. Its strategy involves leveraging Federal funding with its own resources; the Homeless Initiative’s \$22 million annually of state funding leverages about \$85 million in Federal funding each year. DMH also has strong collaborative relationships with other state agencies that control additional resources (e.g., health, community development, housing finance, public housing authorities, employment and training, corrections). Some examples of these collaborations are listed below.

- An agreement with MassHousing, the state’s housing finance agency, ensures that 3 percent of all units developed with MassHousing financing are directed to DMH and the Department of Mental Retardation to house people with serious mental illness or mental retardation. DMH clients now lease more than 400 such self-contained, scattered-site units.
- An agreement is in place with the Massachusetts Department of Housing and Community Development to operate several state-funded programs. Among these are a rental assistance program serving more than 600 DMH clients, a bricks and mortar housing development program through statewide Department of Housing and Community Development grants to local housing authorities for DMH and Department of Mental

Retardation clients with a DMH capacity of more than 600 clients, and special project-based voucher allocations to DMH housing development projects.

- The Massachusetts Department of Housing and Community Development operates the Facilities Consolidation Fund bond program, providing grants and loans to nonprofit developers to develop DMH and Department of Mental Retardation housing and to house homeless persons with serious mental illness. The Fund was established in 1992 with bonding authority to invest capital into community-based housing instead of state hospital campuses. DMH has used the Fund to help develop 83 housing projects for 658 of its clients.
- Agreements with the state's Department of Capital Asset Management ensure housing for DMH clients as part of rental housing projects being developed on five former DMH state hospital campuses.
- Area housing coordinators for local Continuums and DMH central office staff participate in the CoC application process through DMH.
- DMH collaborations with Housing Courts, MassHousing, and some local housing authorities have created several Tenancy Preservation Projects throughout the state. Tenancy Preservation Projects mediate in landlord-tenant conflicts in which tenants with serious mental illness or substance abuse issues are threatened with eviction.

DMH's funding has helped to create partnerships with nonprofits to develop permanent housing with supportive services, supports for community living such as Assertive Community Treatment teams and Clubhouses, and employment and training opportunities. It also contracts for health, mental health, and substance abuse services with a for-profit managed behavioral health care organization, leveraging Medicaid dollars with its own resources for those who do not qualify for Medicaid.

### **Population Served, Targeting Practices**

DMH estimates that approximately 48,000 adults in the state have serious mental illness—the department serves the most disabled and the poorest. Its clients' incomes hover around 15 percent of the area median income and most clients are not employed. These circumstances leave them vulnerable to homelessness should hospitalization or loss of a caretaker disrupt their housing arrangements. Targeting is a matter of clinical assessment to determine if a person's mental illness meets state and Federal criteria for becoming a DMH client. DMH outreach teams actively look for clients and potential clients among homeless people on the streets and in shelters. Identification of potential clients triggers further assessment, formal enrollment as a DMH client, and efforts to help the person move to safe and stable housing. The characteristics that make a person DMH-eligible signify a level of disability indicating a high risk of homelessness if the person has no family or obvious means of support.

To reach homeless people, DMH locates mental health services at the four largest traditional shelters in the state, all operated in Boston by private agencies. These services help shelter guests directly, but also make referrals to other services to help guests determine if they are eligible for DMH continuing care services. If eligible, their prospects for ultimately becoming housed and receiving ongoing community supports through DMH increase substantially.

DMH also has developed transitional shelters affiliated with Metro Boston's mental health centers. These transitional shelters are better prepared than generic shelters to keep people with serious mental illness safe and help them handle their mental health and other issues. Every effort is made to move homeless people with serious mental illness from traditional emergency shelters and the streets to more appropriate settings such as these transitional shelter facilities and, ultimately, into permanent housing.

### **Components and Organization of the Community Strategy**

Since this "community" is an entire state and DMH has responsibility for all of it (counties have little effective role in Massachusetts), its structure of services and oversight is more complex than the other communities included in this study.

The importance DMH places on housing is signified by having a Housing Coordinator in all six of the state's Service Areas, as well as three staff at the state level focused on housing. All participate in the CoC planning and application process, which DMH leads for the balance-of-state application. DMH-affiliated housing has grown from about 2,750 units in 1991 to about 7,650 units in 2004, while changing the mix from mostly group homes to mostly independent and semi-independent living, which clients greatly prefer. DMH uses its housing options at every level of prevention, and provides supportive services in the community to help people maintain their current housing. Secondary prevention efforts are coordinated through outreach to people on the streets and in shelters. People with serious mental illness are identified when they first become homeless and become DMH clients if they are not currently being served. The agency helps these individuals to move to safer and more appropriate accommodations, including permanent housing with supportive services.

DMH interventions span the entire range of primary, secondary, and tertiary homelessness prevention services. Specialized DMH shelters offer short-term solutions that are safer and more appropriate than ordinary shelters for people with serious mental illness. Discharge planning and housing assistance are offered to individuals leaving inpatient care or people with serious mental illness leaving correctional facilities who are at imminent risk of homelessness, are currently homeless, or have been homeless. Community supportive services help people maintain housing regardless of their history of homelessness. Housing Courts work with DMH-funded local mediators to seek solutions with tenants and landlords to prevent eviction and subsequent homelessness. Evidence analyzed for this study indicates that these tenancy preservation activities do reduce the incidence of homelessness.

## Data Collection and Use

DMH maintains extensive data in multiple databases and case records. Its commitment to resolving homelessness among its clients is attested to by the modification of its statewide client database during the early 1990s. At the time, DMH added fields for recording homelessness at admission and at discharge. In a system as large as DMH, it was no surprise that the pertinent data for this study's purposes was dispersed among various information systems and various locations. One analysis for the current study tracked the number of homeless admissions and discharges from continuing care facilities. The analysis found reductions in homelessness at admission and even greater reductions in discharges to homelessness between 1991 and 2004.

DMH staff working with clients have always had access to client records for treatment purposes, but until recently the department had not systematically documented its success at preventing homelessness or used data for system improvements. DMH uses discharge and related data to focus on several fronts. The Metro Boston area office uses its discharge data to assess how well its current system is performing, and to identify gaps in resources as well as populations not currently served that need assistance. Results lead to efforts to fill gaps. Data from the Western Massachusetts Tenancy Preservation Project has been used to argue for more interagency recognition and support for expanding that program and related Tenancy Preservation Projects throughout the state.

Some new data uses emerged following work on this project, including:

- DMH has made major changes and updates to its overall client enrollment and services tracking data system, including new and revised definitions for homelessness, at risk homelessness, former homelessness, and discharge destinations.
- DMH has made arrangements with its central information system director to get routine reports on clients who are homeless upon application for eligibility for DMH services. These people will be tracked to learn how effectively DMH can house them, what services work best, if they are rehospitalized, and the like.
- Another direct outcome of working with the study team is that DMH is working with DMH Area Offices to confirm that DMH clients who were reported as discharged to homelessness actually were and, if so, to explain how this happened. DMH has never done this before and expects to make it a regular practice. The central office monitors local DMH discharges to homelessness; learns about the situations that might lead to these discharges; and highlights gaps in local use of the statewide information system, which could lead to misinterpretation and miscoding of discharges.
- Data on homelessness prevention are also being used to inform workshops and workgroups associated with Boston's project under the HUD/HHS/Veterans Administration Chronic Homelessness Initiative and to stimulate improved data sharing and client tracking across public systems.

## **Relationship to CoC Process and HMIS**

DMH staff in all areas have participated in local CoC processes since their inception; DMH participates at the state level in the balance-of-state application, for which the Department of Transitional Assistance is the lead agency. Much of DMH's permanent supportive housing is financed in part through McKinney-Vento funds. The Department of Transitional Assistance runs the state's HMIS. DMH data systems run independently of HMIS, although any housing projects funded with Supportive Housing Program dollars contribute data to HMIS.

## **PHILADELPHIA, PENNSYLVANIA**

Philadelphia has a long history of organizing to address homelessness, and an even longer history of organizing to address the needs of people with serious mental illness and other behavioral health issues. Strategies, programs, and services in the homelessness and behavioral health systems often overlap, in recognition that the same people are often clients of both systems. For this study, the study team concentrated on the role of the city's Office of Behavioral Health (OBH) in developing and implementing homelessness prevention activities for its clients.<sup>11</sup>

### **Developing the Commitment to Prevention**

Preventing and alleviating homelessness among people with serious mental illness has been on the agenda in Philadelphia for a very long time. Several mayors have supported strong city investment in social services and behavioral health services, and have appointed dynamic staff to make these services work. Respondents frequently mentioned the influence of Estelle Richman, who for at least 10 years increased her breadth of control until she became the Deputy Managing Director for Social Services before moving to the state level when the mayor who appointed her became governor.

Richman's creative bureaucratic negotiations during the mid-1990s established the city's Behavioral Health System, which is now formalized as OBH. OBH comprises the Office of Mental Health, the Coordinating Office of Drug and Alcohol Abuse Programs, and Community Behavioral Health, the city's own Medicaid managed behavioral health care system. Together, these agencies offer prevention, outreach, substance abuse, and mental health services for people with serious mental illness or substance abuse problems. Services are delivered largely through contracts with nonprofit agencies.

Richman saw from the beginning that housing was part of the solution to preventing homelessness among people with severe behavioral health problems. The directors of the Office of Mental Health and Coordinating Office of Drug and Alcohol Abuse Programs, who ultimately answered to her, supported development of housing and service options that continue to play preventive roles in keeping disabled people off the streets. Many city officials interviewed by the

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<sup>11</sup> The history, structure, and accomplishments of the homeless assistance system in Philadelphia, especially in reducing chronic street homelessness, were examined in a previous study (Burt et al., 2004).

study team considered themselves to be following Richman's example, "doing the right thing" first and handling bureaucratic consequences if and when they arise.

Outreach efforts to assist mentally ill homeless people on Philadelphia's streets, especially women, began during the early 1980s and expanded significantly during the late 1990s with the strong support of OBH. In the last five or six years, outreach has been combined with Safe Havens, permanent supportive housing, and other supports to create a complex system. Recent efforts under OBH guidance focus on preparing for an individual's moment of release from an institution such as jail or a psychiatric inpatient setting. They attempt to build supports, including housing, that will prevent entry or re-entry into homelessness.

During May 2004, Community Behavioral Health was in the final stages of developing standards for discharge planning that will span several agencies. These agencies will include the OBH agencies (covering people with mental illness, mental retardation, developmental disabilities, and substance abuse), homeless services, child welfare, and the county jail. The process of integrating services began in 2002, following the recognition that many clients had serious mental illnesses in addition to the problems that brought them to the attention of the various agencies. When the study team visited Philadelphia most of the envisioned prevention efforts had been implemented only recently or were just getting started.

### **Population Served, Targeting Practices**

Eligibility for OBH services is determined through detailed screening and assessment procedures. For people with serious mental illness, these procedures are geared toward identifying a level of mental illness that meets carefully defined criteria established by Federal and state standards for reimbursement under Medicaid and several additional funding streams. One does not have to be an OBH client at first contact to access OBH services, but one does have to meet eligibility criteria eventually. As these criteria include establishing a significant level of disability, they also serve to screen in people whose risk of homelessness, if left to them, is likely to be high.

Working with agencies that were involved in developing the discharge planning standards, OBH is beginning to develop strategies to prevent homelessness. A first step, data sharing to identify people at risk of homelessness, is happening between OBH and child welfare, the county jail, and homeless system intake. Clients identified through these mechanisms are connected to case workers. For child welfare this means learning that a parent's or child's serious mental illness is part of the reality of resolving a family's problems, so more appropriate solutions can be developed. For people with serious mental illness leaving jail or prison, OBH caseworkers help to find housing and assure some support in the community.

Another access point is at shelter intake, where OBH's efforts involve secondary prevention. A person seeking shelter who appears to be mentally ill may be referred to special psychiatric shelter intake units operated by the Office of Mental Health. In addition, OBH is starting to place triage staff at shelters to increase identification of persons with psychiatric impairments. The objective is to divert such persons to specialized shelter environments, where they can receive

assessments and services from OBH. This activity is designed to offer secondary prevention—keeping the period of homelessness as short as possible.

### **Components and Organization of the Community Strategy**

OBH serves individuals with serious mental illness whether or not they have had prior episodes of homelessness. Residential options and assistance to find stable housing are part of the service package, based on the belief that if OBH did not offer these types of support, these individuals would be homeless or very likely to become homeless, since they are both sick and very poor. Within OBH, the Office of Mental Health and the Coordinating Office of Drug and Alcohol Abuse Programs participate in both the regular behavioral health system and the homeless continuum of care for people with serious mental illness.

OBH agencies offer, usually through contracts with nonprofit agencies, the entire range of services one would expect of a public behavioral health agency. These include specialized emergency rooms; a variety of acute and extended inpatient settings; detoxification, hospital-based rehabilitation, and residential rehabilitation programs for substance abusers; respite and crisis beds and residences; outreach; Safe Havens; and nearly 3,000 residential beds in a variety of settings from no-demand to locked facilities.

For at least the past year, OBH and its component offices have been engaged in efforts to prevent homelessness among its clients with serious mental illness who are in the city jail or a state prison. Case management and other services are designed to connect people to appropriate housing in the very likely event that they will not be able to return to a previous residence. Linkages with other city agencies (child welfare, homeless assistance) to identify and intervene with people at risk of homelessness are also part of the organized community approach under the general leadership of OBH. They were described above.

### **Data Collection and Use**

Philadelphia is well known for its long-standing database with information regarding people using public shelters. Researchers at the University of Pennsylvania work with the city to link shelter, behavioral health, welfare, and corrections databases, and answer questions that are important for shaping public policy. Several public information systems contain data pertinent to the issue of primary and secondary prevention of homelessness among people with serious mental illness. These include databases on people leaving hospitals, people receiving housing through OBH agencies, people using shelters, and people being contacted by street outreach.

At present, staff working with households using any one of these systems may use their own system to assess the household's current status, receipt of services, place of residence, and other matters important to case management. OBH managers use the OBH database to decide whether to authorize additional services, analyze service use by individuals and for the client base as a whole, and in many other ways. OBH and child welfare caseworkers have recently gained the ability to check each other's data systems to determine if the client of one agency is also the client of the other, and to alter case plans accordingly. OBH also has the capacity to check the

homeless shelter database to ascertain homeless status or history for its clients. There is potential for increased use of these integrated data. Especially relevant for homelessness prevention would be the ability to match to the shelter database to determine if, after intervention, people experience homelessness and apply for shelter. However, this type of outcomes analysis is not happening routinely, and city analysts were unable to conduct these cross-system analyses for this study.

### **Relationship to CoC Process and HMIS**

OBH staff participate in Philadelphia's CoC process. Much permanent supportive housing in Philadelphia is financed in part through McKinney-Vento funds, including some affiliated with OBH. The Office of Adult Services is the lead agency for HMIS. OBH data systems run independently of HMIS, although any housing projects funded with Supportive Housing Program dollars already do, or will, contribute data to HMIS.

### **URBAN PEAK**

Urban Peak is a private nonprofit agency in Denver and Colorado Springs serving homeless and runaway youth as well as other youth who do not have stable or reliable housing. It provides a full continuum of services for homeless youth, and owns and operates permanent supportive housing for youth who want to leave homelessness. Urban Peak started as a small agency in 1988. Over the years, it has established collaborations with other service providers and gained a reputation through advocacy and persistence as the cornerstone and organizational heart of the Denver area's efforts to end youth homelessness. It is an example of what can be accomplished by way of secondary and tertiary homelessness prevention without the significant involvement of public agencies that four of the other communities in this study enjoyed.

### **Developing the Commitment to Prevention**

In response to the increasing number of homeless youth gathering in the Denver area, Urban Peak opened during 1988 with a small annual budget provided by the Capital Hill United Neighborhood Association. At that time, the agency provided only food and basic counseling services. During 1992, the agency incorporated and expanded services to include a 20-bed youth shelter. Its focus from the beginning has been the population of street youth and other youth with no stable or reliable housing visible on the streets of Denver.

The story of Denver's strategy for youth homelessness is really the story of how a nonprofit agency, Urban Peak, strategized its way from its own tiny beginnings to today's complex of services for homeless youth offered through its own programs and those of its collaborators throughout the Denver area and extending to Colorado Springs. During 2002, the General Assembly of the State of Colorado established an Office of Homeless Youth Services. One of the architects of Urban Peak's community collaboration moved into city government as manager of the Denver Department of Human Services, reporting to the Mayor of Denver. This department has established the Mayor's Commission to End Homelessness and is working diligently toward



this objective; Urban Peak serves on this commission. Urban Peak receives funding from the Denver Department of Human Services to operate the emergency shelter, provide street outreach, and provide drug and alcohol intervention services.

Urban Peak uses a strategic planning process to make decisions about its direction, approach, and strategies. Leadership and a commitment to intensive planning have provided a blueprint for the agency to respond flexibly to new opportunities, the changing needs of youth, budget realities, and necessary changes in organizational structure. The clarity of vision also helped identify areas where allies and collaborators were needed. Urban Peak has been a leader in assembling Denver-area nonprofit agencies serving youth into a supportive collaboration. In the process, one agency—The Spot, a drop-in center—merged with Urban Peak and Urban Peak developed two other agencies. Its presence in Colorado Springs grew out of an appeal by an already-interested group of service providers, who helped raise money locally to start outreach and a drop-in center.

### **Population Served, Targeting Practices**

Urban Peak serves street youth and other youth without stable or reliable housing such as those who spend a night or two with different friends or relatives. Since the large majority of the youth involved with Urban Peak are already homeless, the activities directed toward them fall into the categories of secondary prevention (for those who have not been homeless long) and tertiary intervention (for those who have already been homeless for years).<sup>12</sup> The study team concentrated on these activities.

Targeting well for secondary and tertiary prevention is much easier than targeting for primary prevention. The first criterion is if the person is already homeless; the second criterion is a high probability that she or he will remain so without intervention. The homelessness of the youth served by Urban Peak is easy to document, and their continued homelessness in the absence of intervention is highly likely (especially for the street youth whose homeless spells are already long). Street youth typically enter the Urban Peak service system through street outreach services, while the “hidden” homeless youth are more likely to enter through The Spot or the agency’s shelter facilities. Intake and assessment procedures document homeless history, resources, housing barriers, and what would be needed for the youth to leave homelessness.

### **Components and Organization of the Community Strategy**

Urban Peak is command central for activities to help homeless youth and those at high risk of homelessness in the Denver area. It offers many services itself, links with other agencies to augment its own capacity, and receives referrals from its many collaborators. Activities directed toward ending homelessness for youth ages 14–24 years are described below.

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<sup>12</sup> The Spot, a drop-in center founded in 1994, became part of Urban Peak in 2003. It serves a broader clientele than Urban Peak’s other services: 46 percent of its youth (ages 14–24) live in temporary situations, but the remainder (who are mostly 18 years and older) live with parents, in their own place, or stably with friends.

- The Spot offers a full range of drop-in services for homeless and at-risk youth between the ages of 14 and 24 years, aimed at improving their quality of life and linking them with needed resources.
- The Urban Peak Outreach Team works throughout metropolitan Denver to build relationships with homeless youth to remove barriers that inhibit them from accessing services through Urban Peak and other agencies.
- The emergency shelter and support services at Urban Peak are directed toward youth between the ages of 15 and 21 years. Services include overnight shelter, meals, case management, education and employment resources, medical and behavioral health services, and general drop-in services.
- The Urban Peak Housing Corporation owns two multiunit buildings and manages another for the city of Denver. Two programs that serve eligible youth with disabilities occupy multiunit buildings and receive operating support through their tenants' Shelter+Care grants. A third building was developed and is run collaboratively by Urban Peak and the Denver Department of Human Services. It houses homeless and runaway youth and is subsidized by an HHS Transitional Living Program grant and the state of Colorado's HUD-funded Family Unification Program, which provides Section 8 vouchers for young people aging out of foster care.
- A network of collaborating agencies makes possible many of the services at The Spot and Urban Peak. Six agencies offer on-site medical and mental health care, and services related to pregnancy and sexually transmitted infections. The Denver Public Schools offer General Educational Development (GED) and other educational services. Three additional agencies offer transitional housing opportunities to Urban Peak clients.

### **Data Collection and Use**

For the past five years, the Urban Peak Client Database has been used to collect and store information on the youth who receive services, the services provided, and the costs of services. The program also tracks "positive outcomes," which include leaving homelessness for a variety of housing settings from stable arrangements with family to permanent supportive housing. Urban Peak case managers and counselors use the data daily to help youth; the executive director also uses data to document program outcomes. In addition, Urban Peak has participated in several point-in-time surveys to gather information about drop-in clients' experiences and needs. Urban Peak is currently developing a follow-along, Web-based system for youth to report back regularly to Urban Peak about their current life situations.

### **Relationship to CoC Process and HMIS**

Urban Peak in Denver and Colorado Springs participate in local CoC processes, both for the Metropolitan Denver Homeless Initiative and the Colorado Springs/El Paso County CoC. Most of Urban Peak Housing Corporation's permanent supportive housing is financed in part through

McKinney-Vento funds. Urban Peak’s data systems will run independently of Denver’s HMIS, which has not yet been fully developed. Urban Peak participates in all coordination and planning meetings for development of the Denver HMIS.

## SUMMARY

The six communities selected for this study vary in population focus, size, organization, lead agency, and the types and range of prevention activities they offer. They also vary in the degree to which they use data to support program planning and evaluation. It is now possible to relate the prevention activities of the six communities to the range of prevention activities found throughout the United States and displayed in Exhibit 1. This information is summarized in Exhibit 3, which occasionally collapses some of the Exhibit 1 categories for ease of presentation. Exhibit 3 also categorizes the screening approaches used in the study communities.

The key to understanding the prevention activities available in each community lies in understanding what the different sites are trying to do. The first three rows of Exhibit 3, depicting screening activities, reveal the primary differences. The communities aimed at primary homelessness prevention for families—Hennepin County, Montgomery County, and MAAC—are screening to find short-term problems. Although they often discover family issues that cannot be resolved with one month of cash assistance, for primary prevention they *select* the families whose housing problems *can* be resolved with the resources they have available. The other communities—Massachusetts, Philadelphia, and Urban Peak—are screening to find the people who will need long-term help. They may identify less severely needy people during screenings, but they *select* the ones who need *the most* help. All other service provision follows from this difference, as is obvious from the pattern indicated in Exhibit 3.

- The communities geared toward primary prevention for families (first three columns of Exhibit 3) tend to offer the time-limited crisis intervention services including cash and noncash assistance located at the shorter, less-intensive, and less-expensive end of the array of prevention activities. The preponderance of blank cells in the last five rows of these columns indicates avoidance of the most-intensive prevention activities.
- The communities targeting persons with serious mental illness and homeless youth (last three columns of Exhibit 3) concentrate their resources to offer the long-term, intensive interventions that involve permanent supportive housing and housing assistance, located at the more-expensive end of the array of options. It is important to note that they *also* offer their carefully defined target population virtually all of the prevention activities available through the family homelessness prevention approaches.

It is also important to recognize that some of the more intensive prevention activities serve multiple purposes. For example, Massachusetts DMH uses four interventions—mental health services, supportive services to maintain housing, rental subsidies, and permanent supportive housing—to accomplish both primary and secondary prevention and also to end chronic homelessness. That is, supportive and mental health services help keep never-homeless people with serious mental illness in housing and also help formerly homeless people stay in their new homes. Secondly, the same intervention can be used with different populations. For example,

Hennepin County has a well-developed rapid exit program to assist families with multiple housing barriers to leave shelter and sustain their new housing. Massachusetts DMH also has a rapid exit strategy for people with serious mental illness, whom it identifies among homeless people in shelters and on the streets.

**Exhibit 3. Homelessness Prevention and Intervention Options**

Array of Preventive Interventions	Prevention Strategies with Families			Prevention Strategies with Specialized Populations		
	Hennepin County	Montgomery County	MAAC	Massachusetts	Philadelphia	Urban Peak
Screening to Select For:						
Short-term issues			Yes			
Multiple barriers to housing						Yes
Chronic homelessness						Yes
Noncash Assistance						
Counseling and advocacy						Yes
In-kind emergency assistance						Yes
Short-Term Cash Assistance for Payments to Obtain or Maintain Housing						
Deposits, arrearages, moving costs						Yes
Legal and Other Assistance to Retain Housing						
Negotiating with landlords						Yes
Housing Court interventions				Yes		
Training and employment assistance and support						Yes
Assistance to get entitlements						Yes
Special funds for disabled target populations						Yes
Long-Term Intensive Interventions						
Rapid exit strategies					Yes	
Supportive services to maintain housing before or after homelessness						Yes
Mental health and substance abuse treatment						Yes
Permanent supportive housing						Yes
Mainstream agencies assuming housing responsibilities for their clients					Yes	
Affordable housing, preferences for subsidies				Yes		

Another important insight one can derive from Exhibit 3 is the relationship between common prevention activities and programs that HUD funds within the CoC. Communities already must include prevention activities in the continuum they describe in their annual SuperNOFA application. However, it is not entirely clear how well integrated local prevention activities are with homeless assistance programs funded through the SuperNOFA process.

Looking at the array of interventions in Exhibit 3 that are used to prevent homelessness, one can see that the McKinney-Vento Supportive Housing Program is most likely to be contributing to interventions at the more intensive end (the bottom of the exhibit). Hennepin County has a Supportive Housing Program services-only grant to support its rapid exit services. A good deal of permanent supportive housing in Massachusetts, Philadelphia, and Denver (for youth) is supported in part through Supportive Housing Program funding. Other HUD-controlled funds help to make housing affordable through Section 8 and Shelter+Care. Public Housing Authorities in Massachusetts, for example, work with DMH to establish priorities for subsidies to DMH clients. Other McKinney-Vento programs (Emergency Food and Shelter Program, Emergency Shelter Grants) are major contributors to the short-term cash assistance activities of the family homelessness prevention sites in this study. Further, in Montgomery County and Massachusetts, the agencies visited for this study are the lead agencies for their communities' annual CoC applications to HUD (for the balance-of-state application in Massachusetts), so they are in an excellent position to assure that CoC plans attend to the needs of homelessness prevention.

Chapter Three describes ways that the study communities collected and analyzed data and used these data to evaluate their strategies for preventing homelessness.

## **CHAPTER THREE**

### **USING DATA TO DOCUMENT PREVENTION EFFECTIVENESS**

A critical part of service management is the collection and analysis of data. Normally one might expect a discussion of data and results to follow a discussion of strategies. However, use of data *is* one of the strategies for creating an effective prevention strategy. In addition, a discussion of strategies involves recommendations for effective interventions, and one needs data to determine which prevention activities are effective. Therefore this report discusses documentation before discussing strategies.

Each of the study communities collected basic data and could report on the population they served and the services they provided. Some communities had sophisticated linkages among service providers, while others had more centralized databases. For most, the sharing of data among various systems remained a challenge, even though many communities had developed innovative strategies to meet these challenges.

Many communities do not routinely assess the effectiveness of their homelessness prevention strategies. As the study team discovered when canvassing prevention programs for inclusion in this study, very few homelessness prevention efforts in this country have the ability to assess whether or not the households receiving assistance subsequently became homeless. The communities in this study have made considerable strides in developing systems that could document primary and secondary prevention of homelessness, although most of them were not systematically using available data to get feedback on their prevention efforts.

This chapter describes the study communities' ability to use their data and the implications for evaluating their programs. Suggestions for additional research efforts are included in the Conclusions section at the end of this chapter.

#### **DOCUMENTING PREVENTION EFFECTIVENESS**

The evidence for homelessness prevention assembled in each of the study communities is based on two types of analyses: tracking whether recipients of homelessness prevention services became homeless (i.e., entered shelter) and constructing time-series analyses of prevention outcomes. Findings from these analyses are discussed below.

##### **Proportion of Families Served Who Became Homeless**

Exhibit 4 lists the proportion of families from Hennepin County, Montgomery County, and the Mid America Assistance Coalition (MAAC) in Kansas City who entered a homeless shelter for at least one night within 12 months following receipt of rent or mortgage assistance. Data for families from these communities' primary homelessness prevention components indicate that very few families receiving prevention services entered shelter during the followup period—only 2–5 percent. The rapid exit program in Hennepin County found that 12 percent became homeless again within 12 months of leaving shelter.

**Exhibit 4. Proportion of Families Entering a Homeless Shelter Within 12 Months Following Receipt of Rent or Mortgage Assistance or Rapid Exit Services**

COMMUNITY	Proportion of Families
Hennepin County	
FHPAP prevention	5%
Rapid exit	12%
Transitional housing	4%
Montgomery County	2%
MAAC	3%

***Rent and Mortgage Assistance for Primary Prevention***

For these analyses, the outcome measure that the study communities documented was the proportion of families served who subsequently became homeless. This measure has several limitations. For example, a family could have avoided shelter entry but experienced homelessness by losing its housing, or living in its car. Without case-specific followup or tracking of families’ post-prevention experiences, agencies cannot conclusively determine that homelessness was prevented.

A study in New York City that used a comparison group of families facing imminent eviction who did not receive an intervention to prevent homelessness determined that 20 percent of the families became homeless (Shinn et al., 2001; Stojanovic, Weitzman, Shinn, Labay, and Williams, 1999). Comparing the outcomes listed in Exhibit 4 with the finding from the New York City study demonstrates that the study communities’ outcomes of primary prevention activities are “better.” Without an intervention, 20 percent of the New York City comparison group became homeless; 80 percent did not. With an intervention, 2–5 percent of the families receiving prevention assistance from Hennepin County, Montgomery County, and MAAC became homeless; 95–98 percent did not. Based on these data, it could be determined that 19–23 percent more families avoided homelessness following receipt of a prevention intervention in these study communities than without an intervention in New York City.<sup>13</sup>

This comparison also illustrates the serious inefficiency of this common approach to homelessness prevention. At least 80 percent of the resources disbursed in the name of prevention go to families who would not have become homeless even if they did not receive help from prevention programs.

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<sup>13</sup> New York City is one of the tightest and most expensive housing markets in the United States. It is possible that families find it more difficult to avoid homelessness than they might in other communities, and that the odds of becoming homeless without an intervention are lower elsewhere. On the other hand, tenant protection laws in New York City make eviction extremely difficult—a household must be at least three months behind in rent and the landlord faces a long court process—suggesting that families facing eviction in New York City are in more serious trouble than families in the same situation elsewhere. These conflicting realities of tenancy in New York City may cancel each other out, leaving the 20 percent statistic as a reasonable benchmark to use for assessing the effectiveness of primary prevention for families in this study.

### ***Secondary Prevention—Rapid Exit***

The FHPAP program in Hennepin County offers rapid exit services to families with multiple barriers to housing who are in emergency shelter. In most communities, these families would be candidates for transitional housing, where programs would have several months to work with them to obtain permanent housing. However, rapid exit moves these families into housing in an average of 30 days, and keeps most of them in housing for one year with the support of followup services. Only 12 percent of these families return to shelter within one year. Given that these families have already been homeless once, and thus could be considered at higher risk of a repeat than the primary prevention families might be of actually becoming literally homeless, holding these families to only 12 percent recidivism is a more remarkable achievement than the finding that only 5 percent of the primary prevention families enter shelter within one year.

Since Hennepin County was not able to construct a relevant comparison group from among its own families, the study team used reports of shelter readmission rates in Philadelphia and New York City to assess whether this 12 percent readmission rate represents an accomplishment significantly greater than would have happened without the rapid exit intervention. The Philadelphia and New York City figures range from 19 percent to approximately 36 percent of families who return to shelter within one year (Culhane, Dejowski, Ibanez, Needham and Maccia, 1994).<sup>14</sup> Compared with these sites, the rapid exit results for Hennepin County represent at least one-third, and possibly as many as two-thirds, fewer families returning to shelter. Further, this result was achieved after an average shelter stay of 30 days (compared with 60 days in Philadelphia and 120 days in New York City), and with families who were admitted to shelter after determining that they face multiple barriers to housing.

### **Changes Over Time**

A system that can demonstrate a decrease over time in the number of people receiving homelessness prevention services who later became homeless confidently claim the effectiveness of its prevention services. Several changes indicate that prevention is occurring: decreasing numbers of households requesting shelter, only households with the most complex problems requesting shelter, decreasing proportions of people who are homeless at psychiatric facility intake and discharge, or increasing proportions of homeless youth exiting the street. Three study communities, Hennepin County, Massachusetts Department of Mental Health; and Urban Peak, documented outcomes of this type.

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<sup>14</sup> In this article, the authors did not calculate readmissions in the 12 months following each family's exit from shelter. Rather, they examined how many families with a homeless spell in one 12-month period (June 1, 1990–May 31, 1991) had another spell during (a) the next 12-month period (June 1, 1991–May 31, 1992), or (b) either the same 12-month period of their first spell or the next one. For Philadelphia those figures are, respectively, 12 and 27 percent. For New York City the respective figures are 27 and 65 percent. To calculate the range of families with a return to shelter within 12 months of leaving (19–36 percent), one could: (1) take the difference in the two figures (16 percent for Philadelphia and 38 percent for New York City) and assume this is the rate of recurrence during the same 12-month period as the first spell; (2) take one-third of the recurrences in the second 12-month period (4 percent for Philadelphia and 9 percent for New York City) and assume they happened within 12 months of the end of the first spell; and (3) add those two figures.



Hennepin County used client screening to direct scarce emergency services resources toward those who needed them the most, and tracked changes over time in the targeting of shelter services. The Human Services Department in Hennepin County analyzed its data to demonstrate the impact of its screening and prevention practices. These practices significantly altered the population and reduced the number of families receiving shelter services in the county. Since 2001, Hennepin County has cut its average length of shelter stay by one-half (from 60 to 30 days), eliminated the need for motels, and reduced the number of families in shelter at any given time from 317 to fewer than 116. It also succeeded in reserving shelter resources for families with the higher levels of housing barriers, whom county administrators believe need the most assistance.

Hennepin County operates under the assumption that the most appropriate and efficient use of its scarce resources is to limit the type of intensive help that families receive in shelter to the neediest families, those who are likely to be the greatest burden on the system if their homelessness is not mitigated. (See Exhibit 5.)

**Exhibit 5. Change in Housing Barriers of Sheltered Families in Hennepin County<sup>15</sup>**

Barrier Level	1995	1998	2003
Level 1—No or few barriers	15%	0%	0%
Level 2a—Few barriers	40%	43%	2%
Level 2b—Many barriers	40%	44%	70%
Level 3—Most serious barriers	5%	13%	28%

Using data that it currently collects, Massachusetts DMH analyzed changes in homelessness over time among its clients with serious mental illness as they were admitted to and discharged from inpatient psychiatric facilities operated by the department. Since 1992, Massachusetts DMH has developed community-based housing options and supportive services to help people retain housing and to reduce hospitalizations and homelessness. Since 1993, hospitals have recorded whether patients were homeless at admission or discharge. If the increase in community-based housing and supports was preventing homelessness, one would see the rate of homelessness decreasing at both admission and discharge. Either change could represent primary or secondary prevention, depending on client homeless histories.<sup>16</sup>

Findings from these data are illustrated in Exhibit 6, which indicates that:

- DMH residential community housing capacity in thousands (illustrated by triangles) increased from 2,750 in 1991 to 7,090 in 2003;

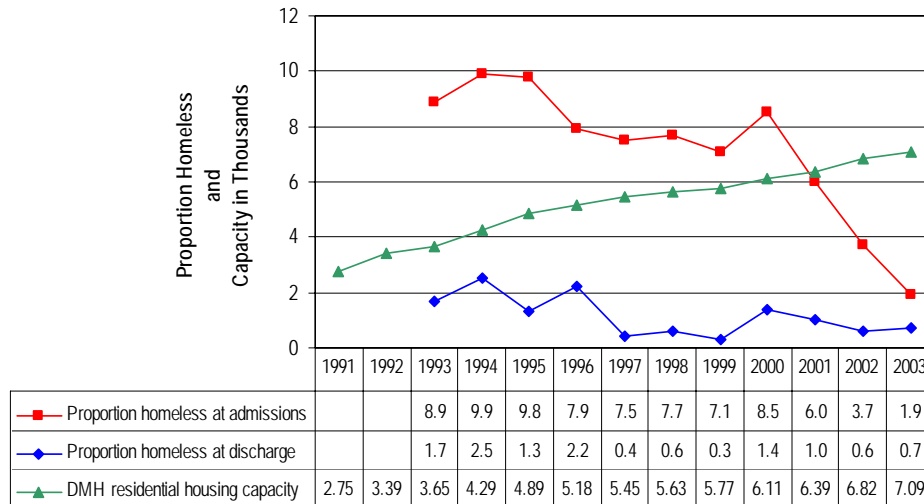
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<sup>15</sup> Hennepin County FHPAP Annual Report for SFY 2003, page 14.

<sup>16</sup> These changes occurred during a time when state hospitals were being closed. These closures accounted for a significant drop in hospital admissions (not shown), but these changes do not wholly account for the drop in homeless admissions. While overall admissions dropped by two-thirds, the proportion of people homeless at admission dropped by almost 90 percent (not shown). A combination of housing and community services to stabilize persons with serious mental illness at risk of homelessness may account for much of this impact. Intensive discharge planning coupled with the existence of housing options developed by the department helps to explain the drop in homelessness at discharge, which affects both people homeless at admission and those who lost their housing while hospitalized.

- The proportion of people entering hospitals who were homeless at admission (illustrated by squares) decreased from 8.9 percent in 1993 to 1.9 percent in 2003; and
- The proportion of people leaving hospitals without housing arrangements or homeless (illustrated by diamonds) decreased from about 1.7 percent in 1993 to about 0.7 percent in 2003.

**Exhibit 6. Changes in Massachusetts DMH Community Residential Capacity and Changes in Proportion of Homeless Admissions and Discharges**



Urban Peak maintains a single database that includes unduplicated counts of the youth served and tracks daily service use. Urban Peak’s data from 1996 to 2004 illustrate its ability to move increasing proportions of the youth served into permanent housing or other positive housing outcomes. Along with moving into permanent supportive housing, positive outcomes for youth served by Urban Peak include returning home, entering an appropriate placement, or securing one’s own apartment. Exhibit 7 shows the total number of youth served per year by Urban Peak and the number and percent of those with successful housing outcomes.

**Exhibit 7. Outcome Measures for Urban Peak, 2000–2004**

Measure	2000	2001	2002	2003	2004
Total number of youth served	642	660	694	655	690
Number of youth with successful housing outcomes	308	343	368	426	435
Percentage of youth with successful housing outcomes	48%	52%	53%	65%	63%

While these findings do not document an overall reduction of homelessness among youth in Denver, they do represent a useful way to assess whether interventions are making a difference. As the findings clearly document an end to homelessness for the youth served, who would have been unlikely to leave homelessness without these interventions, they are valid indicators of secondary and tertiary prevention. Urban Peak is currently developing methods to strengthen these data such as tracking outcomes of all youth served through innovative followup tracking

methods and obtaining improved data on targeting, including prior homelessness of youth served.

## **COMMON MEASURES OF PREVENTION AMONG STUDY COMMUNITIES**

All communities in this study expressed interest in improving the use of data to document prevention. The data that are currently being used, the outcome measures that have been defined or are under definition, and suggestions for additional measures, are discussed below.

### **Data Elements Key to Outcome Measurement**

The following list includes categories of key data elements that appeared to be important for outcome measurement in the study communities:

- Demographic characteristics of recipients of primary (or any other) prevention services;
- Eligibility for homelessness prevention services criteria;
- Start and end dates of primary or secondary prevention services;
- Reason for ending primary or secondary prevention services;
- Receipt of primary or secondary prevention services;
- Receipt of shelter services; and
- Followup data.

### **Developing Outcome Measures and Collecting Outcome Data**

The study communities have developed, or could develop, several outcome measures to assess the effectiveness of homelessness prevention interventions. Most of these measures are multipurpose and can measure either primary or secondary prevention, depending on the context in which they are used. For example, Montgomery County and Hennepin County tracked the number of people becoming homeless within 12 months following receipt of prevention services. This measure could address both primary and secondary prevention. As a measure of primary prevention, one would identify people who received the intervention before they were ever homeless. As a measure of secondary prevention, one would identify people who had become homeless for the first time and then received the intervention.

Tracking housing tenure for formerly homeless persons can also serve as an indicator of the long-term effectiveness of some rent or mortgage assistance interventions. Hennepin County measures the length of housing tenure to illustrate the effectiveness of rapid placement in housing following a first shelter stay.

Communities can also develop measures for mainstream agencies that have responsibility for populations with chronic problems and a heightened vulnerability to homelessness. This is a timely issue as many cities, counties, and states have developed plans to end long-term homelessness. These plans include mainstream agencies as the major arenas where primary

homelessness prevention will take place if the front door to homelessness is to be closed. Examples of these types of measures include the following.

- To gauge if community-based housing options and supportive services help people retain housing and reduce hospitalizations, Massachusetts DMH used hospital records of homeless status at admission and discharge. DMH can track changes in the proportion of people homeless at admission and at discharge over 12 years, and determine that both have decreased over time.
- Child welfare agencies that provide followup services to youth exiting foster care could include housing retention measures to determine the effectiveness of housing policies for youth. Urban Peak tracks housing tenure where the measure of success is youth exiting the streets.

### **Additional Outcome Measures to Consider**

Communities may be able to develop and analyze additional outcome measures. Measures to consider include the following.

- *Reduction in the number of people who enter shelter for the first time (to measure primary prevention) and reduction in the number of people who enter shelter from mental health agencies or jails (to measure discharge policies).* Data may be gathered from local homelessness information system or some other central intake. This measure requires that the data source contain information about the number of times the person has been homeless and where the person lived prior to becoming homeless or entering shelter.
- *Improved targeting of persons to be served.* The homelessness information system or other applicable data system could be structured to record a variety of barriers to obtaining and keeping housing, such as poor credit history, housing violations, and substance abuse issues. Such data could be used to establish homelessness rates for different populations.
- *Agencies, such as mental health departments, with responsibilities for chronic populations could track the number of people who are homeless at admission and if fewer people are homeless at discharge.* The intake data system should be structured to record homeless status at intake. Case records could also record the housing circumstances of people being discharged. Specific periodic studies could be undertaken to attempt to track persons who have been discharged from mental health facilities.
- *Social service agencies could include the systematic data collection of the homeless status of clients and whether the situation was alleviated.* Child welfare services could monitor whether children are being removed from their homes due to unstable housing. An agency could develop a homelessness risk assessment procedure to alert caseworkers to the risk of housing loss; it could also track or followup with clients to determine if their housing status has remained stable.

## **ADDITIONAL RESEARCH EFFORTS**

This section suggests additional approaches that could be used by communities to determine the effectiveness of homelessness prevention interventions. These measures focus on analytical approaches to tracking changes over time, developing evaluation studies using control and comparison groups, and using multivariate approaches to determine which client characteristics warrant targeting.

### **Tracking Changes Over Time**

Tracking changes over time is one way to assess if interventions make a difference. Several of the communities in the study tracked changes over time and most communities have the data available to construct such an analysis. This approach merits consideration as it is possible within most systems and provides useful feedback to guide system change.

This approach is most relevant if a community has made some substantial changes in its prevention activities. One working hypothesis might be that as prevention efforts increased over time, there would be a decrease in the incidence of homelessness. Massachusetts has presented results illustrating how housing development affected homelessness at admission for people with serious mental illness. In addition, Urban Peak was able to illustrate the increased placement of youth into positive housing situations. This type of finding can be presented as a “before and after” picture, illustrating that a situation has improved over the given period of time. On the other hand, the data may show that the problem has not improved. Such information would help programs reassess their priorities and their service designs.

This type of analysis can be conducted prospectively and retrospectively. The choice depends upon the specific research question and the availability of data. With sufficient data points and quality data, it is also possible to use other analytic techniques, such as regression. These techniques can be used to compare statistically the actual outcomes associated with the intervention to a future or forecasted baseline.

### **Program Evaluation Designs**

The fundamental goal of homelessness prevention programs is to provide services that effectively reduce first time homelessness or avoid repeat episodes of homelessness. Many different indicators might be used to measure “effective homelessness prevention,” including:

- Providing emergency services so that people who will be homeless within 24–48 hours receive immediate shelter or other services;
- Providing services to those who are at risk of becoming homeless, perhaps not imminently but in the near future;
- Providing emergency services so that people who become homeless are only homeless for a short period of time;
- Avoiding any need for shelter facilities;
- Avoiding long-term usage of shelter facilities;

- Avoiding repeat occasions of shelter use or other near homeless situations; and
- Reducing shelter costs, possibly other reduced costs for crisis services.

The variation in definitions of effective homelessness prevention raises the question of how best to evaluate the effectiveness of services. Each community and its agencies may determine how to evaluate prevention effectiveness by using the following three steps.

- The first step would be to identify the critical outcome or outcomes that the community desires.
- The second step would be to define the components for measuring that outcome. For example, many programs consider a service effective if a person remains in housing for 12 months or longer. Other programs might set different timeframes. This step also includes defining the study population (e.g., youth) and the service intervention (e.g., outreach) to be measured.
- The third step would be to identify the research strategy best suited to the research question, the needs of the decisionmakers, and the resources of the agency. For example, one way to evaluate a program is to consider the trends in community statistics, as illustrated by some of the communities in this study.

### *Experimental or Quasi-Experimental Approach*

From a research perspective, a controlled experiment with random assignment is the most rigorous evaluation design. However, such designs are not always feasible due to many concerns including the program design and the operating conditions of service provision and availability of data, research staff, and resources to conduct a rigorous study.

Random assignment means that persons are selected and assigned by chance to various experimental conditions. In other words, neither the potential client nor the service provider determines which service option will be offered or received. Indeed, in a control group study, one group of persons will have been randomly assigned to receive “no service,” and the other group will have been assigned to receive the service being studied. The hypothesis being tested is that those who received the service would have better outcomes than those that received “no service.”

Short of random assignment, communities could use several approaches to create useful comparison groups. It is sometimes possible to create “naturally occurring” comparison groups to use in this type of design. Such comparison groups may be approximations of control groups. For example, there may be “random” (unbiased) reasons why an agency might not serve a family or individual. Such reasons might include:

- The agency placed the family or individual on a waiting list for services, and the family or individual either left before the agency offered services or was still on the list; and
- The agency did not have resources when the family or individual applied for help.

If a prevention program has not provided services to clients for “random” (unbiased) reasons and is able to record information about such persons, it could create a control-group-like comparison group. This group would be useful to determine whether its membership experienced a significantly higher likelihood of becoming homeless than the people who did receive services. One difficulty in using such comparison groups is that the program must at the same time guard against “creaming.”<sup>17</sup>

To consider the real world implications of using a comparison group methodology to evaluate homelessness prevention services, the study team used a comparison group to gauge the impact of program services on housing retention in the Western Massachusetts Tenancy Preservation Project. This project involves an alliance among local Housing Courts, MassHousing, DMH, Department of Mental Retardation, Department of Public Health, several local housing authorities, and local service providers. The study team visited one such service provider, the Mental Health Association, Inc., of Springfield, MA. The program was established to help tenants threatened with eviction because of their mental illness, substance abuse, or cognitive disability. The goals of the program were to preserve existing tenancies or connect households to alternate housing.

The Tenancy Preservation Project began in 1998, and since that time has opened 441 cases and closed 366, with 23 households refusing services. Outcomes of cases closed between July 1, 1998 and June 30, 2004 are displayed in Exhibit 8. The top row of the table shows the results for the entire Tenancy Preservation Project caseload. About one-half (51 percent) stayed in their original housing, 34 percent moved to alternative housing arranged through the Tenancy Preservation Project, and 15 percent became homeless. Outcomes differed substantially by diagnoses, as indicated in the table. The Tenancy Preservation Project had the greatest success with elderly and cognitively impaired tenants and the least success with tenants who were both mentally ill and substance abusers.

**Exhibit 8. Outcome Status of Closed Cases at the Tenancy Preservation Project of the Mental Health Association, Inc., of Springfield, MA**

All cases served and closed by The Tenancy Preservation Project (n=366)	Tenancy Preserved	Moved to Alternative Housing	Became Homeless
		51%	34%
By Diagnosis			
Mental health (n=202)	55%	32%	13%
Substance abuse (n=43)	51%	37%	12%
Dual diagnosis (n=83)	37%	35%	28%
Elder/senility/Alzheimer's (n=24)	71%	21%	8%
Other (n=13)	38%	62%	0%

These outcomes can be compared to cases that were wait-listed by the Tenancy Preservation Project and never served. These cases had similar issues and difficulties and comprise a reasonable comparison group to those served by the Tenancy Preservation Project. There were

<sup>17</sup> Creaming refers to the sometimes inadvertent tendency to provide services to persons who are perceived to be more likely to succeed and not to provide services to those who are expected not to succeed. As creaming is what many rent/mortgage/utility assistance activities do, a control or comparison group is especially important to be sure that the prevention activities really do improve on the outcomes that would have happened without them.

21 such cases, for which outcomes were retrieved from court records. The outcomes for this comparison group were:

- Twenty-four percent were resolved favorably for the tenant without the help of the project and these people were able to remain in their housing; and
- Subsequent location is unknown for the remaining 76 percent.

This simple comparison indicates that the Tenancy Preservation Project may have been able to preserve original housing for slightly more than twice as many people as would have kept their housing without Tenancy Preservation Project services—51 percent versus 24 percent.<sup>18</sup>

### *Multivariate Approach*

Analyses using covariates may help a community determine who is at highest risk of homelessness and to plan and adjust a prevention strategy. Covariates are variables that may affect the risk of homelessness or level of housing stability. Most prevention program screening systems make assumptions about applicant characteristics that indicate a higher risk of becoming homeless. A community could combine this information with outcome measures to conduct two analyses:

- Test assumptions about recognized risk factors; and
- Determine whether some interventions work especially well (or not well) with households that have a particular type or set of risk factors.

The data of those who received prevention assistance could be analyzed to determine whether those judged to be at higher risk were more likely to become homeless. Communities may find that some characteristics pose fewer problems than previously thought for attaining and keeping housing. The agency might decide to modify selection criteria to improve the program's ability to target the people who need help the most. Further, communities could test assumptions about the types of services that work best for people with particular types of barriers.

## **CONCLUSIONS**

Comprised of agencies often working with limited staff, facility, and financial resources, the homelessness prevention field has focused primarily on providing services to the most needy or visible populations. Given the size, experience, and diversity of the community agencies that provide these services, many have faced, and continue to face, formidable challenges to recording, collecting, reporting, and analyzing data on clients and their outcomes. Nevertheless, as shown in this chapter, agencies are making progress to develop relevant databases and

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<sup>18</sup> The small numbers of the comparison group provide tentative, rather than conclusive, results.



coordinate with other agencies in the use of data. The experiences of the six study communities can help other agencies to progress in their systematic collection and use of data.

Many prevention approaches already report data describing the households they serve, but very few have the capacity to assess the effectiveness in terms of those households' successes in avoiding future homelessness. Evaluation of homelessness prevention programs joins the evaluation of other social service prevention programs in being in the early stages of development. As data systems are developed and used for program monitoring and service delivery, the likelihood of being able to develop research strategies that address fundamental questions of effectiveness and efficiency will increase. Agencies and communities will need to work with their local universities and others to develop strategies that can be implemented with sometimes restricted resources and that can be meaningful to all stakeholders.

## CHAPTER FOUR

### KEY ELEMENTS OF PREVENTION STRATEGIES

Each study community offered several activities aimed at preventing homelessness, or quickly rehousing those who have already become homeless. Some also developed a coherent community-wide strategy through which they linked services to people who faced homelessness or who recently became homeless. This chapter integrates study findings related to preventing homelessness among families and populations with disabling conditions, with the intent of answering the following two questions.

- **What does it take to prevent homelessness or end it quickly for newly homeless individuals and families?** To answer this question, one needs to know which particular activities *are effective* to prevent homelessness. Independent of targeting, system development, and the activities' acceptability to the population at risk, the issue is, *does this activity work? Does it keep people in housing, or get them back into housing quickly?*
- **What does it take to organize a community so activities that are effective at preventing homelessness are applied where they will do the most good?** To answer this question, one needs to be aware of the issues and problems that can make it difficult to apply prevention activities, and to do so efficiently, and how communities overcome these difficulties.

The following sections examine each of these issues.

#### WHAT IT TAKES—EFFECTIVE PREVENTION ACTIVITIES

To date, evaluation evidence indicates that “housing” prevents homelessness more effectively than any other strategy (Shinn et al., 2001). The communities in this study are trying, through many activities, to preserve housing for people facing homelessness, or to supply housing when it is needed. This chapter summarizes the evidence that exists from evaluation studies, as well as the current study on effective housing strategies, to prevent homelessness.

- **Housing subsidies.** Evidence for housing subsidies as a very effective prevention activity comes from studies other than the present one. Shinn and colleagues (Shinn et al., 2001; Stojanovic et al., 1999) documented the effectiveness of housing subsidies at keeping at least 80 percent of first-time homeless families housed for a minimum of two years. Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, and Holupka (1995) demonstrated similar success (80–85 percent retention over at least 18 months) for homeless families in which a parent's mental illness complicated housing stability. Evidence from simulations (Quigley, Raphael, and Smolensky, 2001) indicates that subsidizing housing costs for extremely low-income people has the strongest effect on lowering homelessness rates compared to several other interventions tested. Thus when used as secondary and tertiary prevention, housing subsidies help 80–85 percent of homeless families or chronically homeless single adults to achieve housing stability.

- **Supportive services coupled with permanent housing:** Studies summarizing the first round of McKinney demonstrations for people with serious mental illness (and often co-occurring substance abuse) show that permanent supportive housing works even for the chronically homeless people targeted by those demonstrations. These programs achieved approximately 80–85 percent housing retention at 18 months (Shern et al., 1997). Burt et al. (2004) collected evidence from seven communities engaged in efforts to end chronic homelessness that showed that permanent supportive housing is effective. (See also Tsemberis and Eisenberg, 2000, for the success of the Pathways to Housing program in New York City.)

It follows that if housing, with supportive services, works to sustain tenancy for people with long histories of homelessness, serious mental illness, and co-occurring substance abuse, it should also be effective with the less-severely affected clients of mental health agencies. The housing options developed by the Massachusetts Department of Mental Health (DMH) and the Philadelphia Office of Behavioral Health (OBH)—coupled with the supportive services they offer to avert a worsening of clients’ mental illness and to address other issues that might affect housing tenure—provide both primary and secondary homelessness prevention. Evidence from Massachusetts indicates declining rates of homelessness among admissions to psychiatric inpatient care over the course of more than a decade, supporting this conclusion for primary prevention. Declining rates of discharges to homelessness from psychiatric inpatient care show the effects of secondary prevention efforts involving housing and supportive services.

- **Mediation in Housing Courts:** Evidence collected in the present study on the effectiveness of mediation under the auspices of Housing Courts shows the ability to preserve tenancy, even after a landlord has filed for eviction.
  - *Hennepin County:* 69 percent of cases filed against families in the Hennepin County Housing Court were settled without eviction, and the family retained housing. If 20 percent of these families would have become homeless if evicted (based on New York City estimates discussed in Chapters One and Three), mediation has successfully prevented homelessness among these families.
  - *Massachusetts:* Evidence presented in Chapter Three on the Western Massachusetts Tenancy Preservation Project showed that mediation preserved tenancy for 85 percent of seriously mentally ill tenants facing eviction, and reduced the probability of becoming homeless by about one-third.
- **Cash assistance for rent or mortgage arrears:** Compared to the finding in New York City that 20 percent of families facing eviction will become homeless if they do not receive assistance, the commonly used interventions offered by the study communities for families facing housing loss were effective. Cash assistance to cover arrears in rent, mortgage, or utility payments to avert eviction, as used in Hennepin County, Montgomery County, and the Mid America Assistance Coalition (MAAC), resulted in only 2–5 percent of assisted families experiencing homelessness in the 12 months following receipt of help. This is a substantial improvement over the 20 percent becoming homeless without assistance. The difference between the results in this study’s

communities and those from New York City used as a comparison are probably attributable at least in part to screening that improves targeting—that is, an effective strategy is being used efficiently.

- **Rapid exit from shelter:** Hennepin County supports a program to move families who enter emergency shelter into housing rapidly, and to promote their housing tenure for at least six months after they leave shelter. Returns to shelter within 12 months were assessed against the county’s Homeless Management Information System (HMIS)—12 percent of the families served experienced a return to shelter. Compared to family shelter readmission rates in Philadelphia and New York City—which ranged from a low of 19 percent to possibly as much as approximately 36 percent of families who return to shelter within one year—the rapid exit results in Hennepin County represented at least one-third, and possibly as many as two-thirds, fewer families returning to shelter (Culhane et al., 1994).

The activities described above may be used for all levels of prevention: primary, secondary, and tertiary. Further, they may be used in combination, and in a variety of settings. For example, Los Angeles has several programs that work with jail inmates with serious mental illness to prevent homelessness at release. These programs have flexible state funding that they may use to offer supportive services in the community, assistance to obtain housing, and short- or long-term rental assistance. The programs have successfully reduced the amount of time this population spends homeless or incarcerated and have increased the amount of time spent housed (Mayberg, 2003).

## **WHAT IT TAKES—ORGANIZING FOR PREVENTING HOMELESSNESS**

Any agency could use these prevention activities, alone or in combination, and they would probably prevent some homelessness. But an agency is unlikely to use prevention resources *efficiently* unless the strategies are part of a larger structure of planning and organization that addresses the issue of targeting, as discussed in Chapter One. A single agency can target and, to some extent, do it well. To get the most from a community’s prevention dollar, indications are that one would need a community-wide system. The system would have a carefully articulated targeting strategy and mechanisms to assure that funds allocated to prevention are used to reach the people at greatest risk of homelessness. The communities in this study each had some elements of such a system, and several had many. The study communities with the most elements, Hennepin County and Massachusetts, were best at preventing homelessness and were certainly best able to document their achievements in homelessness prevention.

The ability to contrast and compare across sites and observe how different communities conduct prevention is central to this type of study—learning happens by observing what is not present, as well as what is. The differences apparent among communities allow one to identify the elements that are relevant to developing and sustaining homelessness prevention efforts, from both practice and policy perspectives. From the site visits and other information gathered about the study communities, the study team identified elements of community organization that helped focus homelessness prevention efforts and influenced their greater likelihood of success.

Chapter Two described each study community on a number of dimensions, and the Appendices provide even more detail. Without repeating much of that material here, this section analyzes the elements found in the study communities that appear to contribute to homelessness prevention—the elements all concern community organization of one type or another. The more comprehensive and sustained these elements are, the more likely they are to contribute to developing a *system* of homelessness prevention. A list of key elements by domain follows; Exhibit 9 summarizes the elements.

- Elements Affecting Ability to Target Well:
  - Information sharing across agencies and systems; and
  - Control over the eligibility determination process, including agreed-upon criteria, combined with housing barrier screening and triage.
  
- Elements Reflecting Community Motivation
  - Community accepts a legal or moral obligation to shelter; and
  - Fulfilling this obligation costs a lot of money, and the community is motivated to use it wisely.
  
- Elements that Maximize Resources
  - Collaboration among public and private agencies; and
  - Nonhousing mainstream agencies accepting their clients' housing stability as one of their responsibilities.
  
- Elements Affecting Direction, Sustainability, Control, and the Use of Data to Guide Future Development:
  - Leadership;
  - Having a clear goal of preventing homelessness;
  - Developing a strategy to reach the goal;
  - Having mechanisms that provide feedback on progress, stimulate new thinking and innovation, identify gaps and next steps; and
  - Knowing what is needed and making sure contract agencies are committed to providing it.

**Exhibit 9. Organizing for Community-Wide Homelessness Prevention**

Element		Community-Wide Strategies with Families			Community-Wide Strategies with Specialized Populations		
					People with Serious Mental Illness		Homeless and Runaway Youth
		Hennepin County	Montgomery County	MAAC	Massachusetts	Philadelphia	Urban Peak
Targeting Aids	Information sharing across agencies and systems	All prevention and rapid exit agencies share a data system	Prevention and shelter services through one agency, with common database	All private agencies handling prevention funds share common database, which also tracks shelter referral and usage	Acute inpatient, shelter, DMH transitional programs share information through outreach; courts and DMH contract agencies share information through Tenancy Preservation Projects; working with Medicaid and TANF agencies	OBH shares data with child welfare, the homeless system, jails/prisons, and internally among its mental health and substance abuse service agencies	No
	Housing barrier screening and triage	Yes, measure via scale	Yes, though no formal measurement	No	Formally, to become DMH client (must meet diagnostic and disability criteria); informally for housing (related to level of need, absence of alternatives)	Formally, to become OBH client (must meet diagnostic and disability criteria); informally for housing (related to level of need, absence of alternatives)	No
Motivators	Public jurisdiction recognizes a legal or moral obligation to shelter	Yes, moral, from County Council	Yes, moral, from County Council	No	Yes, part of legislative and DMH commitments	Some, from city	No
	Significant mainstream resources are invested (other than Federal)	Yes, state and local	Yes, mostly local	No	Yes, mostly state	Yes, mostly local	Only from child welfare to youth leaving foster care
Maximizing Resources	Collaboration among public and private agencies	Public and private, extensive	Public and private, extensive	Private only	Public and private, extensive	Public and private	Public and private
	Nonhousing mainstream agencies accepting housing their clients as one of their responsibilities	Yes, child welfare, TANF, mental health caseworkers included in rapid exit case planning for families	Yes, child welfare, behavioral health, and domestic violence case workers coordinate housing services	No	Yes, DMH itself and to some extent corrections, for people with serious mental illness	Yes, OBH for people with serious mental illness	No

**Exhibit 9. Organizing for Community-Wide Homelessness Prevention (continued)**

Element		Community-Wide Strategies with Families			Community-Wide Strategies with Specialized Populations		
		Hennepin County	Montgomery County	MAAC	People with Serious Mental Illness		Homeless and Runaway Youth
					Massachusetts	Philadelphia	Urban Peak
Direction, Sustainability, Control, and Feedback	Leadership	Yes, strong, sustained, for both prevention and rapid exit	More coordination than leadership	Coordinating function, but not for new or developing prevention strategies	Yes, strong, sustained, for prevention, rapid exit, and community-based housing for people with serious mental illness	Just beginning for prevention, long been present for community-based housing for people with serious mental illness	Strong leadership to organize community to address youth homelessness, but no significant public role
	Clear goal of preventing homelessness among target population(s)	Yes	Yes	Yes	Yes	Just beginning	Yes
	Clear strategy with ways to track success and progress	Have strategy, track progress, use feedback to adjust system; prevention success tested against shelter database	Only beginning to develop a strategy; prevention success tested internally and against Sheriff's eviction database; have data to do more	Do not have a strategy for system development; have data to track progress but have not to date	Have strategy, track some kinds of progress, but not yet specifically for prevention	Just beginning to develop strategy and tracking	Have had strategy and some data; just beginning to use data for tracking outcomes
	Lead agency has control of funding and contracting for all or most of system	Yes	Yes	No	Yes	Yes	No
	Uses outcomes-based contracting with adjustments based on performance	Contracts specify outcomes, not process or services; contractors have been terminated or not renewed for not meeting outcome commitments	No	No	No	No	No

### **Elements Affecting Ability to Target Well**

System efficiency depends on targeting well. The study communities used several strategies to improve targeting and ensure that prevention resources go to the people at highest risk of homelessness. These strategies are discussed below.

#### *Information Sharing Across Agencies and Systems*

The lead agencies in the six study communities had a single data system, some of which could link to other relevant agencies and offices. These data systems were essential for unifying the community's prevention strategy. No community had a true "single point of entry," if by that one means all people seeking services enter through a single location to get help. But the agencies offering prevention in each community were all linked to a shared, real-time data system, and therefore enjoyed and continue to enjoy such advantages as those listed below.

- Agencies are able to view service histories, client characteristics, and diagnoses and treatments to determine client eligibility and what services to offer.
- In cases where a client needs a service that an agency does not offer, the agency can search the data system for an appropriate provider and help the client make arrangements to get the service. In some communities, agencies may find other agencies with remaining funds if their own have run out.
- Agencies collect client descriptors for identical fields and code them in identical ways. As a result, information is comparable across and within agencies, offices, and regions. Each user knows what another agency's data mean, and can share screening criteria and make similar decisions based on similar evidence.
- MAAC has the advantage of having both prevention and shelter services recorded in the same database. MAAC can regularly check its own database for evidence that families who received homelessness prevention assistance do not become homeless.

Several communities also had arrangements to share or compare data with other systems for purposes of service delivery, as well as to assess prevention success. These arrangements evolved over several years and were motivated by leaders and planners who saw the system advantages, as well as the advantages for serving clients better. Examples of these ongoing arrangements are listed below.

- To evaluate its primary prevention efforts with families, Hennepin County compares the families who received prevention assistance and rapid exit services through the Family Homeless Prevention and Assistance Program (FHPAP) with the county's HMIS to determine if families who were served enter shelter. To offer the most appropriate services, its rapid exit screening process accesses county Housing Court and police systems to search for barriers related to housing or criminal history, and uses the information to design better service plans for families.



- To evaluate primary prevention, Montgomery County checks families who received prevention assistance against the Sheriff's eviction records. Because Montgomery County Department of Health and Human Services is an umbrella agency incorporating many services, its integrated agency-wide data system contains information on health, mental health, and family services that in another county might require interagency arrangements to access.
- Philadelphia's OBH can access the HMIS and child welfare's data system to determine a family's multisystem involvement to develop the most appropriate service plans. OBH also receives information on jail inmates, allowing OBH to identify its own clients and see that they receive casework services to, among other things, avoid homelessness upon release.

### ***Control Over the Eligibility Determination Process***

Chapter One identified careful targeting as the key to an efficient use of resources for homelessness prevention. Shared data systems, such as the ones these communities maintain, are vital tools for any community that is serious about targeting resources to those most in need. Once targeting criteria are developed and agreed upon, system managers can use system data to assess whether the criteria are being used correctly and provide feedback to improve targeting.

All study communities exercised some degree of control over which families received prevention assistance. But some communities maintained significantly more control than others and targeted the most intensive interventions toward the families who experienced the most barriers to housing. The Hennepin County system of screening and triage for families seeking shelter was the most carefully articulated targeting procedure among the study communities. It is described below as an example of a strategy that developed through several iterations. Equally important, it would never have happened without strong managers who had a vision of how they wanted the system to operate, as well as knowledge of what was going wrong based on careful monitoring of system performance.

Any family seeking shelter in Hennepin County is screened by the rapid exit coordinator, as explained in Chapter Two. The rapid exit coordinator checks for the existence of housing barriers against a formal screening tool, shown in Exhibit 10. Any barriers identified are discussed with the family to learn more about them, and entered onto the screening sheet, which also contains columns for a family's service plan. The rapid exit coordinator refers the family to a rapid exit provider, and sends the screening sheet along so the provider has full information as work with the family begins. The county exercises additional control over the rapid exit process by linking approval for continued shelter stay to progress on the plan developed between the family and rapid exit provider. The system leaves very little room for a family to drift along without taking steps to return to housing quickly.

Montgomery County has a screening process that resembles that of Hennepin County in terms of types of identified barriers. The county does everything it can to divert the families with fewer barriers away from shelter by supplying appropriate cash and in-kind assistance. But it does not

use effective strategies for shortening the length of shelter stays, such as Hennepin County’s rapid exit services, when it makes a shelter referral.

**Exhibit 10. Hennepin County Housing Barrier Screen**

**ASSESSING HOUSING BARRIER LEVELS** When screening (Rapid Exit) families for referrals for housing assistance, the following are guidelines for assessing a family’s housing barriers and categorizing the barriers into three levels:

**Level 1: No barriers.** Family has a good rental history, no UD’s (unlawful detainer/eviction), no criminal history, and no active chemical dependency or abuse issues. Families would be given an information packet and a sample rental application form. No FHPAP/RE referrals will be made. Family may return to RE Coordinator for help with application fees.

**Level 2a: Has some of the following barriers:**

- No rental history
- New to the area
- Large family
- One easily explained UD
- History of battery but abuser not in the area
- Non-English speaking
- No high school diploma
- Physical disabilities that affect housing
- One parent/child household
- Needs financial help with moving, furniture, misc. services
- Head of household under 18 years of age

**Does NOT have the following barriers:** Criminal record, active CD/alcohol issues, more than one UD. Families would be given the information packet, a sample rental application, and referral to a FHPAP/RE or short-term provider.

**Level 2b: Family has some of the following barriers:**

- Poor rental history (up to three UD’s or evictions)
- Recent minor drug or criminal history
- Mild behavior problems—adult
- Mild behavior problems—child(ren)
- Male teenager in the home
- Recent domestic abuse with the abuser in the area
- Just released from jail
- Not currently abusing drugs
- May also have some of the barriers from Level 2a
- Open child protection case

**Does NOT have any Level 3 barriers.** Families would be given the information packet, a sample rental application and be referred for longer term case management services to a FHPAP/RE or other provider who provides such services. Transitional housing services may also serve 2bs.

**Level 3: Has some of the following barriers:**

- Actively using drugs
- Adult with severe behavior problems
- 4 or more UD’s
- Children with severe behavior problems
- Recent serious criminal history
- Current sexual abuse in the family unit
- Current battering with the abuser in the family unit
- Has recent record of property damage to rental housing

Families may be referred to Project Connect or a similar service. The difficulties in obtaining housing will be explained to families along with alternatives. They may be referred to non-FHPAP housing search options and FHPAP/RE providers, including transitional housing.

**SERVICE REFERRALS TO FHPAP RAPID EXIT & TRANSITIONAL HOUSING PROVIDERS** Referrals for each barrier level are summarized above. Since FHPAP/RE services are directed to Level 2 and lower Level 3 families, referrals of Level 1 and high barrier Level 3 will not be made to FHPAP/RE providers. Referrals to other services such as Project Connect (transitional housing) can be made for Level 3.

**FHPAP RAPID EXIT ELIGIBLE FAMILIES** As of 7/1/95, FHPAP rapid exit providers are to serve Level 2 and lower Level 3 families referred by the FHPAP Rapid Exit Coordinator (REC). This will assure that FHPAP providers serve the target group and that the appropriate families reach services soon after shelter entry.

**AVAILABILITY OF RAPID EXIT & TRANSITIONAL HOUSING SERVICES** Rapid exit providers are to communicate with the FHPAP REC what their current capacity is and how many referrals they are ready to accept. This communication is essential to facilitating services for families.

**REC SCREENING GOAL** The target goal is for families to be screened and referred within 5 days of their first voucher into shelter.

**APPLICABILITY OF POLICY** These guidelines will be used not only by the FHPAP Screener/REC but by all FHPAP service providers, including SHP and ESG, who are assessing housing barrier levels for a family under the FHPAP Umbrella Program.

(modified version of County form: SJH 04 RECBBarrierLevels04)

MAAC is an example of an excellent data system that links many agencies and supplies providers with much-needed information. It promotes targeting by facilitating the use of shared eligibility criteria by all prevention providers. However, the system stops there because MAAC

does not have any mechanisms of control, or any right to exercise control, over which families its member agencies serve. To the extent that efficient targeting of prevention resources happens among MAAC agencies, it arises from voluntary agreements and the requirements of the funding streams that supply the money for prevention assistance. MAAC thus represents the probable limits of targeting efficiency in communities without an overall strategic plan that includes continuous efforts to improve efficiency and effectiveness.

The remaining study communities had a targeting challenge that is quite different from that faced by the strategies focused on helping high-risk families. Massachusetts, Philadelphia, and Urban Peak serve individuals whose history and disabilities already put them at high risk for homelessness. In addition, much of the population they serve has already had at least some experience of homelessness, making their future risk that much more obvious. Each of these sites applies assessment procedures to judge homelessness risk, and all offer remedies commensurate with the risk level observed. Often, this means the relevant agencies supply actual housing after determining that, without it, a client faces a very high risk of homelessness. With or without the housing, these sites are most likely to offer ongoing community-based supportive services to keep clients in housing and, for the mental health agencies, to keep mentally and emotionally stable people in the community rather than in hospitals.

### ***Rationale for Screening Criteria***

The communities selected for this study represented two targeting strategies. One strategy, usually employed by communities seeking to prevent family homelessness, targets the families best able to resolve their current housing problems. Among the study communities, Hennepin County, Montgomery County, and MAAC follow this strategy for primary prevention—selecting families who do not appear to have chronic problems and helping them with a temporary problem.

The second strategy, usually employed by communities seeking to prevent homelessness among populations with chronic disabilities (such as people with serious mental illness) or severe situational disadvantages (such as those exiting correctional facilities, foster care, or who are already on the streets) targets people with multiple and complex problems. In this study, these communities include Massachusetts, Philadelphia, and Urban Peak. These communities first screen for agency eligibility, which addresses psychiatric diagnosis, disability, and duration. Once eligibility is determined and the person becomes an agency client, screening for various needs and services is ongoing. Income is not a criterion for agency eligibility; however, the majority of public mental health agency clients is extremely poor and experience difficulty finding, affording, and keeping housing without agency assistance.

Of the two targeting strategies, the second is more likely to be efficient in selecting people who are demonstrably at higher risk than the families helped through the first strategy. The family prevention agencies' task is difficult because they are seeking those who are in real trouble, but who are close to having their difficulties resolved. Relatively few of these families are likely to become homeless, even without the help of prevention agencies or when they can prove to the

agency that they are facing eviction. These agencies must be rigorous in their screening procedures to determine that the risk of homelessness is reasonably high.

### **Elements Reflecting Community Motivation**

In this study, the communities with the strongest publicly held motivation to prevent homelessness did the most to develop community-wide prevention strategies. Legal or moral obligation to act was part of this motivation, but so was a concern with cost, and wanting public dollars to be used most effectively. These elements are discussed below.

#### ***Obligation to Shelter***

Two study communities took on a moral obligation to help families avoid homelessness. County Councils in Hennepin County and Montgomery County had long-standing policies that no family would spend the night on county streets. The study team did not ascertain the origins of these policies, which went back at least a decade. One clear consequence of these policies, and a measure of the Councils' commitment to them, was that both counties paid for shelter for families.

Two study communities—Massachusetts and Philadelphia—have a legal obligation to care for people with serious mental illness, as well as the responsibility for allocating public funds to this end.<sup>19</sup> Both communities recognized the importance of housing as a necessary component of that responsibility.

#### ***Significant Investment of Public Funds***

These four jurisdictions (County Councils in Hennepin County, Montgomery County, Massachusetts, and Philadelphia) invested significant state or local monies in homelessness prevention. This investment, coupled with their policy commitment, has motivated them to develop systems that offer effective prevention activities efficiently. Massachusetts DMH has focused on preventing homelessness among its clients for more years than OBH in Philadelphia. In part, the difference arises because DMH as a state agency simply has more resources. The Special Homeless Initiative appropriation that began in 1992 resulted from the combined efforts of the Massachusetts Housing and Shelter Alliance (Boston's largest shelter providers) and DMH, working with the governor and legislature to make the case for investment and to shape the legislation.<sup>20</sup> Legislative directives also charge the department with preventing Commonwealth citizens with serious mental illness from becoming or remaining homeless, and

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<sup>19</sup> All state mental health systems have similar obligations, although not all states invest the resources that Massachusetts does in fulfilling these obligations. As a city, Philadelphia has taken on more extensive commitments to assist people with serious mental illness than would be mandatory under state law.

<sup>20</sup> Money has been appropriated for the Homeless Initiative every year since 1991 in the governor's annual budget proposal to the legislature, which is always House Bill 1. The Homeless Initiative has never been authorized as a program.

the Homeless Initiative money is extremely flexible, permitting DMH to “do what it takes” to prevent homelessness. Over the years, advocacy and provider pressures, coupled with its own commitments, have pushed DMH to develop a long-term strategy and provide the leadership to carry it out.

### **Elements That Maximize Resources**

No single agency or program has the resources needed to prevent homelessness. Every study community recognized the need for collaboration among key players to bring more resources to the table. The primary differences among the communities were in the nature of the players and the resources they commanded. Where public agencies lead or shape prevention strategies, the resultant activities command many more resources and offer more comprehensive approaches.

### ***Collaboration Among Public and Private Agencies***

Two study organizations—MAAC and Urban Peak—illustrate collaborations of private nonprofit agencies without much public contribution of ideas, resources, or power. MAAC boasts many member agencies that work together to share resources and maximize appropriate use within the bounds of its network. However, it has not succeeded in recruiting significant public involvement, nor does it strategically plan to develop new and more effective approaches to homelessness prevention. Conversely, Urban Peak has thought strategically about preventing and ending youth homelessness and has greatly expanded its collaborative network since it began 17 years ago. It is an example of how far a nonprofit agency can go toward organizing a community strategy without the participation of mainstream agencies.

The FHPAP Advisory Committee in Hennepin County is an interesting example of how collaborative relationships can help a community strategy focus and expand.<sup>21</sup> The Committee’s membership includes: shelter operators; providers with and without FHPAP contracts; advocates; formerly homeless people; representatives of legal services; Minnesota Housing Finance Agency; Twin Cities Voicemail (a company that provides free voicemail for homeless people); the Minneapolis Public Schools homeless programs; Minnesota Coalition for the Homeless; and other homeless planning groups such as the Continuum of Care. In addition, supervisors of direct service units in county departments—who have responsibilities for homeless-related services—attend meetings and provide input.

The FHPAP Advisory Committee is essential to smooth program operation. The committee establishes outcome goals; assesses service gaps and recommends services for funding; designs requests for proposals and reviews proposals; seeks new providers; provides cross-fertilization through members who serve on other committees; promotes new partnerships; and reviews contract performance. The makeup of the Advisory Committee is especially important for establishing and maintaining standards of performance. Members are knowledgeable about the

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<sup>21</sup> FHPAP providers also operate in a strong collaborative network similar to MAAC, as does the Emergency Assistance Coalition in Montgomery County.

population to be served, as well as the options for helping them, and are supportive of the use of outcomes-based contracting. If a provider's performance is unsatisfactory, it must appear before the Advisory Committee to explain what happened and how it will improve its performance. If the provider is unable to improve its performance, the FHPAP Advisory Committee will suggest that it not be refunded. Under such scrutiny, nonperforming providers usually agree to drop the contract rather than have the county terminate it. This process of winnowing and sifting to engage the most effective providers is essential to improve overall system performance.

Massachusetts offers the best example of leveraging resources controlled by other public agencies in pursuit of its homelessness prevention goals. As detailed in Chapter Two, DMH leverages its own resources to obtain housing investments from the state housing finance agency, state agency for community development, the state property management agency, and several local public housing authorities. It works with the state health department to leverage Medicaid dollars for its clients and with the state's labor department to obtain employment and training resources. DMH also works with the state welfare agency to coordinate the state's overall strategy for addressing homelessness, and with Housing Courts in several parts of the state. In addition to these public collaborators, DMH works and contracts with a host of nonprofit providers and the for-profit agency that manages behavioral health care for its clients.

### ***The Role of Nonhousing Public Agencies***

A final issue related to maximizing resources for prevention is the involvement of public agencies whose mandate includes assistance to vulnerable individuals and families. Examples include child welfare, corrections, Temporary Assistance for Needy Families (TANF), and mental health agencies. Agencies of this type often have not recognized a housing component as part of their responsibilities, but in some communities their understanding is changing, and with it their investments. The lead prevention agencies in four of the study communities provide obvious examples.

For families, these agencies include the Human Services Department in Hennepin County and the Department of Health and Human Services in Montgomery County, both of which combine responsibilities for TANF, child welfare, and mental health. Not only have these agencies taken the lead on homelessness prevention, they have also assured that families involved in any of their agency's services will receive coordinated case management and shared agency resources.

The public mental health agencies in Massachusetts and Philadelphia have long recognized the importance of stable housing for their clients' well-being. Both have involved corrections agencies in their efforts. Philadelphia has also been working with the child welfare and TANF agencies to develop a system that alerts caseworkers quickly to a family's impending housing crisis so that timely intervention and assistance may prevent homelessness. In Massachusetts, DMH works closely with the Department of Transitional Assistance, which is the lead agency for addressing homelessness in the state.

### **Elements Affecting Direction, Sustainability, Control, and Feedback**

Many of the elements falling under this heading—leadership, having clear prevention goals, and having a strategic multiyear plan for achieving the goals—are so interdependent that they cannot be discussed separately. It is also impossible to say “which came first,” as they often evolve together.

The three study communities with the best-developed multiyear approaches were Hennepin County, Massachusetts DMH, and Urban Peak. (Urban Peak differs from Hennepin County and Massachusetts DMH in the absence of public agency investment and commitment.) Each community had a different goal: preventing family homelessness within one urban county for Hennepin County; preventing first-time and subsequent homelessness by providing stable housing and community supports for people with serious mental illness for Massachusetts DMH; and helping already-homeless youth gain housing and stability for Urban Peak. The remaining three study communities had some aspects of a coherent approach, but lacked others. These differences allowed the study team to identify the aspects of prevention approaches that appear to be most important to developing a coherent, multiyear strategy for homelessness prevention.

### ***Leadership, Goal Orientation, and Planning***

The three communities with multiyear strategies had leaders who were committed to the goal of prevention. In two of the communities (Hennepin County and Massachusetts), public agencies had the authority and responsibility to set goals and develop plans. In the third, a nonprofit agency developed into a leader over time even without the backup of public authority. These leaders, knowing that implementing their overall strategies would take years, pursued many activities at once. A clear goal and sustained leadership has enabled them to take advantage of many opportunities for joint funding from the U.S. Department of Housing and Urban Development and other Federal, state, and local agencies. Leadership in each of these communities worked with local legislatures over the years to obtain enabling legislation, funding, and waivers; add eligible populations to their funding streams; and create new programs based on their experience of what was necessary to prevent homelessness. Alliances and collaboration with the sources of capital and operating funds for housing have been essential to prevent homelessness among people with chronic conditions.

Centralized control of much funding for prevention makes it easier to establish an efficient system to handle both primary and secondary prevention. This control can also provide leverage to establish systematic monitoring to determine what works at the various stages of the prevention and emergency shelter phases. This knowledge enables agencies and communities to buy effective services and achieve desired objectives. If exercised in a spirit of collaboration and collective system-building, centralized control of funding encourages community-wide support of prevention and creative problem solving to reach the goal of preventing homelessness.

For example, Massachusetts DMH has consciously directed its funding toward meeting strategic prevention objectives. Since 1992, the department has developed independent and semi-independent housing options, as well as an extensive array of community-based supportive

services for its clients. Homelessness prevention and rapid exit have been one theme in a broader agenda of developing a community-based service structure to maintain DMH clients in stable housing in the community, thus avoiding rehospitalization and homelessness. DMH establishes partnerships and collaborative arrangements with other funders and with providers, seeking contracts for specific supports to advance the department's overall strategy.

### ***Feedback for System Improvements***

Of the four study communities with high levels of funding control (Hennepin County, Montgomery County, Massachusetts DMH, and Philadelphia), Hennepin County is the most advanced in its conscious use of the contracting process to obtain specific outcomes that reflect progress toward goals. FHPAP managers routinely solicit proposals to achieve explicit outcomes for families with specified housing barriers. This method of contracting enables providers to do “whatever it takes” (with the exception of paying for shelters, building housing, or subsidizing housing for more than 24 months) to prevent homelessness or assure rapid exit from shelter. Hennepin County staff track outcomes and, together with a broadly representative Advisory Committee, make contract renewal decisions based on providers' abilities to achieve the promised outcomes. Because these activities uniquely maximize investment in prevention, they warrant a detailed presentation.

- *Controlling the whole system:* When FHPAP was established, program managers reasoned that pressure on one service component would merely push families into another service component unless the county controlled access to the entire system. For example, refusing prevention assistance might push a family into emergency shelter. The county created the primary prevention and rapid exit components of its system together to ensure that family housing crises must be addressed.
- *Using its data to create a feedback loop for monitoring and system improvement:* The FHPAP program manager was the moving force behind the FHPAP data system. She uses it routinely to monitor the system and check on performance. Issues she looks for include the housing barrier levels of families being admitted to shelter, the speed of exit from shelter, and smooth operation of the primary prevention component. Targeted screening combined with careful monitoring has succeeded in reserving scarce shelter resources for the hardest-to-house families. Other study communities have not been as focused on control through feedback and adjustment, although some communities could do so with data they have on hand. Massachusetts, Philadelphia, and Montgomery County use data to inform and guide their approaches to preventing homelessness. These jurisdictions are beginning to think strategically about homelessness prevention and the use of data to guide system development.
- *Using outcomes-based contracting:* Because it has a comprehensive strategy with clear goals, the FHPAP is able to document outcomes of service receipt. In its Request for Proposals seeking prevention and rapid exit providers, it specifies the level of performance it wants to purchase. Specifications are stated in terms of outcomes, not persons served or services delivered. Bids must also be clear as to the outcomes being



promised, and expected outcomes are clearly stated in county contracts. FHPAP managers generally receive 30–40 proposals in response to each RFP, of which 10–15 percent receive funding. Due to a high level of choice, FHPAP is able to select providers that best understand its outcomes-based approach and provide evidence that they will fulfill the performance commitments. FHPAP monitors and evaluates providers based on outcomes. Providers that do not fulfill these contract obligations may be terminated.

Montgomery County and OBH in Philadelphia control many of the resources that could be devoted to homelessness prevention and rapid exit. They also have data systems that could provide feedback to guide the contracting process toward using outcomes as the basis of awarding and renewing funding. Both jurisdictions also have control over who receives prevention services, and Montgomery County controls access to shelter as well. In both communities, the payment structure could, in the abstract, establish the types of performance feedback mechanisms that Hennepin County uses to ensure that resources are expended in the most effective and efficient manner.

## CONCLUSIONS

This chapter identified two issues confronting communities desiring to prevent homelessness: knowing what prevention activities are effective and developing a system to deliver them efficiently (i.e., to the families with a very high risk of becoming homeless if they do not receive help). Several effective prevention strategies were identified, including some that are most likely to be used for primary prevention and others that are more likely to be used for secondary prevention or even tertiary intervention.

With respect to organizing a community for prevention, the study team identified two overall strategies. The first—most commonly applied to families threatened with housing loss—screens for short-term problems that nonetheless constitute crises for particular families, and applies short-term solutions. The second seeks people whose disabilities or other circumstances indicate chronic problems, and applies the long-term solutions of housing with supportive services. When these solutions are made available before homelessness occurs, they have a stabilizing and preventive effect similar to what happens when they are offered to chronically homeless people with disabilities.

These two strategies operate through several mechanisms that other communities could begin to develop. These include careful targeting toward populations at very high risk of homelessness, and organizing and controlling access to preventive services to maximize targeting. The best organized among the study communities reached their present situation deliberately and over time, in a process that involved leadership, analytic thinking, strategic planning, alliance building, and collaboration. Developing better data and using existing data more strategically can improve performance, identify and fill gaps, and further the development of a community's approach to homelessness prevention.

This study has not found definitive proof that these prevention efforts work, as it has not been able to identify or construct control or comparison groups from the study communities to assess

how much homelessness would have occurred without the interventions. It did, however, identify some comparative data, in light of which one can make some claim to the effectiveness of homelessness prevention activities described in this chapter. The study has also helped to identify circumstances under which activities designed to prevent homelessness have the greatest chance of actually doing so.

Communities interested in supporting homelessness prevention activities should think very carefully about targeting, how and toward what ends it is allocating prevention resources, and how it could obtain feedback to assess effectiveness and improve system performance. Communities should also identify a person to lead the effort to organize for prevention, and give that person the authority to plan and make things happen over the long term. It is impossible to say how much each element identified during this study contributes to effective and efficient prevention. However, one can conclude that the communities whose prevention efforts include the most elements seem to be making the most difference, and are certainly able to supply the best documentation that their activities have prevented some homelessness.



## CHAPTER FIVE

### POLICY, PRACTICE, AND RESEARCH IMPLICATIONS

Chapter Four identified two issues for prevention: the *effectiveness* of any particular activity, and the *efficiency* with which that activity could be delivered. *Effective activities* are those that avert initial homelessness (primary prevention), or end a homeless experience quickly (secondary prevention). *Efficient systems* are those that target well, delivering effective activities to people who are very likely to become homeless unless they receive help.

Policymakers intending to prevent homelessness will want to support effective activities. However, this will not be sufficient for most communities. Policymakers and administrators will also need to consider the elements that comprise an efficient community-wide prevention strategy if they want to assure that resources are used wisely. This study identified several prevention activities that have some evidence to support their effectiveness, as well as elements of community systems that appear to be important in making a prevention strategy efficient.

Findings from this study, combined with updated summary of prevention effectiveness research (Shinn et al., 2001), point toward some new directions for policy and practice. Implications for future research are apparent, given the paucity of adequate documentation that exists regarding prevention effectiveness.

#### IMPLICATIONS FOR POLICY AND PRACTICE

Some communities in the United States have committed to ending all homelessness in 10 years. Many communities have committed to ending *chronic* homelessness in that timeframe. Communities are not likely to succeed in either endeavor without preventing new entries into homelessness and quickly resolving any homeless episodes that occur.

#### Select Effective Prevention Activities

The following prevention activities may be implemented at all levels of prevention: primary, secondary, and tertiary. These activities may be used alone or in combination as part of a coherent community-wide strategy. Any funder considering an investment in homelessness prevention—whether nonprofit, for-profit, or government at any level—would do well to concentrate its support on one or more of the following activities.

- **Housing subsidies.** Evidence for housing subsidies as a very effective prevention activity comes from studies other than the present one. Shinn and colleagues (Shinn et al., 2001; Stojanovic et al., 1999) documented the effectiveness of housing subsidies at keeping at least 80 percent of first-time homeless families housed for a minimum of two years. Rog, McCombs-Thornton, Gilbert-Mongelli, Brito, and Holupka (1995) demonstrated similar success (80–85 percent retention over at least 18 months) for homeless families in which a parent’s mental illness complicated housing stability. Evidence from simulations

(Quigley, Raphael, and Smolensky, 2001) indicates that subsidizing housing costs for extremely low-income people has the strongest effect on lowering homelessness rates compared to several other interventions tested. Thus when used as secondary and tertiary prevention, housing subsidies help 80–85 percent of homeless families or chronically homeless single adults to achieve housing stability.

- **Supportive services coupled with permanent housing.** For people with serious mental illness, with or without co-occurring substance abuse, permanent supportive housing works to prevent initial homelessness, to rehouse people quickly if they become homeless, and to help chronically homeless people leave the streets (Burt et al., 2004; Shern et al., 1997; Tsemberis and Eisenberg, 2000).
- **Mediation in Housing Courts.** This study collected evidence indicating that mediation succeeds in maintaining housing for about 69 percent of families and up to 85 percent of people with serious mental illness, even when their landlords have filed a formal eviction.
- **Cash assistance for rent or mortgage arrears.** This commonly used prevention activity can be effective—the challenge is to administer it in a way that makes it well targeted and therefore efficient.
- **Rapid exit from shelter.** These secondary prevention activities are directed toward families just entering shelter to ensure that they quickly leave shelter and stay housed thereafter. Using this innovative strategy, Hennepin County halved the average length of a shelter stay (from 60 to 30 days) and achieved an 88 percent success rate in keeping formerly homeless families from returning to shelter.

In addition to selecting effective prevention activities, a community's prevention strategy must offer activities that are accessible and acceptable to all, or some significant subgroups, of the target population. In developing any system of homelessness prevention, consultation with consumers assures investment in acceptable housing options. Offering consumers a role in selecting among housing options for themselves will increase the likelihood of satisfaction with housing and willingness to stay in that housing (Tsemberis, Gulchar, and Nakae, 2004).

### **Develop an Efficient Community-Wide Prevention System**

Whether a community chooses to concentrate on preventing homelessness among people with short-term risk, people who require long-term support, or both, its prevention strategy should strive for maximum efficiency. The short-term solutions would be similar to current practices, but with increased and more accurate targeting to prevent homelessness. Strategies for populations with chronic conditions, which make them vulnerable to homelessness, should identify and serve these persons with housing and support options that are acceptable to them. Critical to efficiency is community-wide collaboration in all aspects of system organization and development. Mainstream agencies such as those focusing on mental health and corrections should be involved in developing these strategies, developing mechanisms to assure appropriate housing for people leaving institutional settings, foster care, and other venues. Communities

should also consider developing community supports for people at high risk of repeated homelessness, to keep them in housing. Consumer input should be valuable in these efforts, identifying the factors that cause people to leave housing when they have nowhere else to go.

The Continuum of Care (CoC) planning process helps ensure that communities pay attention to homelessness prevention, in that CoC applications for HUD funding must describe prevention offerings as part of their community continuum. The CoC process is a reasonable mechanism for developing more comprehensive prevention plans, as many community stakeholders are typically involved. Incorporating data collection through a local Homeless Management Information System (HMIS) and other approaches would also be appropriate for a CoC, and the resulting feedback could be used to shape responses to fill the gaps in primary and secondary prevention in the jurisdiction's CoC.

### ***Improve Targeting***

For investments in homelessness prevention to be used efficiently, they must target the people with the highest risk of homelessness. Regardless of the specific activities adopted, the importance of appropriately targeting prevention activities suggests that certain elements should be established to increase the likelihood of prevention efficiency.<sup>22</sup> These elements include:

- Determination to target prevention resources to those at highest risk, occurring at several levels—policy, program management, and direct service worker; and
- Mechanisms to assist with identifying the high-risk people and households, including:
  - Knowledge of risk factors and agreement on those that, alone or in combination, comprise very high risk;
  - Adequate screening procedures to identify people and households that exhibit the risk factors; and
  - Community-wide consistency with applying screening procedures and eligibility standards.

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<sup>22</sup> This chapter has separated the issues of effectiveness and efficiency to make the point that many different activities may prevent some homelessness, but that a great deal depends on the system that delivers them. An evaluation researcher would say that an inefficient prevention *system* could not be effective. That is, if one compared a treatment and control group drawn from a poorly targeted population (one that was very unlikely to experience homelessness even without an intervention), one would find “no difference.” A statistical finding of “no difference” is usually interpreted to mean that the intervention is not effective. But with respect to prevention interventions it probably means that the population had such a low risk of homelessness initially that the intervention could not make enough difference to be statistically significant.

### *Develop Strong Collaborations*

For homelessness prevention to work, a community will need to make available a range of prevention activities—from counseling to housing—that is acceptable to the target population(s), or commit to identifying and creating such options. To this end, it is useful to engage many stakeholders and establish collaborations within the community. Allies are needed to prevent homelessness, as no single agency has the resources or the responsibility to do it alone. Communities or entire states should conduct the following activities.

- Fund the mainstream agencies responsible for people with chronic disabilities (e.g., mental health, mental retardation, and substance abuse agencies) and direct them to identify households at risk of losing housing. These agencies should take responsibility for helping at-risk households to prevent housing loss by providing supportive services coupled with community-based housing. Examples in this study include Massachusetts and Philadelphia.
- Engage mainstream child welfare and welfare (Temporary Assistance to Needy Families, or TANF) agencies in homelessness prevention. These agencies also need to develop mechanisms to recognize risk of housing loss among their clients and act to prevent it. The communities in this study provided several examples of how these agencies can be involved in homelessness prevention, including the child welfare agency in Philadelphia, and TANF agencies in Hennepin County, Montgomery County, and Massachusetts.
- Enlist corrections agencies, which are beginning to realize that it is in their own financial interest to offer short-term (e.g., six months) housing, links to employment, and supportive services to reduce the odds that recently released prisoners will return to very expensive correctional settings. (At present, about two-thirds of released prisoners return within three years, and many return much sooner.) Examples in this study include Massachusetts and Philadelphia.
- Fulfill the promise of developing community-based housing following state hospital closings. Jurisdictions can reinvest into the community the capital and operating resources previously used to fund state hospitals. An example from this study is the Facilities Consolidation Fund bond financing in Massachusetts, which was recently renewed for an additional 10 years. This fund provides capital resources for community-based housing for people with serious mental illness and mental retardation who previously might have been housed in state institutions.

### *Develop and Use Data Systems*

Data systems are needed to record homelessness risk factors for households, as well as previous, current, and subsequent homeless status, either at the time a household applies for assistance or at high-risk moments such as institutional entry and discharge. In addition to collecting information to conduct the risk assessments and targeting activities described above, communities or entire states should conduct the following activities.

- Adopt one or more of the outcome measures described in Chapter Three. Communities could use their HMIS, modify existing systems, or create new data systems to include information about homelessness or housing status and barriers. Determining the data needed to make informed decisions about system improvements should be part of a CoC's planning process, just as using the data to assess effectiveness and make investment decisions should be part of regular system reviews. Communities should be able to adapt their HMIS to assist in this effort.
- Collect data on the selected outcome and explanatory variables for people served by prevention interventions.
- Train staff throughout the system to use the new fields or new data system, and introduce quality control to ensure the system is accurately recording the information.
- Collect equivalent data on one or more of the groups identified in Chapter Three to provide comparison data (e.g., people on waiting lists who are never served or not served for long periods of time, or people turned away because resources are not available). Examine outcome measures for both groups to assess progress or success.
- Adjust practice according to progress or successes. Disseminate results demonstrating success to build confidence in the approach and bolster support for sustained funding and participation.

### ***Leadership***

Designating someone with the primary responsibility of “minding the store” is essential if communities expect to improve their ability to prevent homelessness. An organized, persistent effort is required. The resulting strategy has to include feedback capable of revealing that mid-course corrections are needed, the ability and authority to make mid-course corrections, and the information to demonstrate that the strategy operates better following such corrections. These requirements imply active leadership committed over the period of years it takes to develop and sustain a comprehensive community-wide strategy. It is also highly desirable that the strategy provides the opportunity for creativity, serendipity, and synergy, which flourish when partners bringing a wide range of resources and skills to the table work collaboratively toward common goals. The best strategies identified in this study have these characteristics.

### **The Role of Federal Agencies**

Federal agencies can promote adoption of more effective prevention strategies through their policy positions and by the way they structure funding opportunities. Federal agencies need to continue to emphasize the role of prevention in community-wide strategic planning and integrated approaches for reducing homelessness for those at greatest risk. Federal agencies in charge of block grants and formula grants with potential for use to prevent homelessness should emphasize the importance of improved targeting and measurement of outcomes. These agencies



should also and encourage the local agencies controlling the funds to incorporate more strategic and community-wide planning as they distribute these resources. Relevant programs include Emergency Food and Shelter Grants, Emergency Shelter Grants, and the community support aspects of some programs and block grants from the U.S. Department of Health and Human Services (e.g., Projects for Assistance in Transition from Homelessness, Community Mental Health Services Block Grant, Substance Abuse Prevention and Treatment Block Grant). Finally, Federal agencies should continue to make technical assistance available to communities that are trying to improve targeting and measure outcomes as part of their strategic planning to prevent and end chronic homelessness. HUD's technical assistance guide on using ESG for homelessness prevention is an excellent example of a resource that can benefit grantees as they incorporate a homelessness prevention component into their service delivery.

## **IMPLICATIONS FOR FUTURE RESEARCH**

The implications of this study's findings for future research are formidable. They arise from the finding that even the few communities that systematically collect data on their prevention efforts are not able to provide solid evidence that activities intended to prevent homelessness actually do so. The role of Federal agencies in promoting and sponsoring the following research suggestions is vital, as there is little likelihood that local programs will mount extensive research efforts, or that they will establish the control or comparison groups that are so important for verifying that prevention really happened. State agencies or foundations might also sponsor evaluations of homelessness prevention activities, but HUD and other Federal agencies are in the best position to do so, and are most likely to have the necessary resources.

For primary prevention, control groups are necessary to prove that significant levels of homelessness would have occurred if the intervention had not been offered. Comparison groups that approximate randomness would also contribute to these findings. In the absence of control or comparison groups, documenting changes over time in relation to significant changes in the intensity of interventions or precipitating factors (e.g., unemployment) may be convincing. The research suggestions presented below may help fill the most glaring gaps in current knowledge and indicate whether approaches to preventing homelessness are effective.

### **Control or Comparison Groups**

For prevention interventions, conducting controlled experiments (with randomly assigned control groups) or quasi-experiments (with comparison groups that are matched as well as possible but are not randomly assigned) is the only sure way to assess effectiveness. The types of control or comparison groups may vary based on the population being studied.

### ***Families***

To demonstrate prevention effectiveness among families, control groups may be constructed by randomly assigning families to either the treatment or control group to perform a true experiment. Quasi-experimental designs may be used with comparison groups developed from waiting lists. Literal homelessness may be measured as an outcome, as well as more refined measures such as less stable housing and doubling up. These measures may help determine whether without rent, mortgage, and utility assistance and other short-term prevention activities, families begin the slippery slope to homelessness or manage to stabilize again after temporary economic setbacks.

### ***People with Chronic Disabling Conditions***

For people with chronic disabling conditions such as serious mental illness, HIV/AIDS, and chronic substance abuse, control groups may be constructed using random assignment and comparison groups may be constructed using waiting lists. If intervention levels vary significantly, one could track this variation over time against homelessness among people with the relevant disability. These data could be gathered at admission and discharge from institutions such as state hospitals, private psychiatric inpatient settings, substance abuse treatment settings, correctional institutions, and emergency shelters.

For secondary prevention, one could track interventions and their success and speed at housing people as well as the length of time the interventions are able to keep people housed. Also, one could document the supportive services used to stabilize housing to determine what is required to keep people in the target populations housed.

### **Comparison Groups**

Larger efforts that span over a number of jurisdictions could include supporting a reasonable sample of providers whose prevention efforts focus on distributing rent, mortgage, and utility payments to help people retain housing. This support would help these providers to collect and maintain better data on the families they do and do not assist. These providers could be concentrated in selected communities whose housing and employment opportunities varied systematically, to provide some level of contextual variation to help explain both demand for assistance and success in homelessness prevention. Required data elements for both categories of families include:

- Family characteristics, housing barriers, and histories at intake;
- Interventions provided; and
- Followup for at least 12 months to assess levels of housing retention and various economic hardships.

These data should be assembled at the national level. This approach would be less expensive than an ideal research design, but would still contribute significant new data on important issues, including the effectiveness of rent, mortgage, and utility assistance as homelessness prevention. To give this approach the greatest chance to contribute high quality information, a national research effort would have to be established to manage data collection within programs and conduct followup interviewing to assure acceptable completion levels.

### **Longitudinal Tracking**

Longitudinal tracking studies should be funded to document housing retention and stability and to follow people after they receive a prevention intervention. A primary outcome to observe would be housing stability and the factors contributing to it. One could also observe the supports available to and used by households that do not receive prevention interventions. This information would add to the understanding of why households do or do not become homeless.

### **Targeting**

Communities should identify and disseminate better targeting practices to help prevention programs determine those who are at high risk of becoming homeless without the intervention. This study described the targeting practices of Hennepin County in great detail. Even before the evidence from more controlled research is available, this and other targeting schemes for family homelessness prevention should be identified and assembled, compared, and disseminated. Detailed information should be assembled on mental health system practices for identifying clients who need housing to prevent homelessness or a slide into chronic homelessness. This process could start with the two mental health systems examined in this study. Any evidence available from system records for the success of this targeting should be extracted and analyzed, using information from all mentally ill clients to determine whether targeting has been accurate. Targeting information from these analyses should be assembled and disseminated to other mental health systems and to mental health advocacy organizations.

Once results are known from one or more of the controlled research studies suggested above, the targeting schemes should be modified based on the results.

## **CONCLUSIONS**

Community-wide approaches to prevent homelessness are an essential part of ending homelessness, because only prevention can reduce or eliminate new cases of homelessness. Many communities offer a wide range of activities intended to prevent homelessness. Researchers (Lindblom 1997, Shinn, Baumohl, and Hopper, 2001) have concluded that strong evidence is still lacking that homelessness prevention efforts are effective, but the bulk of their criticism has to do with targeting and inefficiency, not with the underlying effectiveness of different activities. This study found examples of promising policies and practices, including

approaches to targeting that could be adapted to local circumstances and applied by other communities.

These policies will have the greatest chance of success if they are part of a coherent, multiyear approach supported by strong leadership, adequate resources, and mainstream agency commitments, particularly for the policies involving populations with chronically disabling conditions. Communities could also begin to improve their prevention targeting and establish one or more of the innovative strategies described in this report. The CoC planning process that occurs in many communities is an appropriate vehicle for implementing many of this report's suggestions. Federal and state programs, as well as national organizations, that encourage community-wide, collaborative thinking and help fund such efforts would contribute significantly to their success.



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## APPENDICES

This section of the report includes in-depth descriptions of each of the communities visited for this study, an expanded description of the study methodology, and a glossary of acronyms used throughout the report. The appendices are as follows:

Appendix A	Hennepin County, Minnesota
Appendix B	Montgomery County, Maryland
Appendix C	Mid America Assistance Coalition
Appendix D	Massachusetts
Appendix E	Philadelphia, Pennsylvania
Appendix F	Urban Peak
Appendix G	Methods
Appendix H	Glossary

The three study sites that provide prevention strategies for families are described first and include Hennepin County; Montgomery County; and the Mid America Assistance Coalition serving Kansas City. The three study sites that focus on longer-term, more intensive interventions with persons who are seriously mentally ill or who are homeless youth are summarized next—Massachusetts Department of Mental Health, the Philadelphia Office of Behavioral Health, and Urban Peak.

The information presented in each of the site appendices varies; however, each of the site appendices is organized in terms of four major headings:

- Practices of Potential Interest to Other Jurisdictions;
- Developing the Commitment to Prevention;
- Components and Organization of the Community Strategy; and
- Data Collection and Use.





## **APPENDIX A**

### **HENNEPIN COUNTY, MINNESOTA**

During 2003, the population of Hennepin County consisted of approximately 1.1 million people, 383,000 of whom lived in Minneapolis, the county's largest city. The county encompasses more than 20 suburban cities. The county is prosperous and its 1999 poverty rate was lower than for the nation as a whole (8.3 percent versus 11.3 percent).<sup>23</sup> Although the local economy was affected by a recent recession, unemployment is lower than for the nation. Unemployment information was not available specifically for Hennepin County or Minneapolis, but the January 2005 unemployment rate for the Minneapolis-St. Paul metropolitan area was 4.6 percent compared to the national rate of 5.2 percent.<sup>24</sup>

The affordable rental housing market in Hennepin County has softened considerably since the late 1990s, when units were difficult to find, even with a subsidy. Reasons for the softening market include: new construction and increases in home ownership (abetted by low interest rates and the departure of many low-income working families when service sector employment, including the airlines and tourist industries, collapsed after September 11, 2001). As described below, the current availability of rental units helps many of the county's prevention strategies to be more successful than they would have been in the tight market of only a few years ago.

During the study team's visit to Hennepin County during June 29–July 1, 2004, the team interviewed 12 people representing several offices of the county's Human Services Department (HSD). The HSD oversees the Family Homeless Prevention and Assistance Program (FHPAP) and rapid exit system (nonprofit agencies providing prevention and rapid exit services under contract with the county) and a data analyst at the Wilder Foundation, who provides the system's documentation. A complete listing of persons interviewed is located at the end of this appendix. Meetings with these persons provided information about the system and how it works, as well as how it fits into the larger scope of HSD responsibilities. The study team also learned about the reports currently used to document prevention effectiveness. Below is a description of the family homelessness prevention and rapid exit system in Hennepin County including the county's documentation of program impact.

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<sup>23</sup> Population data were obtained from the U.S. Census Bureau at: [quickfacts.census.gov/qfd/states/27/27053/html](http://quickfacts.census.gov/qfd/states/27/27053/html) and [quickfacts.census.gov/states/00000.html](http://quickfacts.census.gov/states/00000.html) (accessed 7/16/2004).

<sup>24</sup> Unemployment data were obtained from the Bureau of Labor Statistics at: [http://www.bls.gov/xg\\_shells/ro5xg02.htm#msa](http://www.bls.gov/xg_shells/ro5xg02.htm#msa) (accessed 3/29/2005).

## **PRACTICES OF POTENTIAL INTEREST TO OTHER JURISDICTIONS**

The contact for all Hennepin County practices discussed in this appendix is Shirley Hendrickson ([Shirley.Hendrickson@co.hennepin.mn.us](mailto:Shirley.Hendrickson@co.hennepin.mn.us)). Practices that are of potential interest to other jurisdictions are presented below.

1. *Data system shared by all FHPAP providers.* Hennepin County and the Wilder Foundation developed a database that all FHPAP providers currently use. It is valuable to providers for helping clients, to the FHPAP manager for monitoring and assuring system performance, and to the county for documenting success that assists in sustaining funding.
2. *Outcomes-based contracting.* Hennepin County uses FHPAP funds to support prevention and rapid exit services, and a services-only grant from the U.S. Department of Housing and Urban Development's (HUD) Supported Housing Program (SHP) for rapid exit services. The county contracts with nonprofit agencies to deliver services. For more than a decade, requests for proposals (RFPs) have asked bids to produce outcomes (e.g., move four families into housing each month and keep them housed) rather than solely providing services to families (e.g., counseling, case management, and budgeting information). Only bids offering outcomes are funded, and providers are monitored and evaluated based on the outcomes they produce. Providers not fulfilling their contract obligations may be terminated if efforts to move them toward outcomes fail.
3. *Control of the whole system—program concept and its execution.* Prevention contracts use state money to do “whatever it takes,” within contract limits, to keep families at imminent risk of homelessness in housing. The county also pays for shelter for families and uses SHP and some FHPAP funds to contract for services to move families out of shelter into housing and keep them there. Some transitional housing is also under county control. The breadth of the FHPAP Umbrella Program gives the county the scope to analyze what works at the various stages and contract for such programs, without risking that controlling one part of the system will result in unintended consequences at another part.

## **DEVELOPING THE COMMITMENT TO PREVENTION**

Hennepin County has traditionally been a jurisdiction that takes seriously its responsibility “to promote the general welfare.” With respect to family homelessness, the County Board of Commissioners has a long-standing policy that the county will do what it takes to assure that no family spends a night on the streets. Several factors help explain both why the county was motivated to create its current system of family homelessness prevention and why it has succeeded to a considerable extent. These factors are:

- The county's commitment to prevent *all* family “street” homelessness;
- Traditions of activist local government;

- The county’s investment in sheltering families—the county pays for this shelter, through contracts with shelter providers;
- The county’s ability to shape and control the various parts of the system through contractual arrangements; and
- The county’s use of data to facilitate daily assistance to clients and to provide daily, monthly, and annual feedback to improve the system.

A turning point for family homelessness prevention in Hennepin County and the state occurred during 1993. Facing the reality that the current system could no longer adequately serve the increasing number of homeless families, the county decided that it needed to do something very different. The county worked with the Minnesota Housing Finance Agency (MHFA) to draft creative legislation that addressed the increasing homeless problems of the state. The result was the FHPAP, which MHFA administers. The FHPAP legislation established a set of outcomes related to preventing family homelessness, including shortening lengths of stay in shelter, preventing first-time entry, and eliminating re-entry.

In Hennepin County, FHPAP refers to the prevention funding, services for prevention and rapid exit from shelters, and to the FHPAP Umbrella Program that includes additional prevention and rapid exit programs funded through Federal and county dollars. FHPAP is flexible outcomes-based funding, allowing grantees to do “whatever it takes” to prevent homelessness. (Exceptions include paying for shelters, building housing, or subsidizing housing for more than 24 months.) Grantees apply for funds every biennium and are awarded funding based on outcomes accomplished—or on the initial plan to achieve the outcomes. Initially designed for families and youth, single adults were subsequently added as a target population and have been covered in the county since 1998. Nevertheless, the bulk of funding is committed to preventing family homelessness.

The family rapid exit program began during 1993 as providers identified that shelter residents were in need of assistance to find housing. Analysis of the system found that the current methods were not identifying the neediest families. During 1995, the county introduced a centralized housing barrier screener, the rapid exit coordinator, and an assessment process for those entering shelter to target shelter services to those with moderate to great housing barriers. The rapid exit program evolved into a systematic process to review the barriers of each family entering county-paid shelter, and to connect them with the most effective housing placement agencies.

Also during 1995, the county began expecting families to contribute toward their shelter stay costs. Prior to this time, families could stay in shelter, free of charge, and keep their entire welfare check, as well as gain access to many benefits including food stamps, Medicaid, and childcare. Since the county was providing all housing and food needs while the family retained its grant, there was little incentive to move quickly out of shelter.

The cost for one night in shelter is approximately \$30 per person (regardless of age) until the family’s money runs out, after which the county pays. The average state welfare check equals approximately five days of shelter. Having families contribute toward their shelter stay may

appear punitive; however, the county uses all funding sources—including FHPAP, Federal SHP, emergency assistance, and county taxpayer dollars—to help pay for costs associated with obtaining housing such as first and last months' rent, security deposits, and moving expenses. Prior to when the county decided to charge for shelter, families could save their welfare checks to cover these costs. In addition, the county offers many supports, which keep families from needing to enter shelter and help them exit quickly. The operating assumption is that this use of resources is better for the family and for the county. The county does not have to pay for costly long shelter stays, which do little to move the family toward housing and stability.

During 1995, HSD also recognized that FHPAP resources were not sufficient to address all the needs of the population. HSD was awarded two SHP grants to supplement services already provided. One grant supported Project Connect to serve the hardest to serve, multibarrier families. The second grant, awarded to the Homeless Outcome Project, increased the number of rapid exit services for the moderate- to high-barrier families.

The present system evolved from a crisis moment during the fall of 2000, when HSD found itself with all (116) of its family shelter units full, an additional 201 families in motels funded by county vouchers, no systematic approach for moving families out of shelter or staunching the arrival of more, and no end in sight. HSD could not refuse shelter as a result of the Board of Commissioners' policy of no street homelessness for families. Finding itself in an untenable situation, county staff sought to improve two dynamics—preventing families from needing shelter and working with those in shelter to shorten their stay and improve their circumstances upon exit from the shelter.

The first change effort involved establishing priorities, namely: identifying families to be placed in shelter, and using the priorities to triage applicants for shelter. Pregnant or parenting teens, families with more than two children or infants, and families in which a parent or child received Supplemental Security Income (SSI) were given priority for available shelter space. Each family was interviewed and asked where they had spent the previous night and whether they could stay there one more night. They were informed of the shortage of shelter space and advised to try and make other arrangements for shelter for that night. Listings of community resources and private shelters were provided to each family. Sheltering assignments were delayed until mid-afternoon, when all of that day's families had been screened. These procedural changes increased the number of families who were able to secure alternative housing and reduced the number of families entering shelter.

The second change established a coordinated plan for each family to exit shelter more quickly. The HSD Shelter Team began a coordinated partnership with the FHPAP-funded rapid exit program and its advocates. As currently practiced, the rapid exit coordinator becomes involved within one to three working days of the family entering shelter. The rapid exit coordinator is co-located with the HSD Shelter Team and communication between the two supports a coordinated approach to assist families in exiting shelter. The HSD Shelter Team also established or improved relationships and communication with the employment services providers, legal aid, school social workers, and resources to address medical and health issues. This process succeeded, and still does, with most families. Those who do not want to comply with rapid exit activities or HSD Shelter Team plans sometimes leave shelter and do not return.

Within six months of implementing these changes, the county reduced the shelter population to a level the shelters could accommodate and eliminated the use of motels for supplemental shelter space. The county-supported system can now accommodate all homeless families with major housing barriers within its contracted 115 family shelter units, where the average length of stay is 29.5 days. Since the peak during late 2000, the county has reduced shelter length of stay by one-half and the number of families in shelter by 63 percent. Two practices contributed to the reduction in shelter use: diverting families with fewer barriers to prevention providers kept some families from entering the homeless system, and assigning rapid exit workers to families who did enter the system helped to shorten their lengths of stay and prevent their return.

Other opportunities for families seeking shelter in Minneapolis and neighboring cities include a 50-unit downtown shelter that has a 30-day maximum length of stay, as well as an association of suburban churches through which families spend nights in a different church each week. Families accessing only these resources never enter the county-supported system. However, these additional family shelter programs do not have sufficient resources to assist very difficult families to find and sustain housing and typically refer families with multiple barriers to the county.

## **COMPONENTS AND ORGANIZATION OF THE COMMUNITY STRATEGY**

The system in which prevention and rapid exit activities are embedded in Hennepin County makes prevention effective in the county. Hennepin County has found that it can bring people together, in part because funding is an incentive. Without funding, there is little incentive to keep people engaged for the length of time it takes to learn each other's language and come to recognize common objectives. With the money, people communicate and can begin to construct a functional system. The county's system for family homelessness prevention and services has changed a great deal since 1993. The change has been slow but steady, as the county continues to bring people together to make further improvements. The integral aspects of the system that contribute to success are discussed below.

- The approach covers most parts of the system—from a family's first contact with a contracted provider because of a housing crisis to providing shelter and rapid exit services. The approach also includes some transitional housing for families.
- Families receive assistance in relation to their level of need, which for shelter is carefully determined through screening by the rapid exit coordinator. Rapid exit services are only available through referral by the screener.
- A collaborative network of nonprofit agencies provides prevention and rapid exit services, with many agencies doing both. Each agency has a geographically-defined catchment area, and each family must go to the single provider covering the area where the family lives or most recently lived.
- County requests for proposals (RFPs) for prevention and rapid exit services specify the families to be served, by numbers and level of difficulty, and the outcomes to be

achieved. Agencies that apply commit to meeting these goals, and outcomes-based contracts specify the goals to be met. Agencies that cannot produce the outcomes proposed in their contracts receive interventions and assistance to correct the situation. If the situation is not corrected, the contracts are not renewed.

- All prevention and rapid exit agencies are linked with a custom-designed data system that allows access to real-time family service histories dating back to 1995.
- An Advisory Committee with a carefully considered membership supports the system through a number of key roles to keep the system nimble and outcome oriented.
- Creativity is encouraged; cross-agency cooperation is standard operating procedure; partnerships, collaborations, and new developments are commonplace.

Respondents in Hennepin County consider it essential for the same system to coordinate families' access to prevention, emergency shelter, and some transitional housing services. Further, they want this level of coordination to include all transitional housing and other services. Starting with four funding sources and proceeding to service components, the system includes:

- State FHPAP funding for preventing eviction, sustaining housing, and some rapid exit services;
- Federal SHP and Emergency Shelter Grant (ESG) funding for some rapid exit services, transitional housing for homeless people, and SHP Project Connect;
- County Emergency Services Program prevention-services funding;
- Emergency Services Program, through the Economic Assistance system, provides financial assistance using Federal, state, and county dollars to prevent the loss of housing;
- The County Shelter System provides emergency shelter with intensive planning and assistance for exiting to housing and sustaining tenancy; and
- Cooperating social services, education, and health programs, including: Health Care for the Homeless; ACCESS service for people with mental illness; City of Minneapolis Public Schools Homeless programs; and Twin Cities Voice Mail.

Hennepin County contracts with a community agency to provide a screener (a rapid exit coordinator) to assess housing barrier levels for each family seeking shelter. The screening policy, which currently has four barrier levels, has been revised several times based on experience as to which barriers constitute the biggest challenges for obtaining and retaining housing. When the county first developed and contracted for the screening services, the system had three levels—no barriers (Level 1), some barriers (Level 2), and serious barriers (Level 3). After some experience, it became apparent that Level 2 was too big and should be split into 2a and 2b. The screener instructions are included in Exhibit A.1 (on the following page and modified slightly to explain some terms). The screener considers the criteria used to assess a

family, as well as the resources that may be most suitable for the family. The intensity and variety of assistance is related to the barrier level assessment.

The screener has access to relevant county databases to check for barriers, including Housing Court (for previous evictions and eviction proceedings) and criminal court (for warrants, convictions, incarcerations, and restraining orders). No family gets more than seven nights in shelter, and most get only one to three nights, until this screening process is complete. Credit checks from credit bureaus can be run as needed. The rapid exit coordinator works with the County HSD Shelter Team to assure that families follow through with housing referrals.

**Exhibit A.1. Hennepin County Housing Barrier Screen**

**HC POLICY FOR FHPAP RAPID EXIT COORDINATOR  
HOUSING BARRIER SCREEN AND REFER SERVICES  
AND RAPID EXIT SERVICES**

3-04

**ASSESSING HOUSING BARRIER LEVELS**

When screening (Rapid Exit Coordinator) families for referrals for housing assistance, the following guidelines for assessing a family's housing barriers and categorizing the barriers into three levels will be used:

**Level 1: No barriers.** Family has a good rental history, no UDs (=unlawful detainer/eviction), no criminal history and no active chemical dependency or abuse issues. Families would be given an information packet and a sample rental application form. No FHPAP/Rapid Exit referrals will be made. Family may return to Rapid Exit Coordinator/Screeners for help with application fees.

**Level 2a: Has some of the following barriers:**

- No rental history
- No high school diploma
- New to the area
- Physical disabilities that effect housing
- Large family
- One parent/child household
- One easily explained UD
- Needs financial help with moving, furniture, misc. services
- History of battery but abuser not in the area
- Head of household under 18 years
- Non-English speaking

**Does not have the following barriers:**

- Criminal record
- Active CD/alcohol issues
- More than one UD

Families would be given the information packet, a sample rental application and be referred to a FHPAP/Rapid Exit Coordinator or other provider who has shorter term services (and subject to service availability).

**Level 2b: Family has some of the following barriers:**

- Poor rental history (up to three UDs or evictions)
- Recent domestic abuse with the abuser in the area
- Recent minor drug or criminal history
- Just released from jail
- Mild behavior problems—adult
- Not currently abusing drugs
- Mild behavior problems—child(ren)



- May also have some of the barriers from 2a. above
- Male teenager in the home
- Open Child Protection Case

Families would be given the information packet and a sample rental application and be referred for longer term case management services to a FHPAP/rapid exit or other provider who provides such services (subject to service availability). Transitional housing services (which also have shelter stay requirements) would serve 2bs.

**Level 3: Has some of the following barriers:**

- Actively using drugs
- Recent serious criminal history
- Adult with severe behavior problems
- Current sexual abuse in the family unit
- 4 or more UDs
- Current battering with the abuser in the family unit
- Children with severe behavior problems
- Has recent record of property damage to rental housing

Families may be referred to Project Connect or any similar service. The difficulties in obtaining housing in this area will be explained to such families along with the alternatives they have including that they may be eligible for a bus ticket from their financial worker. They may be referred to non-FHPAP housing search options. Level 3 families will be referred to FHPAP/rapid exit providers, including transitional housing, as capacity allows and subject to the Provider's assessment on whether they can adequately serve the family referred.

**SERVICE REFERRALS TO FHPAP RAPID EXIT & TRANSITIONAL HOUSING PROVIDERS**

Referrals for each barrier level are summarized above. Since FHPAP/Rapid Exit services are directed to Level 2 and lower Level 3 families, referrals of Level 1 and high barrier level 3 will not be made to FHPAP/Rapid Exit providers. Referrals to other services such as Project Connect, if available, can be made for Level 3.

**FHPAP RAPID EXIT ELIGIBLE FAMILIES**

As of 7/1/95, FHPAP rapid exit providers are to serve Level 2 and lower Level 3 families referred by the FHPAP Rapid Exit Coordinator. This will assure that FHPAP providers serve the target group and that the appropriate target group of families reach services soon after shelter entry.

**AVAILABILITY OF RAPID EXIT & TRANSITIONAL HOUSING SERVICES**

Rapid exit providers (including transitional housing) are to communicate with the FHPAP rapid exit coordinator what their current capacity is and how many referrals they can accept/are ready to accept. Communication between the provider and the FHPAP rapid exit coordinator is essential to facilitating services for families.

**RAPID EXIT COORDINATOR SCREENING GOAL**

The target goal is for families to be screened and referred within 5 days of their first voucher into shelter.

**APPLICABILITY OF POLICY**

These guidelines will be used not only by the FHPAP Screener/Rapid Exit Coordinator but by all FHPAP service providers, including SHP and ESG, who are attempting to assess housing barrier levels for a family under the FHPAP Umbrella program.

(modified version of County form: SJH 04 RECBARRIERLEVELS04)

For the purpose of delivering human services, including family homelessness prevention, Hennepin County is divided into geographic regions. Each region may have several providers with FHPAP contracts for prevention, but each provider has its own catchment area. Families seeking prevention services must go to the FHPAP provider that covers the location of the family's current or most recent address. Providers know each other well and can access a shared database to find out what services the family has already received and by which agency. Families work with agencies that know their history, which assures that the family cannot apply for the

same assistance in different places. In contrast, rapid exit services are centrally controlled and all shelter is provided by one agency located in Minneapolis. Rapid exit service providers are assigned to families based on availability, geography, and specialized services.

The contracting process to identify FHPAP and rapid exit providers begins with an RFP distributed widely in the community to encourage new providers to apply. On average, the county receives 30–40 proposals for each RFP, of which it usually funds 10–15 percent. The county selects the providers that appear to understand its outcomes-based approach and provide evidence that they will fulfill their performance commitments. Over the years, providers have come to understand the county’s “whatever it takes to achieve the goal” approach.

The Advisory Committee includes shelter operators; providers with FHPAP contracts; similar providers without FHPAP contracts; advocates; formerly homeless people; and representatives of legal services, MHFA, Twin Cities Voice Mail, the Minneapolis Public Schools homeless programs, Minnesota Coalition for the Homeless, and homeless planning groups, such as the Continuum of Care. In addition, supervisors of direct service units in county departments with responsibilities for homeless-related services attend meetings and provide input, but do not vote. The Advisory Committee is essential to the smooth operation of FHPAP in Hennepin County. It has many important duties, such as establishing outcome goals, assessing service gaps and recommending services for funding, designing RFPs and reviewing proposals, seeking new providers, providing cross-fertilization through members who also serve on other committees, promoting new partnerships, and reviewing contract performance.

The Advisory Committee’s makeup is especially important for establishing and maintaining standards of performance. Members are knowledgeable about the population to be served and the options for helping them, and support the use of outcomes-based contracting. If providers’ performance is unsatisfactory, they come before the Advisory Committee to explain what happened and how they expect to improve their performance. If it appears that they cannot improve it, the Advisory Committee will suggest that they not be refunded. Under such scrutiny, nonperforming providers usually agree to drop the contract rather than have the county terminate it. This process is essential to improve overall system performance.

The result is a very cooperative, collaborative, creative system. FHPAP and rapid exit providers are linked by a single data system. They refer back and forth, often exchanging resources when one provider is bereft of a particular resource (e.g., food, clothing, or funding) and another provider has the needed resource, thus avoiding duplication of services. For example, one provider offers a budgeting class while another offers a financial class that discusses credit and how to improve one’s credit record while still another offers no-interest loans for car purchase and emergency car repairs. Clients may use these services regardless of which provider offers them and which provider is helping the family.

In addition to routine daily contacts, the suburban providers meet monthly, share resources and resource information, participate in training, and plan services for their area. Minneapolis providers have similar, but not as formalized, contact. In addition, all FHPAP providers meet every two months as a Provider Council, with additional service-specific coordination meetings

as needed. Several new services have emerged from provider and Advisory Committee interactions that promote the goal of preventing homelessness. Examples include:

- Legal Aid and the Housing Court once had severely adversarial relationships. Through their interactions prompted by the FHPAP service delivery system, they recognized some common ground in keeping people housed and developed a mediation approach that is offered to landlords filing eviction papers. Mediation, with volunteers as mediators, is able to resolve 69 percent of the cases out of court, saving the landlord the filing fees and the family the disruption of moving and having an eviction on its public record.
- One FHPAP and rapid exit provider has developed a basic training course to help people learn how to find housing. The provider holds classes in the local jail, and Legal Aid takes a similar curriculum to the high schools. Most people receiving the training have no idea how to find housing, so the course, however basic, provides new and important knowledge. Other materials that serve a training purpose are an illustrated booklet and a game, both called “Housing Challenge.”
  - The booklet was developed and written at an eighth-grade reading level. It uses a story format to show how different people in a shelter find housing despite various barriers (e.g., youth, unemployment, previous evictions, criminal record, many children, and racial or ethnic discrimination) and what they need to do to retain housing. The booklet is appropriate for high schools, service centers, social work offices, and other settings.
  - The game resembles “Family Feud.” It pits one-half of a class or group against the other to “build its community” by correctly answering questions about housing. Each correct answer earns the team a new house to put into its community, until the community is complete. The “Housing Challenge” game is intended for use by direct service workers, school teachers, and groups to teach about housing laws and how to retain housing.
- A recent training session to teach caseworkers and counselors how to help clients with finding and keeping housing drew 65 attendees from community agencies. The demand suggests that another session would also be filled.
- A housing “barrier” training video received a Telly Award for excellence. Like the booklet “Housing Challenge,” this video, “Shoe Box on the River,” follows three different housing situations that can cause housing loss and helps people learn the basics of how to retain housing. The video is shown at the shelters and used in housing training classes.

## **FHPAP and Preventing Housing Loss**

The prevention part of the FHPAP Umbrella Program serves Hennepin County families experiencing a housing crisis that threatens housing retention. All clients are currently in housing. For prevention families whose cases closed in State Fiscal Year (SFY) 2003, 72 percent were facing eviction, 14 percent had income loss that threatened housing, 4 percent were doubled-up in untenable situations, 7 percent faced a very hazardous situation in their housing or their housing was condemned, and 3 percent were in other situations.

### ***Getting to an FHPAP Prevention Provider***

A family in housing crisis may get to one of the 18 FHPAP prevention providers in several ways. The United Way's First Call For Help (211) hotline has the providers' numbers and confirms the family's address before referring a family to assure it gets to the correct provider. Most prevention providers also offer other emergency and crisis services and are well known in their communities. Churches, schools, the police, community centers, Legal Aid, YM/WCAs, health care providers, and many landlords are familiar with FHPAP prevention as a consequence of good publicity, outreach, and past experience. A few FHPAP providers take only referrals but, for most, clients are primarily walk-ins.

### ***Eligibility Criteria for FHPAP Prevention***

In addition to being a county resident, a family must be verified to be in a short-term financial crisis, rather than an ongoing condition, to be eligible for FHPAP. Specifically, the FHPAP provider must see it as a reasonably "good bet" that the family will be able to sustain itself in housing after receiving one month of cash and other assistance from FHPAP. The assistance provided is for one month and the expectation is that the family can take over after that month. These are typically families whose inability to pay rent stems from a temporary illness, job loss, or other short-term problem, and relief in the form of returning to work, a new job, or a new income source is on the horizon. If a family needs a longer-term solution (e.g., a housing subsidy, a change to more affordable housing, a job), assistance is frequently offered in the form of "other than cash" services while the provider helps the family to obtain the longer-term subsidy or address working concerns.

### ***Eligibility Determination at an FHPAP Provider***

Preliminary screening may be done on the phone or in person. FHPAP providers determine if the family meets FHPAP eligibility criteria and ask about the cause of the present emergency, the length of residence, where the family is in the eviction process, what resources the family has and is likely to have in the near future, and similar issues.

Completing an application requires in-person contact. An FHPAP worker reviews the family's income sources and budget to determine the feasibility of covering housing costs in the future.

One recommendation might be to move to a smaller or cheaper apartment; others may involve giving up nonessentials on which the family currently spends money. The family must verify information with respect to residence, rent, employment, benefits, and other matters. Releases are requested for access to information related to benefits receipt and in order to contact landlords. Providers report that about two-thirds of the applicant families receive assistance. Failure to complete the application process is the main reason why a family does not receive assistance. Providers usually serve everyone they can, stretching the definition of a family being a “good bet” to its broadest possible interpretation.

### ***Approach with Families***

The type of assistance offered to a family depends on the family’s situation. A family suffering a short-term setback, but otherwise reasonably stable, might receive help with rent and perhaps budget counseling to establish a savings plan for emergencies, even if it is only a few dollars each week. Someone whose landlord is not making needed repairs may get legal help or help moving while they await return of their security deposit. A family who is experiencing greater difficulty might get more extensive help under a different program the agency offers, but may not receive prevention services because they are reserved for short-term needs. In this case, partnering services can be very effective.

FHPAP providers describe their approach as “we’re here to help you; how are you planning to get out of this crisis situation?” Providers rarely offer a family the entire amount of cash assistance available through FHPAP; instead, they negotiate. If the family needs \$500, a provider may offer \$200 and ask if the family can produce the balance. Usually it can. FHPAP providers will require that families assess their eligibility for public benefits and help with applications. They will work with families to develop reasonable budgets given their circumstances. Providers also have many forms of non-cash assistance to offer families to tide them over through short-term crises, including limited case management, legal services, volunteers, food banks, clothing shelves, advocacy, budgeting, furniture, car repairs, and even an occasional night in the basement of a church belonging to a suburban consortium of churches offering this type of emergency shelter. Once a family’s housing is secure, FHPAP prevention providers may hear from families again with respect to other assistance the family may need, but unlike rapid exit caseworkers, they do not necessarily provide systematic followup.

### ***Approach with Landlords***

An essential element contributing to FHPAP prevention providers’ success in keeping families housed is their highly developed cooperative relationships with landlords. Over the years, landlords have come to appreciate that FHPAP providers can help them retain tenants, thus saving re-rental costs. Landlords have been willing to negotiate payment plans for back rent, moving tenants to smaller and more affordable apartments, reducing the overall rent for a given apartment (especially for families with Section 8, for whom the landlord can anticipate steady payments from the housing authority), and making other accommodations. Some landlords are beginning to provide their own tenant services staff, having learned from FHPAP that preventive

steps are more cost-effective than evictions. Landlords also know they can call the prevention provider if a problem arises with the client.

### ***Staffing and Caseloads***

Staff providing FHPAP prevention have four-year degrees in a human services field or “decades of experience.” At any given time they are only working intensively with a few families for homelessness prevention, although they may have larger caseloads of less problematic clients.

### ***Funding Sources and Arrangements***

Several funds are available to assist families experiencing a housing crisis. HSD uses Federal, state, and county taxpayer dollars. Funds for family homelessness prevention come from FHPAP, county funds, and an array of smaller pots of money that individual providers have at their disposal. All these funds are for direct services; FHPAP providers shoulder most of the staff and administrative costs (10 percent is the standard amount provided from FHPAP), as does the county for its administrative work. Most providers match FHPAP with other funding so they can do this.

FHPAP prevention providers have made some different local policies on a regional basis. Chief among their choices is whether FHPAP resources should be given as grants or loans. In Minneapolis the actual cash distributed for rent and other payments is given as a grant, but in the suburbs it is given as a voluntary loan. Suburban providers find their families appreciate the opportunity to repay the providers. The providers offer very flexible terms and can accommodate very low monthly payments (e.g., \$5 per month) and gaps in payment if they are explained. Repayment can help a family establish a good credit history, and the agencies give credit referrals upon repayment. Families are not “hounded,” but providers have gotten more serious about following up on loan commitments. The only penalty for non-repayment is that future cash assistance may not be available, depending upon the circumstances of the non-repayment. Collectively, suburban FHPAP agencies have gone from getting back about \$1,000 each year to receiving \$30,000–\$40,000 in loan repayments each year.

### **Rapid Exit**

All families in rapid exit have housing barriers; most are Level 2b or lower Level 3 families (see pg. A–7 for definitions of the categories). Every homeless family seeking shelter is referred to the Shelter Team of the county’s HSD. This team of 23 staff and three supervisors is available from 7:00 a.m. to 3:00 a.m. weekdays and 5 p.m. through 3 a.m. on Saturday and Sunday,

leaving little uncovered time when a family might be in need of overnight shelter.<sup>25</sup> Earlier in the shelter system development, coverage included regular working hours Monday–Friday, with United Way authorizing shelter on the weekends. United Way, however, did not assess need so having emergency assistance coverage extended was a positive step for both the family and the county.

The HSD Shelter Team assesses whether any viable alternatives exist where the family could stay for the evening. This assessment usually takes about 15 minutes. If no alternatives exist, the family receives a shelter voucher for the number of days it will take to see the rapid exit coordinator—usually one to three days, sometimes up to seven days.

Each family is screened by the rapid exit coordinator to determine barriers to housing and the most appropriate service to address its housing needs. One person, the rapid exit coordinator, does all the screening and referral (approximately 1,100 families each year) for rapid exit housing services. The rapid exit coordinator has a donated office and computer in the county’s HSD offices but actually is employed by a nonprofit rapid exit and transitional housing provider. This independence from the county often helps the rapid exit coordinator work with families who express concerns about telling the county some things about themselves and their histories.

The screening process, which was described earlier in this appendix, takes about one hour. Seven slots each day are scheduled in advance, leaving the 11:00 a.m. hour available for quick access to reschedule missed appointments.

The rapid exit coordinator uses a detailed interview format that is intended to facilitate both the screening process and the next step, which is determining eligibility for rapid exit housing services. The interview covers educational, vocational, housing, credit, chemical use, mental health, legal, physical health, relationships, and family of origin issues. The rapid exit coordinator also gathers facts, including checking both Housing Court and Criminal Court proceedings online, and completes a preliminary needs assessment. The assessment information is forwarded to the rapid exit agency assigned to help the family find housing.

Families are assigned to rapid exit agencies on either a rotating basis, if there is more than one appropriate agency, or by agency service, if there is only one appropriate resource. Rapid exit providers can only accept referred families; they do not maintain waiting lists and must take the families that the county refers to them. However, if other barriers are found or if the client subsequently has needs the program is unable to fulfill, the client could be referred back to the rapid exit coordinator for a different referral. Once the family has been screened by the rapid exit coordinator, the HSD Shelter Team will extend the shelter voucher while the rapid exit agency assists the client to obtain permanent housing and the family begins to work on a plan with the Shelter Team to exit shelter.

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<sup>25</sup> In 2000, the county consolidated its shelter vouchering, making it the sole province of this Shelter Team rather than having it spread among eight or nine teams that saw families with a variety of emergency needs, not just for shelter. The consolidation has meant that the Shelter Team staff that control access to shelter know the rules and procedures, know the families, know the resources, and are better able to allocate resources efficiently and appropriately.

The rapid exit agency receives the screening information and assigns a rapid exit caseworker to the family. Together, they develop a housing stabilization plan that looks at all aspects of the family's need. The family signs and dates this plan, which includes action steps and timetables. The rapid exit caseworker attends mostly to the housing portion of the plan and uses mainstream resources for other family services. The HSD Shelter Team worker identifies any other county services with which the family is involved (e.g., public assistance, employment services, child welfare, services to the disabled). The Shelter Team notifies county caseworkers that the family is in shelter and is receiving housing services. The Shelter Team coordinates requirements the family may face from various county departments so that the family is not caught in demands that cannot be met simultaneously. The county also has certain priorities that are absolute—school age children must be registered for and in school.

The timetables attached to the action steps tell the family and rapid exit caseworker when each step should have been accomplished. These timeframes and tasks may be revisited if circumstances warrant. If a family fails to complete an action step on time it gets another chance. Repeated failure leads to a re-examination of the action step to ascertain why the family has not completed it and whether it is possible for the family to succeed. The more days a family has been in shelter, the more assistance it receives to complete action steps and move on to housing, aiming for the system average of no more than 30 days in shelter. Relatively few families fail in the process, but about 1 percent (16 of 1,463 families during 2003) receive an “involuntary discharge” from rapid exit services or leave shelter.

The rapid exit caseworker will continue with needed supports to help the family stabilize and sustain housing through six months after the family moves to housing. Throughout this period, the caseworker is in regular contact with the Shelter Team and other relevant HSD staff involved with the family, to the extent that this involvement is required. Although rapid exit agencies and the FHPAP system administrator believe that six months of followup is sufficient for many families, a significant number of families require a longer period of support.

The six-month restriction derives from a HUD decision to allow the same length of followup for rapid exit as it allows for transitional housing. From the perspective of the level of difficulty of the families involved, the rapid exit and transitional housing families may look fairly similar. But from the perspective of how much time a provider has had to work with the family before housing placement, the transitional housing provider has had up to 24 months, plus the six-month followup, while the rapid exit provider has had, on average, 30 days plus six months.

The following is one rapid exit agency's list of housing services—other providers offer similar services, also available to FHPAP prevention families since many providers offer both prevention and rapid exit services:

- Co-sign leases;
- Provide or assist in obtaining deposits, first month's rent, and startup needs such as furniture and food packages;
- Guarantee to cover eviction and damage costs;
- Repair damage to apartments;



- Coordinate temporary funding for housing subsidy that supports a client through transition while avoiding a second move;
- Serve as mediators in landlord disputes;
- Offer extensive case management;
- Teach responsible tenancy and money management;
- Refer clients to and coordinate treatment for chemical dependency;
- Refer clients to employment services;
- Coordinate and assist in obtaining other needed services; and
- Help ex-offenders.

### **Staffing and Caseloads**

Rapid exit caseworkers have four-year degrees in a human service field plus training in their specific work. Some are formerly homeless people who have extensive experience in the field. Each caseworker handles between 30 and 40 rapid exit families at a time, some in the placement phase and some in followup.

### **Funding Sources**

Rapid exit services are funded by a HUD SHP “Services Only” (SSO) grant to the county, which in turn contracts with nonprofit providers. This Federal funding is backed up by FHPAP for services and some placement costs that SHP will not cover. The county uses SHP resources exclusively for services. It coordinates the contracting and covers all county staff related to the project. Nonprofit organizations also “donate” much of their administrative time, as the SHP rapid exit funds are used exclusively for service costs.

### **DATA COLLECTION AND USE**

The county designed its own FHPAP data system along with the Wilder Foundation staff who selected and modified the software. The Wilder Foundation is also under contract to the county to manage the data collection and produce requested reports, which the county uses to satisfy routine and special reporting requirements. One unique and significant feature of the software design is the number of controls built into the system to assure the accuracy of the data entered at provider sites. ZIP codes are used to enter city names to avoid misspellings (the system accepts only ZIP codes within the county), age range controls are on birth dates (no one younger than 16 or older than 65 for the adults in a family), and cases cannot be saved unless all required data are entered. These controls circumvent incomplete data.

The database administrator at the Wilder Foundation receives monthly backups of each FHPAP agency’s database, which she downloads and integrates to create both a complete longitudinal file and point-in-time files for the whole system. The database is kept in ACCESS, and the administrator keeps it current as new versions of ACCESS are issued. It fits the needs of the system very well, along three dimensions:

- *Addressing FHPAP and rapid exit providers' immediate needs as they serve families.* The system's fields contain the detail and family history that FHPAP and rapid exit providers need, when they need it. Service receipts are accessible dating back to 1995. The system administrator can make assessments of the overall program and performance of any provider on a longitudinal and immediate basis.
- *Monitoring the system.*
  - *Provider uses.* Providers use their individual agency section of the database to track service delivery levels weekly or monthly. Providers may review cases opened, cases closed, payments made during the month, how much FHPAP money has been used during the month, and other issues. Providers can also answer special questions asked by the executive director by using the built-in reports or by downloading the data into ACCESS and doing their own reports.
  - *Administrator uses.* The system administrator uses the system to determine whether families are accessing services in more than one location, whether providers are meeting contracted obligations, and to provide reports from funders and agencies. Annual audits check such things as inappropriate spending patterns (e.g., erratic service patterns during the year) and outcomes (not saving people's housing or stabilizing families in housing). Regular feedback to providers and to the Advisory Committee helps keep all parts of the system on their toes.
- *Reporting to the legislature, MHFA, the county, HUD, and other parties.* Routine reports are generated for funders and other interested parties. Especially relevant to the purposes of the present study, the database is compared to county shelter data to assess whether recipients of FHPAP or rapid exit return to shelter within a 12-month period. The results of these analyses are reported below.

## **Access to the Data**

FHPAP providers have access to both current and historic data from their own agency. They contact other providers based on the client's former address to determine if services were provided in other areas. At this time, access to the complete database for all providers has not been shared due to data privacy concerns. The rapid exit coordinator has a full history of all clients served since 1995 to be used in screening for housing barriers. The database manager at the Wilder Foundation and the county's FHPAP administrator have access to the entire system, both current and historic.

## **Data Elements**

- Basic descriptive information includes social security number, name (first, last), birth date, gender, race, veteran status, ZIP code, city, county of residence, homeless status, citizenship, number of children by age group, and number of adults.

- Service data include date of intake, service type and date of receipt, housing placement date, referral source, shelter admit and discharge dates, voluntary discharge, discharge to, referral to, handicapping conditions, and other (non-financial) services.
- Outcome data include intake status on outcome variables, annual declared income and income source at intake, income and income source at exit, barrier codes at intake and exit, and housing stability at three and six months.

### **Outcomes—Success at Preventing Shelter Use or Return to Shelter**

Each year a report is prepared for MHFA with grant outcomes. As part of completing this report and analyzing contract and program-level performance, the FHPAP grant manager assesses whether the families who were served in the previous calendar year, in both prevention and rapid exit, have had a shelter episode in the 12 months since receiving FHPAP assistance.

Three caveats are worth keeping in mind as one looks at the documentation of homelessness prevention in Hennepin County. First, there is no control or comparison group—virtually every family who approaches the system will receive some type of assistance. Second, due to the nature of the criteria used to accept families for prevention services—short-term economic crisis combined with the ability to pay for housing after the crisis month has passed—the families helped might not resort to shelter even if they do not receive the county’s help. However, all prevention families are screened to identify other resources (family, friends, savings, emergency assistance), and FHPAP is used only if no other resources exist. The funding available is not sufficient to meet the total community need for prevention services, so the county prioritizes its limited resources to prevent the loss of as much housing as possible among those most likely to succeed.

Finally, some family shelters are not part of the data system the county uses to assess post-FHPAP shelter use. The shelter stays tracked in this analysis are those for which the county pays (i.e., shelters that are vouchered through the HSD Shelter Team). As already noted, there are two other opportunities for a family to access shelter—one in Minneapolis and one through a network of suburban churches. Most families in need of more than a few nights of shelter will find their way to the county system in relatively short order. The county’s documentation of prevention will pick up shelter use by the families with the most barriers to housing, but perhaps not some with fewer issues.

The county has succeeded in cutting its average length of shelter stay by one-half (from almost 60 days to approximately 30 days), eliminating the need for motels, and reducing the number of families in shelter from 317 to fewer than 116 at any given time. It has also succeeded in reserving shelter resources for families with the most serious housing barriers (Level 2b and lower Level 3).

**Exhibit A.2. Change in Housing Barriers of Sheltered Families**

Barrier Level	1995	1998	2003
Level 1—No/few barriers	15%	0%	0%
Level 2a—A few barriers	40%	43%	2%
Level 2b—Many barriers	40%	44%	70%
Level 3—Most serious barriers	5%	13%	28%

Source: Hennepin County FHPAP Annual Report for SFY 2003, page 14

In the recent FHPAP Annual Report, covering the period of July 1, 2002–June 30, 2003, Hennepin County reports the following rates of shelter use within the 12 months following receipt of FHPAP assistance:

- *Family prevention*—95 percent of families did not use shelter within 12 months; 5 percent did. This FHPAP component served 1,170 families (or approximately 4,149 members), at an average cost to the county of \$472 per family.<sup>26</sup>
- *Family rapid exit from shelter*—88 percent did not return to shelter within 12 months; 12 percent did. This FHPAP component served 1,024 families (or approximately 3,573 members), at an average cost to the county of \$93 per family. Much of rapid exit is paid for through a Federal SHP SSO grant; including Federal funds, the average cost per family is still less than \$800.
- *Family transitional housing*—96 percent did not return to shelter within 12 months after their case was closed; 4 percent did. This FHPAP component served 47 families (or approximately 193 members), at an average cost to the county of \$3,668 per family.

**HENNEPIN COUNTY SITE VISIT PARTICIPANTS**

Richard Amos, St. Stephen’s Housing Services, Program Manager  
 Peg Douglass, Hennepin County Economic Assistance, Unit Supervisor  
 Sara Frerotte, St. Stephen’s Housing Services, Case Manager/Family Advocate  
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 Amanda Jackson, Person to Person, Homelessness Prevention Advocate  
 Elizabeth M. Johnson, People Responding in Social Ministries, Executive Director  
 Stephanie Miller, Community Emergency Assistance Program  
 Annette Marie Poeschel, Intercongregation Communities Association, Executive Director  
 Milton A. Schoen, Hennepin County Veterans Services, Area Director  
 Lisa Sell, Wilder Research Center, Database Associate  
 Anita L. Shoemaker, Northwest Hennepin Human Services Council, Senior Projects Coordinator  
 Scheryl Wilson, Elim, Rapid Exit Coordinator

<sup>26</sup> To estimate the number of family members served, Hennepin County assumes each family consists of four persons.

**HENNEPIN COUNTY ACRONYMS**

ESG	Emergency Shelter Grant
FHPAP	Family Homeless Prevention and Assistance Program
HUD	U.S. Department of Housing and Urban Development
HSD	Human Services Department, Hennepin County
MHFA	Minnesota Housing Finance Agency
RFP	Request for Proposal
SFY	State Fiscal Year
SHP	Supported Housing Program (HUD)
SSI	Supplemental Security Income
SSO	Supported Housing Program, Services Only grant

## **APPENDIX B**

### **MONTGOMERY COUNTY, MARYLAND**

Montgomery County had a 2003 population of 909,411. This prosperous suburb of Washington, DC, has a median household income of \$76,439 and ranked eighth highest of all U.S. counties. The high cost of housing poses serious problems for the almost 5.6 percent of individuals who live below the poverty level. The fair market rent for a two-bedroom unsubsidized unit in Montgomery County is \$1,218 per month and the median rent ranked the 14<sup>th</sup> highest of all U.S. counties.<sup>27</sup> Over the past several years, because less than 4 percent of housing units are vacant throughout the county, most of the jurisdiction's low-wage earners struggle to afford or maintain housing.<sup>28</sup>

To address these unique economic and housing challenges, Montgomery County government—in partnership with the nonprofit community—has for longer than 20 years provided funds and services to prevent evictions for those at risk of homelessness. With respect to family homelessness, the county government has a longstanding policy that no family spends a night on the streets.

During the study team's visits to Montgomery County between June 19 and July 8, 2004, the study team interviewed 10 people representing several offices of the Montgomery County Department of Health and Human Services (MCDHHS), which oversees the single point of entry for families and individuals in need of homelessness prevention or shelter. MCDHHS also collaborates with local nonprofit agencies and the public housing authority to provide community-wide homelessness prevention coverage. The study team interviewed representatives from two nonprofit partners—Community Ministry of Montgomery County and Montgomery County Coalition for the Homeless—and the Housing Opportunities Commission (HOC), the county's public housing authority. The study team learned about the various automated systems that collect data on families, services, and payments to document prevention effectiveness. The homelessness prevention program in Montgomery County is described below, including the county's outcome measures and their use of data.

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<sup>27</sup> Housing data were obtained from the U.S. Department of Housing and Urban Development at: [http://www.huduser.org/datasets/FMR/FMR2004F/FMR2004F\\_County.xls](http://www.huduser.org/datasets/FMR/FMR2004F/FMR2004F_County.xls) (accessed on 11/9/04).

<sup>28</sup> Income and housing statistics were obtained from the U.S. Census Bureau at: <http://www.census.gov/acs/www/> (accessed on 11/9/04).

## **PRACTICES OF POTENTIAL INTEREST TO OTHER JURISDICTIONS**

The contact for Montgomery County practices described in this report is Corinne Stevens (corinne.stevens@montgomerycountymd.gov). Practices that are of potential interest to other jurisdictions are presented below.

- *Single Point of Entry:* In Montgomery County the same system controls families' access to prevention, emergency shelter, and transitional housing. The advantage of a single point of entry to prevention services for families and individuals facing eviction or needing shelter is in standardized procedures that maximize use of all available resources in the community to prevent families from entering shelter.
- *Public-Private Partnership:* The community-wide response to prevention involves a close working partnership with more than 40 nonprofit agencies, coordinated through the Emergency Assistance Coalition sponsored by the Community Ministry of Montgomery County. After public funding for an emergency financial situation has been exhausted, MCDHHS works with nonprofit agencies or faith communities that serve in a safety net support role. These agencies and communities are organized into a regionally based approach, along with MCDHHS, to serve people in designated ZIP codes. All families who seek emergency assistance receive help of some kind.
- *Outcomes Data Collection:* The county collects data on recipients of emergency assistance and services using three different automated systems. These databases can be merged to document several prevention outcomes.

## **DEVELOPING THE COMMITMENT TO PREVENTION**

While Montgomery County began serving families and individuals at risk of homelessness during the early 1970s, these services took several years to evolve into a community-wide approach to homelessness prevention. Two county agencies provided services. The Department of Social Services provided eviction prevention services to help families and individuals with past due rents and utility bills, and the Department of Family Resources partnered with the nonprofit community to develop and provide emergency shelter.

It was not until 1987 that the Department of Social Services had new leadership with the vision to realize that prevention was an essential part of a continuum of services to address the growing problem of homelessness. The Department of Social Services assumed leadership for both the prevention services and the contractors providing emergency shelter services, but initially served only for families. This was the genesis of the single point of entry for homelessness prevention.

The Department of Social Services created the Division of Emergency Services, to prevent and remediate homelessness. The first and most important change involved establishing triage, screening criteria, and priorities for which families would be sheltered. Standardized procedures were established to assess level of need, coupled with a service plan that placed the responsibility on the family to address the issues that led to its homelessness. However, the county at this time

determined that it would not allow a family to spend a night on the streets. Within six months of its inception, the Department of Social Services was more than \$500,000 over budget, due mostly to the high costs of assistance with utilities and past due rents.

Although prevention funds were originally designed for both at-risk families and individuals, when the demand exceeded the budgeted funds, the county-controlled funding for individuals was curtailed for a brief period. Prevention funding was reinstated for both families and individuals and remains so today; however, families constitute the highest proportion of households served. With respect to family homelessness prevention, one system controls the single point of entry. Individual prevention strategies are coordinated across several different access points. Therefore, the study team targeted the description to the family homelessness system in this report.

Creating a single point of entry for family homelessness fostered a collaborative public-private partnership to reduce family homelessness. Key changes in both county government and the nonprofit sector further reinforced this collaboration. During 1995, county human services agencies—health, mental health, social services, and family resources—reorganized into one agency, MCDHHS. This move united homeless families with mainstream services, once dispensed by numerous agencies and divisions within agencies. Also during 1995, the nonprofit community, through the Community Ministry of Montgomery County, organized an Emergency Assistance Coalition. The Emergency Assistance Coalition coordinates a regional network of 40 nonprofits that work with MCDHHS to coordinate public and private resources to prevent eviction.

## **COMPONENTS AND ORGANIZATION OF THE COMMUNITY STRATEGY**

In Montgomery County, one system controls families' access to homelessness prevention, emergency shelter, and transitional housing. Linking shelter access to homelessness prevention assures that shelter is only offered as a last resort and to those families with the most serious barriers. Coupling MCDHHS social work assessments and case management with shelter services is reducing numbers and length of stay for homeless families in shelter. The key elements of the approach to prevention and emergency shelter are discussed in the following section.

### **Accessing MCDHHS Emergency Services**

MCDHHS emergency services are accessible to those in need via several options. Many landlords, community agencies, churches, schools, the police, community centers, Legal Aid, and healthcare providers know to refer to MCDHHS as a single point of entry for families facing a housing crisis. Community agencies and churches that also offer emergency services know to check the family's address before referring to the appropriate regional office of MCDHHS. All crisis hotlines and the county information and referral numbers know the appropriate phone numbers and addresses to give families or individuals seeking help with a housing crisis.



Any family or individual in need of emergency assistance must appear in person to one of three regional MCDHHS offices of Emergency Services in the county. The co-location of homeless prevention services with mainstream services provides access to screening, history, and eligibility determination not only for emergency assistance but also for mainstream resources such as Temporary Assistance for Needy Families (TANF), medical assistance, and food stamps. The MCDHHS Crisis Center provides services for families in housing crisis after regular business hours.

### **Eligibility Criteria for MCDHHS Emergency Services**

MCDHHS provides emergency services to any family or individual who requires financial assistance to remedy an eviction, foreclosure, or utility disconnection. In addition to having a verifiable county address, a family must appear to be in a short-term financial crisis rather than an ongoing condition. Prevention efforts focus on families or individuals whose inability to pay rent stems from a temporary illness, job loss, or other short-term problem, for which returning to work or a new job or income source is verified. The MCDHHS Emergency Services worker determines that the family will be able to maintain housing after receiving the cash payment and other assistance for one month.

MCDHHS will not provide financial assistance if a client at risk of eviction or foreclosure has arrears in excess of several thousand dollars. Further, if the client or family is involved in a recidivist situation and has never followed through on a service plan to resolve the crisis, MCDHHS may deny assistance.

### **Eligibility Determination for MCDHHS Emergency Services**

When a family presents at a MCDHHS regional office, a screener first sees them. If eligible, the screener sends the family to the social worker to begin the planning to resolve the emergency. Many problems can be solved with information and referral or helping a family to obtain entitlement benefits. Often, families are instructed to return with appropriate documentation, including writ of eviction in 30 days, utility shut-off, and documentation of income and expenditures.

The social worker assesses the precipitating factors that led to the housing crisis and reviews the family's income sources and budget to determine the feasibility of covering housing costs in the future. The family develops a service plan and agreement with the social worker to resolve the housing crisis. The family must complete required action steps of the service plan before payment is authorized to the landlord or utility company. For example, a family must attend drug screening or treatment, obtain credit counseling, or apply for income supports and entitlements.

Failure to complete the application process is the main reason a family does not receive emergency assistance, as the service plan places the responsibility on the family to complete the steps to successfully resolve the housing crisis.

Families with financial crises that exceed MCDHHS guidelines are referred to Emergency Assistance Coalition Lead Agencies. The Lead Agencies serve individuals residing within a particular ZIP code. These agencies may provide eviction prevention funds, utility assistance, food, clothing, transportation, and other goods and services. These providers collaborate to fulfill the particular needs of a family or individual. The goal of this approach is to gather community-wide resources in an efficient and effective manner.

### **Approach with Landlords**

An essential element contributing to prevention success is the cooperative relationship that MCDHHS has with landlords. Over the years, landlords have depended on MCDHHS intervention to help them keep tenants and avoid eviction and re-rental costs. Landlords have been willing to negotiate payment plans for back rent and to make other accommodations to avoid the costs and time involved in court-ordered evictions.

### **Approach with Tenants in Subsidized Housing**

The Montgomery County public housing authority, HOC, subsidizes almost 6,000 households in the county. Families who lose subsidized housing due to nonpayment of rent or lease violations present the greatest challenge to homeless service providers, as they have no viable housing future in the county. HOC and MCDHHS have partnered to provide emergency assistance for HOC residents to keep them housed. MCDHHS has posted satellite positions in three regional HOC offices to provide help with utilities and past due rent. In addition, HOC, primarily through its Division of Resident Services, intervenes and develops service agreements to keep people housed and to avoid their entering the homeless system.

### **Staffing and Caseloads**

Staff have four-year degrees in a human services field or a B.A. in Social Work. Masters-level social workers provide the intensive screening, assessment, and case management for homeless families. Two of the MCDHHS regional offices have a shelter worker dedicated to prevention activities with homeless families. The regional office in Rockville has the greatest number of shelter assessments and caseloads and has two shelter workers.

### **Funding Sources and Arrangements**

Since 1995, the county has met residents' demand for emergency assistance, regardless of the budget. The services and financial assistance provided in the county are funded with Federal, state, and county funds to prevent family homelessness. The approach to coordinating a financial package for clients emphasizes referral to other mainstream sources such as TANF, food stamps, and Medicaid; working with the community-based Emergency Assistance Coalition to garner

additional funds; and securing Federal Emergency Management Agency funds through the nonprofit agencies that administer the Emergency Food and Shelter Program.

MCDHHS Emergency Services staff assess need and compile a package of resources intended to resolve the housing crisis. Resources are typically a combination of Emergency Assistance to Families with Children Grants and county Emergency Services Grants. Each funding source has different eligibility requirements, so that the total financial package can be flexibly applied depending on the circumstance. For example, some families may be eligible for a Welfare Avoidance Grant to receive a one-time lump sum payment of up to six months of their welfare grant. This payment is intended to remedy a work-related crisis so the recipient can obtain or maintain employment and income. However, unaccompanied adults in need of assistance to prevent eviction are not eligible for Emergency Assistance to Families with Children funds. Workers will use a combination of county grants coupled with Emergency Assistance Coalition funds to assist in resolving the emergency. Emergency Assistance Coalition funds can often be used for medications and health needs that can be particularly costly to the uninsured, elderly, or disabled adult not yet eligible for Supplemental Security Income, Medicaid, or Medicare.

To avoid a recurrence of the housing emergency, workers assist families and individuals to apply for any or all benefits for which they might be eligible. MCDHHS oversees the county Rental Assistance Program and the Maryland Energy Assistance Program and can often expedite applications to prevent an immediate eviction, as well as to help with long-term rental and utility bills.

In many cases, families and individuals first appear at MCDHHS when an eviction is imminent and housing cannot be preserved. In these situations, assistance with security deposit, moving costs, and first month's rent is far more expedient than allowing the family to enter the shelter system. Unlike the state Emergency Assistance to Families with Children grants, county grants can be flexibly applied to preserve or re-house families, given that they have a workable plan to remain housed.

MCDHHS contracts with HOC to provide the same emergency financial assistance service to households at risk of homelessness that reside in HOC-owned units. The Department of Housing and Community Affairs also allocated funds to the Office of Landlord Tenant Affairs to provide emergency financial assistance for at-risk households to avoid eviction.

### **Approach with Transitional Housing**

For those families not helped before becoming homeless, the major challenge is in determining what other housing alternatives are available to them. Assessment and case management services that are focused on finding housing as soon as possible have led to more rapid exit from homelessness. Those that remain in shelter are those who have no other alternatives. The families in shelter with the most serious housing barriers are referred as early as possible during their shelter tenure to an advisory group called the Family Provider Team. This team, consisting of all family nonprofit provider agencies of both shelter and transitional housing, meets monthly with MCDHHS to review and prioritize each family in shelter for transitional housing placement. This

teaming assures that the most difficult families are prioritized for the scarce transitional and permanent supportive housing resources. This strategy prevents families from languishing in shelter without a housing plan, increases provider accountability, and encourages creative use of collaborative case management and resources.

### **Approach with the Larger Community**

To increase interagency cooperation and early intervention to prevent evictions, the Montgomery County Coalition for the Homeless developed an Eviction Prevention Committee as an action step of the county's 10-year plan to end homelessness. The Eviction Prevention Committee convened in July 2003 to increase collaboration and coordination of all stakeholders and their resources to prevent homelessness. The Eviction Prevention Committee includes representatives from Montgomery County Coalition for the Homeless, HOC, MCDHHS (Special Needs Housing and Emergency Services), Core Services Agency (mental health), Adult Protective Services, Child Welfare, Housing and Community Affairs, Office of Landlord and Tenant Affairs, and the Sheriff. Some of the strategies planned for the next six to 12 months include:

- Delivering information to landlords, as part of rental agency annual license renewal procedures, about how to provide tenants with eviction prevention resources to prevent court filings;
- Pulling weekly court filings for earlier intervention with educational packages to prevent evictions;
- Targeting neighborhoods with high rates of evictions to deliver educational packages to increase financial literacy; and
- Including MCDHHS information and referral number on eviction notices by the Sheriff's office so tenants can seek assistance to avoid evictions.

### **Approach with Tenants with Special Needs**

Often mentally ill clients engage in behaviors or cause neighborhood disturbances that can jeopardize their housing. The MCDHHS Crisis Center serves as liaison to the Sheriff's office and to landlords' complaints about mentally ill or vulnerable tenants whose behaviors might otherwise lead to eviction.

### **Promising New Strategies**

Montgomery County found that prevention services alone were not enough to reduce family homelessness. Since 2000, the county has experienced a large increase in the number of homeless families in need of emergency shelter. Faced with large numbers of families in motels awaiting shelter placement and all family shelter units at capacity, MCDHHS leadership

recognized that what they were doing was not working. Due to the long waiting list for shelter and the difficulty of conducting assessments while families were staying in motel rooms, MCDHHS instituted a pilot program to focus on placing families in shelter *first* for a 14-day assessment period, rather than using motels.

### ***Housing Assessments***

This approach emphasizes that families must take responsibility for their housing plan from the moment they first approach MCDHHS. Shelter placement is a last resort, only considered after all other alternatives for housing have been explored or verified.

Each homeless family is screened for shelter eligibility and housing barriers prior to assignment to the MCDHHS shelter worker. The shelter worker then uses a detailed interview format that facilitates the assessment process and formulation of a detailed action plan. The interview covers educational, vocational, housing, credit, criminal, mental health, chemical dependence, legal, physical health, family of origin, and relationship issues. Once facts have been gathered they can be verified with mainstream and housing databases to assess the family's housing barriers.

The shelter worker then begins a housing stabilization plan that involves action steps to help the family obtain housing as quickly as possible. The family signs and dates the plan, which includes action steps and a timetable. The family is then sent to a shelter placement for a 14-day assessment period to be conducted jointly by the shelter provider and the MCDHHS shelter case manager. The shelter provider receives the screening information and coordinates with the MCDHHS case manager to attend to the action steps and timetable of the action plan.

Since October 2003, this housing assessment program has led to reductions in the length of time that families have remained in emergency shelter. MCDHHS is now expanding the pilot program to all three family shelter providers. The goals of this program are to:

- Reduce the numbers of families housed in motels awaiting shelter placement;
- Reduce the average length of stay in the family shelter; and
- Target shelter services to only those who need them.

### **DATA COLLECTION AND USE**

The major barrier to documenting prevention outcomes is the inability of a number of databases to “speak” to one another. Created for different purposes, each database collects different components of prevention—clients served, payments distributed, and shelter or other homelessness services. The following three databases are used to determine the effectiveness of prevention assistance in Montgomery County.

- The Client Information System identifies clients who requested any type of emergency assistance between July 2002 and July 2003. This system was developed and is maintained by the Maryland State Department of Human Resources.

- The Client Payment System identifies recipients by type of emergency assistance. These data are from two databases: SOTAS collected data between July 2002 and March 2003 and J.D. Edwards collected data after March 2003. These two data sets were merged on all matching variables.
- The Homeless Tracking System identifies those who were homeless or entered the shelter system at some point between July 2003 and July 2004. This system was developed and is maintained by Montgomery County information technology resources.

**Analysis**

The study team developed a data analysis plan for Montgomery County to determine how many families who received emergency services subsequently received eviction prevention payments and then became homeless. To determine the impact of emergency assistance, each of the three databases listed above was unduplicated and matched using three fields of data for each case—first name, last name, and social security number. The selected families’ data were analyzed around three main outcomes:

- Receipt of emergency assistance;
- Receipt of homelessness prevention payment; and
- Experience of homelessness following receipt of assistance.

**Initial Findings**

Of the more than 3,500 families for whom cases were opened for emergency assistance at MCDHHS, the analysis indicated that 80 percent did not receive financial assistance. Approximately 19 percent of the families received an eviction prevention payment and approximately 2 percent used emergency shelter within the following year. Of those families who received an eviction prevention payment, a very small number (13) became homeless during the following year. (See Exhibit B.1.) Because analysis of the payment data alone indicates much higher receipts of eviction payments, there were too many cases dropped in the initial data matching to validly assess outcomes.

**Exhibit B.1. Outcome Measures for Families**

Outcome Measures	Families	
	Number	Percent
Recipients of emergency assistance only	2,788	80%
Recipients of a payment only	663	19%
Recipients of shelter only	40	2%
Recipients of a payment followed by shelter	13	0%
Total recipients of homelessness prevention services	3,504	100%

## **Future Analyses**

Montgomery County has rich data on homelessness prevention and homelessness. By continuing to unduplicate these data, matching databases together, and developing questions to be answered, the county is positioned to develop robust outcomes. Recommendations for continued monitoring of outcomes include:

- Merging the payment data set with the Homeless Tracking System to track outcomes for all emergency services clients; and
- Developing standardized measures of housing barriers to target more intensive services to those clients most at risk of homelessness.

## **Caveats and Limitations of Outcomes Data**

Several caveats apply to the outcomes developed for Montgomery County. There is no comparison or control group, so that one can argue that most families who received assistance would have avoided shelter regardless of receipt of county help. Those who did not receive assistance may indeed have lost their housing and have become homeless. The available funding for eviction prevention assistance is not sufficient to meet the total need, so the county prioritizes its resources to prevent loss of housing for those most likely to be successful in the long term. Because of the single point of entry and the total coverage of all family shelter providers by the Homeless Tracking System, the county's documentation of prevention will measure shelter use by the families with the most barriers to housing.

## **Documentation of Reduction in Family Homelessness**

Prevention activities, coupled with strategies to help families find housing and exit shelter as quickly as possible, are demonstrating promising outcomes. Continuing to measure outcomes related to these new strategies would demonstrate if the county can eliminate the shelter waiting list and if the family shelters can reduce the average length of stay for homeless families. Recommendations for continued monitoring of outcomes include utilizing the Homeless Tracking System to track all families screened for emergency shelter, the number who are placed and how long they stay, and their dispositions at exit and six- to 12-month followup for repeated shelter episodes.

## **MONTGOMERY COUNTY SITE VISIT PARTICIPANTS**

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Rosetta Robinson, Community Ministry of Montgomery County, Director Congregation & Community Emergency Support  
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Corinne Stevens, MCDHHS, Special Needs Housing, Chief  
Dudley Warner, MCDHHS, Behavioral Health and Crisis Services, Senior Administrator  
Alex Wertheim, MCDHHS, Homeless Services Coordinator  
Charles Wilkerson, Community Ministry of Montgomery County, Loan Program

**MONTGOMERY COUNTY ACRONYMS**

HOC	Housing Opportunities Commission
MCDHHS	Montgomery County Department of Health and Human Services
TANF	Temporary Assistance for Needy Families





## **APPENDIX C MID AMERICA ASSISTANCE COALITION**

The Kansas City metropolitan area comprises five counties in two states: Clay, Jackson, and Platte counties in Missouri, and Johnson and Wyandotte counties in Kansas. According to the 2003 American Community Survey conducted by the Census, these counties are home to more than 1.8 million residents.<sup>29</sup> The urban core of Kansas City with the highest poverty level is located in Jackson County, MO, and Wyandotte County, KS. Clay and Platte Counties in Missouri have the challenges of a suburban area and rural setting, but with less poverty.

To address the needs of low-income and homeless families and individuals across the Kansas City metropolitan area, the Mid America Assistance Coalition (MAAC) developed a comprehensive data system that stores homelessness prevention and homeless services data. This data system—MAACLink—is the centerpiece of the community-wide approach to homelessness prevention in Kansas City. More than 175 social services agencies are connected through MAACLink, providing a systematic approach to coordinate community resources and to document client services and outcomes for funders and community stakeholders.

During the study team's visit to Kansas City on May 10–11, 2004, the study team interviewed 12 staff from MAACLink and community agencies to learn about MAACLink's community-wide approach to homelessness prevention and services. The study team also learned how MAACLink documents services and outcomes. A listing of all persons interviewed is included at the end of this appendix. The MAACLink system approach to homelessness prevention is described below, including the data analysis to document program impact.

### **PRACTICE OF POTENTIAL INTEREST TO OTHER JURISDICTIONS**

The contact for MAAC and MAACLink is Jan Marcason ([maacexec@maaclink.org](mailto:maacexec@maaclink.org)). The MAACLink system is a model, community-wide data system that provides standardized tracking of homelessness prevention and homeless services data. The MAACLink data system is a practice of potential interest to other jurisdictions. The highlights of the system include:

- The integration of at-risk and homeless population data;
- The ability to share client data among all member agencies;

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<sup>29</sup> Population data were obtained from the U.S. Census Bureau at: <http://www.census.gov/acs/www/Products/Profiles/Single/2003/ACS/Narrative/380/NP38000US3760.htm> (accessed on 10/12/2004).

- Highly standardized intake and service provision processes;
- Ongoing collaboration among social service agencies throughout the community; and
- System development that is directly influenced by the users themselves.

## **DEVELOPING THE COMMITMENT TO PREVENTION**

During 1974, the need for social services in the Kansas City metropolitan area was rising, while resources were shrinking—social service agencies were only able to apply “band-aids” to clients’ situations. The Metropolitan Inter-Church Agency reached out to five counties and found that clients often bounced among providers, which raised the question of how to track these clients. In 1975, 21 agencies in the Kansas City area established the Emergency Assistance Coalition of Food Pantries. During 1977, members from the Missionary Baptist Church’s Drifters organization and Metropolitan Lutheran Ministries founded the Warmth and Light Utility Assistance program. In 1984, these long-established assistance organizations merged and became MAAC, which incorporated as a nonprofit in 1985.

With the shared goal of improving emergency assistance provision to low-income and homeless individuals, MAAC merged centralized client tracking and information and referral to provide better reporting on services and payments. The energy crisis in the mid-eighties further underscored the need for detailed reports on the use of funds and services. MAAC and collaborators from local social service agencies, especially funders, thought it was a good idea to develop a centralized database to avoid duplication of services, to track case management, and to determine whether funding was meeting its goals.

MAACLink was developed as a DOS-based application in 1994. The network of participating providers defined requirements to track basic information about recipients, services, and case management outcomes. The database system design was predicated on manual record keeping on index cards used by all participating agencies to standardize their tracking and data collection. The resulting automated system was user-friendly and provided for efficient record keeping and reporting.

Demand for additional agency participation prompted MAAC to upgrade the software to a Windows-based application, expanding its ability to share information across multiple agencies and communities. In 1997, the Department of Commerce provided additional funding. Additional matching funds from Kansas City area foundations, businesses, and individuals supported an upgraded and expanded system. The U.S. Department of Housing and Urban Development (HUD) awarded MAACLink a 1999 “Best Practice” award for its information tracking system that enables agencies throughout the Kansas City area to communicate about services and clients in real time.

Upgrades to MAACLink have also incorporated the functionality needed to become the Kansas City metropolitan area Homeless Management Information System (HMIS). The Kansas City continuum of care adopted the MAACLink system as its HMIS in 2002. Currently, 95 percent of shelter beds are logged on the system. This enables tracking the prevention of homelessness as it is possible to determine if an individual or family who received prevention services ultimately

received shelter or other homeless services. Having expanded from only six agencies on line in 1994, MAACLink currently includes more than 175 agencies inputting information about emergency assistance needs and homeless services in the metropolitan area.

## **COMPONENTS AND ORGANIZATION OF THE COMMUNITY STRATEGY**

The MAACLink system coordinates the provision of emergency assistance and homeless services throughout the Kansas City metropolitan area. MAACLink allows the Kansas City community to track how funds are used to deliver services or provide emergency assistance to prevent homelessness. MAACLink is a proven system whereby multiple agencies across state and county jurisdictions can share recipient and payment information confidentially. The elements of the approach to homeless prevention are discussed in the following sections.

### **Services**

The Kansas City community-wide approach to preventing homelessness includes 175 social service agencies. Each of these agencies provides a variety of services within their own funding limitations and conditions. The main homelessness prevention service that these agencies provide is assistance with utilities payments. Utility assistance is provided in one of two ways:

- MAAC administers seven utility assistance programs and certifies eligibility for the Federal Emergency Management Agency (FEMA) funds. Forty agencies in the Kansas City metropolitan area receive utility funds to assist their clients. MAACLink is adept at managing these funds—the system automatically checks a client’s eligibility and reports real-time fund balances.
- Some individual agencies administer their own funds. For example, the Salvation Army administers a utility fund and uses the MAACLink application to allocate and deliver the funds. The fund management application of MAACLink allows the managing agency to generate checks in the client’s name for immediate distribution.

Additional services are provided through the 175 agencies that use the MAACLink system. Services are organized and delivered according to the particular agency. Catholic Charities reports that it often uses larger community funds to supplement internal agency funds. This practice is bolstered by the ability to determine which other agencies have community funds available and whether the client has already received certain funds through another agency. For example, a client can receive utility assistance from the Dollar Aide fund from only one agency. An agency intake worker can search MAACLink to determine if the client has already received utility assistance with Dollar Aide funding from other agencies that share the fund. If the intake worker fails to check the client’s service history before granting the service from Dollar Aide, MAACLink’s built-in safeguards inform the intake worker that the client is ineligible, prompting him or her to seek an alternate funding source for the service.

Examples of additional services include the following:

- Job counseling;
- No-interest loan program for individuals with barriers to maintaining employment;
- Food baskets and congregate meals;
- Clothing and thrift store; and
- Drug and alcohol counseling.

### **Screening and Eligibility Issues**

In the Kansas City metropolitan area, an individual or family in need can contact either MAAC's information and referral hotline or any of the service providers in the area. Most of the social services agencies that participate in the system provide emergency assistance with the ultimate goal of preventing homelessness. There is no single point of entry for clients, but there is no wrong door—MAACLink allows a family or individual to walk into any agency and receive services or a referral to another agency that can provide services.

When a client enters any agency that is a MAACLink user, workers at that agency conduct a standard intake of basic client demographics. When an agency provides a service, the worker enters that information as well. Any agency that is part of the system can see a client's service history including rental, mortgage, and utility assistance, as well as other services such as food, transportation, case management, and bed nights at a homeless shelter. To maintain client confidentiality, information regarding certain services, such as those provided through a domestic violence agency, cannot be accessed through MAACLink.

Each agency and each funding mechanism has its own criteria for eligibility and its own restrictions as to how many times a family or individual may receive services. Typically, there are limits on the number of times that a family may receive services, as well as the number of dollars that can be spent on the person's behalf. Although the specific requirements for each utility assistance fund vary, the general requirements for the utility funds administered through MAACLink are the following:

- Applicant must have income at or below 150 percent of the Federal poverty level;
- Client's name and address on the MAACLink screen must match those on the utility bill;
- The client and agency intake staff member must sign a confidentiality and consent agreement;
- The intake date on the client's service file in MAACLink cannot be more than 45 days old;
- The date on the utility bill must be within 30 days of the client's request for service;

- The client can receive assistance twice in one year from each of seven funds from one agency;
- The amount of the assistance is equal to or less than the amount of the bill;
- The payment of the utility bill must be delinquent or the client must provide proof of a disconnect notice; and
- No agency personnel may receive MAAC-managed funds from the agency that employs them.

Agencies have a certain amount of discretionary flexibility depending on a client’s needs and available funding. In general, most providers make exceptions and provide services only for clients who have “hit a bump” rather than those with chronic issues or those who are at imminent risk of homelessness. The overall focus is on helping clients who are more likely to resolve the issue and have a long-term positive outcome. Not all funds managed through MAACLink are flexible, however. The Salvation Army is very strict in terms of eligibility—all services are need-based (client must verify income and expenses); client must have paid at least 25 percent of the bill during the past 90 days and must often provide a copay; client may only receive financial help once each year; the cap for aid is \$250 for rent and \$150 for utilities each year; and the client must make a plan toward paying the next bill.

Because the system was originally designed for use by professional case managers who employ a strengths-based case management method, MAACLink does not specifically identify families or individuals at imminent risk of homelessness.<sup>30</sup> However, the system has the capacity to inform the provider about whether a client’s homelessness is acute (i.e., client receives many services and often) or if it is a momentary slip. This information helps workers to know the best way to intervene—those who “slip” may just need a quick intervention to help them avoid or quickly end an episode of homelessness.

### **Selected System Components**

The MAACLink data system is MAAC’s most outstanding feature. Its capacity for data collection, as well as analysis, is broad. The unique aspects of the system are the ability to view a client’s service history among all participating agencies; the ability to manage funds within the system so that workers know where to refer clients who request financial assistance; and the ability to compare homelessness prevention services against homeless services to determine some level of prevention effectiveness within the community.

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<sup>30</sup> The strengths-based case management program trains workers in the Kansas City area to serve homeless families using a case management module in MAACLink. This method builds on participants’ existing strengths to help them leave homelessness and secure permanent housing. Workers using this program have access to discretionary funds for program participants. The housing status and risk level for these participants is known; therefore, a measure of imminent risk of homelessness was not built into the MAACLink system.

Another striking characteristic of MAACLink is the leverage that it has in the community. MAACLink has been successful in developing a large collaboration of social service agencies, partially due to the financial and programmatic benefits that it parlays to its members. Specifically, only agencies that utilize MAACLink are eligible for the energy assistance funds managed by MAAC. Therefore, participation in MAACLink increases agencies' financial resources.

The coordination among services and providers is the hallmark of the MAACLink system. Currently, the network of service providers that is coordinated through MAACLink includes 175 agencies, most of which are nonprofits that provide emergency assistance. Even homeless service providers that receive no government funding report and track data using MAACLink. The administration of the MAACLink system is centralized at MAAC while each agency has remote, real time access to the system where they can enter and access data on all clients.

Homelessness services are provided under the auspices of the providers associated with the Homeless Services Coalition. The Homeless Services Coalition works to move people out of homelessness while MAACLink providers work to prevent homelessness from occurring. Homeless Services Coalition statistics are tracked through MAACLink.

Examples of collaboration and coordination within the MAACLink system include the following:

- Any agency on MAACLink can look up other agencies' shared fund balances and refer clients to an agency that may have aid available. This effective referral network saves the clients' time and helps reduce frustration for people seeking emergency assistance.
- City Union Mission is the largest provider of emergency shelter in the Kansas City metropolitan area. This agency was not required to go on-line with MAACLink, but did so because it recognized the value of sharing its services with the community. City Union Mission does not receive any Federal funding, but uses MAACLink to ensure that it serves clients in the best possible way. MAACLink is the connection between emergency assistance and homelessness services for City Union Mission.

### **Mainstream Agency Involvement**

Because MAAC is a private agency with a collaboration of members, it does not have access to mainstream funds and services. While MAAC has created a community-wide system, Low-Income Home Emergency Assistance Program (LIHEAP) and Emergency Crisis Intervention Program funds are distributed through another agency. LIHEAP and Emergency Crisis Intervention Program funds are distributed through the state of Missouri to the Community Action Programs (CAP) in the Kansas City metropolitan area. The CAPs use a separate data system and do not collaborate with MAACLink. MAACLink encourages intake workers to help clients apply for mainstream resources, such as LIHEAP, by prompting a pop-up referral screen based on the monthly household income. This screen reminds intake workers to ask the client if he or she has applied for or received LIHEAP or Emergency Crisis Intervention Program

assistance. Intake workers may refer clients to the CAPs for Federal funds and thereby leverage resources in the private social services sector. Because MAACLink is not used by the CAP agencies, there is a significant gap in its community-wide approach to preventing homelessness.

## **Funding**

MAAC and MAACLink are funded through several sources—corporate and foundation grants, Heart of America United Way, government grants, program income, individuals, religious organizations, and other sources. The utility assistance funds that MAAC administers are funded through Kansas City Power and Light Company, Missouri Gas Energy, Aquila (an electricity and natural gas company), *Kansas City Star* (the newspaper for the Kansas City area), and KCTV5. Additionally, each of the individual emergency assistance providers in the community is funded through several different sources, based on the particular agency. Each of these funding sources is tracked through MAACLink and all services are associated with a particular funding source, allowing MAACLink to accurately determine the costs of services provided.

## **Community Relations and Advocacy**

The collaboration among service providers was established first and eventually led to the creation of the MAACLink data system. One of the biggest barriers to implementing a management information system was the collaboration among agencies and a foundation of trust among stakeholders. Since the Kansas City metropolitan area service providers had already established this; MAAC was charged with the task of creating a simple system that appealed to service providers. MAACLink is central to maintaining and facilitating the ongoing collaboration among the agencies.

## **DATA COLLECTION AND USE**

MAACLink collects a vast amount of data; however, the data previously have not been used to measure outcomes. The study team worked with MAACLink to measure the impact of the provision of emergency assistance on whether a family or individual becomes homeless within 12 months of receiving services. To assess this impact, the study team recommended that MAACLink examine the effect of rental and mortgage assistance to families, individuals, and youth on the probability that they will experience homelessness within 12 months following the service.

## **Analysis**

The study team proposed that MAACLink determine the percentage of families and individuals who received homelessness prevention services and then became homeless. The team defined the population served as families and individuals who received rental and mortgage assistance



during fiscal year 2002 (October 2001–September 2002). This population was compared with recipients of shelter services during fiscal years 2002 and 2003 (October 2002–September 2003).

The reason for limiting the population definition was that rental and mortgage assistance are generally considered to be the essential intervention used across jurisdictions to avoid shelter placement and to preserve housing for those most at risk of homelessness. Rental and mortgage assistance are also typically the highest expenditures and have stricter eligibility requirements, such as a plan indicating that the housing can be sustained over a period of 12 months.

### Initial Findings

Using the data collected through the MAACLink system, staff at MAAC conducted a basic analysis of outcomes data. By using the analyses and variables described above, MAAC was able to calculate a percentage of families and individuals who received homelessness prevention services during 2002 and then became homeless during 2002 or 2003. The number of homelessness prevention services recipients is an unduplicated number based on unique heads of households.<sup>31</sup> Of the 4,235 households who received homelessness prevention services during 2002, 3.4 percent became homeless during 2002 or 2003. Of these same households, 2.7 percent became homeless in 2003.<sup>32</sup> (See Exhibit C.1.)

**Exhibit C.1. Recipients of Rent and Mortgage Assistance  
Who Became Homeless the Following Year**

Recipients of homelessness prevention services	4,235
Recipients of shelter, 2002 & 2003	145
% Recipients who became homeless	3.4%
Recipients of shelter, 2003 only	116
% Recipients who became homeless	2.7%

### Future Analyses

Two characteristics of MAACLink make future analyses and development of outcome measures feasible and promising: the wealth of data collected by MAACLink and the ease with which adjustments can be made to the system to improve data collection. Using the data that MAACLink currently collects, the study team recommends conducting the following analyses:

- Determine the households that are “acute” as opposed to those that have hit a difficult point;<sup>33</sup>

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<sup>31</sup> The MAACLink system could not identify the number of unique heads of household that requested but did not receive homelessness prevention services during the indicated period of time.

<sup>32</sup> The 2003 numbers may seem disproportionately higher because that was the first full year that 95% of beds were being documented consistently in MAACLink (the Shelter Bed application of MAACLink was completed in 2002 and fully implemented toward the end of that year).

<sup>33</sup> In this case, acute refers to those families and individuals who have experienced repeat episodes of homelessness.

- Compare the characteristics of acute and nonacute households to accurately target prevention services;
- Compare the characteristics of households who become homeless following rent and mortgage assistance with those who do not; and
- Compare outcomes between families and individuals.

Several simple variables could be added to the MAACLink data system to allow a more robust analysis of outcomes data. A variable could be added to flag individuals who requested rental or mortgage assistance but did not receive it, as opposed to those who requested it and then received it. This variable would allow analysts to select out a control group to compare whether receipt of rental or mortgage assistance impacted the percentage of households becoming homeless during the following year.

### **Limitations of Data and Outcomes**

The barriers to documenting service effectiveness by MAACLink include inconsistent data entry among service providers and the lack of data fields that may prove vital to the development of outcome measures. In addition, the database has the capacity for users to track clients who request services but are denied, but this has not been done. With the addition of these data, robust outcomes could be measured for the community.

### **MID AMERICA ASSISTANCE COALITION SITE VISIT PARTICIPANTS**

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Kathleen Kennedy, Bishop Sullivan Center (Kansas City, MO)  
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### **MID AMERICA ASSISTANCE COALITION ACRONYMS**

CAP	Community Action Program
FEMA	Federal Emergency Management Agency
HMIS	Homeless Management Information System

HUD	U.S. Department of Housing and Urban Development
LIHEAP	Low-Income Home Emergency Assistance Program
MAAC	Mid America Assistance Coalition

## **APPENDIX D**

### **MASSACHUSETTS DEPARTMENT OF MENTAL HEALTH**

Massachusetts (estimated population of 6.4 million in 2003) runs its public services through state agencies, with local governments playing relatively small roles. The Massachusetts Department of Mental Health (DMH) is responsible for all persons in the state with severe behavioral health problems, most of whom have extremely low incomes. The system operates through six regions, of which the study team visited two: Metro Boston and Western Massachusetts. The study team selected these two regions because Metro Boston is the state's most populous region and has the highest prevalence of homelessness and the most extensive development of interventions for primary and secondary homelessness prevention. Western Massachusetts is geographically the largest region, covering the western portion of the state, and is home to some innovative programs to prevent homelessness.

DMH's Metro Boston Area covers Boston and the surrounding cities of Cambridge, Somerville, Brookline, Chelsea, Revere, and Winthrop. Boston is the largest city in the state and the 20<sup>th</sup> largest city in the nation. The 2000 population was 589,141.<sup>34</sup> With its concentration of higher education, health care, financial services, professional and business services, and tourism and hospitality, Boston and the surrounding area transitioned from a manufacturing economy to a knowledge-based one. By 2000, the Boston Area was enjoying one of the strongest economies in the nation—employment was at an all-time high with more than 113,000 jobs added between 1992 and 2000, and unemployment was at a near-record low of 2.9 percent. The situation changed when a national recession and depressed stock market, coupled with the events after the September 11, 2001 terrorist attacks, led to job losses and reductions in state revenues and budgets (revenues declined by 26 percent during the spring quarter of 2002). These cuts threatened many social services and public health programs, especially those serving low-income and other vulnerable populations.

Western Massachusetts, by contrast to Metro Boston, is an area of small towns with a regional population of approximately 626,000 adults. Springfield (2000 population of 152,000) is its largest city, and the location of DMH's Western Massachusetts regional office. Also in contrast to Metro Boston, Western Massachusetts has suffered job and population loss for several years, so the recent economic downturn did not represent as drastic a change as it did for Boston.

Preventing homelessness among people with serious mental illness has been a strong element of DMH's agenda for nearly two decades. DMH efforts have been greatly strengthened since 1992, when the state passed its first Special Homeless Initiative legislation to provide the resources to

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<sup>34</sup> Population data were obtained from the U.S. Census Bureau at: <http://quickfacts.census.gov/qfd/states/25/2507000.html> (accessed on 3/30/05).

reduce the incidence of homelessness among people with serious mental illness. Housing development, specifically for homeless people and more generally for people with serious mental illness, has been a strong component of the DMH effort. This effort has also included protocols for discharge planning, staff training to focus on housing issues, funding for outreach, development of transitional shelters for people with serious mental illness, and other aspects of prevention described in more detail below. The study team's site visit concentrated on learning about the primary and secondary prevention efforts in the Metro Boston and Western Massachusetts regions.

During the study team's site visit to the state on July 13–15, 2004 and August 12, 2004, the team interviewed more than 70 people who represented state and local agencies devoted to behavioral health care and homeless services, psychiatric hospitals and inpatient units, nonprofit behavioral health and case management agencies, and data managers and analysts. A full listing of persons interviewed is presented at the end of this chapter.

Most meetings provided information about the system and how it works; other meetings focused on understanding data to assess prevention and developing analytic strategies to document effectiveness. This report describes the services available for behavioral health (mental illness and substance abuse) and how they are structured; housing options developed by DMH; and existing and developing practices to assure that institutional release or other disruptive events, such as loss of a caretaker, do not render a person homeless. Information on the growth of the DMH housing and community services system, as it relates to homelessness, and analyses of data reflecting DMH's effectiveness at preventing homelessness for people with serious mental illness are also described below.

## **PRACTICES OF POTENTIAL INTEREST TO OTHER JURISDICTIONS**

Practices that are of potential interest to other jurisdictions are presented below. All inquiries about Massachusetts DMH practices should be addressed to Walter Jabzanka at [walter.jabzanka@state.ma.us](mailto:walter.jabzanka@state.ma.us).

1. *Discharge planning policies and procedures*—DMH has a highly evolved set of policies and procedures related to discharge planning, along with training materials and other means of dissemination. Assuring appropriate housing and support services is a major element of discharge planning, which DMH emphasizes by establishing central office and area housing coordinators to promote adequate supplies of appropriate housing and facilitate access for the people who need it.
2. *Special Homeless Initiative*—DMH has substantial state resources explicitly targeted to prevent homelessness and assist already homeless people to regain and retain housing. These resources are flexible, allowing the department to “do what it takes” to reach the initiative's goals within broadly defined parameters.
3. *Housing development*—Housing development has been an explicit DMH focus for nearly two decades, during which the department has created many units and shifted the

emphasis from group homes to independent and semi-independent living with supportive services. Since the late 1980s, the Homeless Initiative and the housing development process have been part of DMH's successful efforts to develop a solid community-based system of care while minimizing institutionalized care and homelessness among persons with serious mental illness. While not designed exclusively to prevent homelessness, growth in the community-based system has coincided with and supported the downsizing or closure of several state hospitals. Through well-documented plans and financing strategies, state administrators and the legislature reallocated resources to the community system. This dynamic underscored the importance of discharge planning and housing development, which in turn made available effective homelessness prevention.

4. *Tenancy Preservation Project (TPP)*—The initial impetus for TPP came from the state's housing finance agency (MassHousing), which proposed an alliance with DMH, local Housing Courts, and other agencies. DMH supports TPP with funding and planning input. TPP includes several projects across the state with specially appointed neutral mediators who work with people with mental health and other behavioral problems. TPP receives referrals of pending evictions, including many for which mental illness is a contributing factor, and seeks solutions with tenants and landlords to prevent eviction and subsequent homelessness.

## **DEVELOPING THE COMMITMENT TO PREVENTION**

DMH has been evolving its current discharge planning and community-based system, including homelessness prevention and mitigation, since the late 1980s. Advocates from shelters and the Massachusetts Housing and Shelter Alliance (MHSA) provided a key stimulus for the department's increased focus on homelessness in the early 1990s by documenting the significant number of people with serious mental illness who sought help from emergency homeless shelters within days or hours of being discharged from inpatient psychiatric facilities.<sup>35</sup> The evidence, combined with active lobbying, stimulated the first Special Initiative to House and Serve Homeless Persons with Mental Illness, most often referred to as the Special Homeless Initiative (HI).

The HI received funding in state fiscal year (SFY) 1992 with state resources of \$1 million and in SFY 1993 with \$2 million. Ongoing advocacy from MHSA, in collaboration with DMH and the governor's office, increased that amount to funding levels of approximately \$22 million each year in SFY 2001. HI is supplemented with an additional \$1 million each year in DMH services funding explicitly devoted to this population. DMH HI and supplemental homeless funding levels have remained constant during the last few years despite severe state budget shortfalls, testifying to the state's commitment to support approaches to prevent or end homelessness for people with serious mental illness.

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<sup>35</sup> MHSA is a statewide coalition of housing and shelter providers that organizes, lobbies, advocates, and otherwise works to promote solutions to homelessness in Massachusetts.

DMH has used these and other department funds to purchase services, leverage additional funds for housing development with supportive services supplied by DMH, and focus increasing attention and resources on preventing and ending homelessness for the target population. In addition to funding, DMH commissioners have understood the need for housing and the difficulties of homelessness for people with serious mental illness. These commissioners have been proactive in leading the department to develop housing and systems aimed at preventing and ending homelessness for persons with serious mental illness.

DMH, which serves the most disabled and the poorest, estimates that approximately 48,000 adults in the state have serious mental illness. Its clients' incomes hover around 15 percent of the area median income and most clients are not employed. These circumstances leave them very vulnerable to homelessness should hospitalization or loss of a caretaker disrupt their housing arrangements. Targeting is a matter of clinical assessment to determine whether a person's mental illness meets state and Federal criteria for becoming a DMH client. DMH outreach teams actively look for clients and potential clients among homeless people on the streets and in shelters. Identification of potential clients triggers further assessment, formal enrollment as a DMH client, and efforts to help the person move to safe and stable housing. The characteristics that make a person DMH-eligible signify a level of disability that indicates a high risk of homelessness if the person has no family or obvious means of support.

## **COMPONENTS AND ORGANIZATION OF THE COMMUNITY STRATEGY**

DMH has invested heavily, both directly and indirectly, in addressing homelessness among persons with serious mental illness.<sup>36</sup> Elements of homelessness prevention are present throughout the department's multifaceted system of inpatient and outpatient continuing care. Most of DMH's core services are relevant to homelessness associated with serious mental illness. The department also sponsors initiatives aimed at preventing first-time homelessness and assuring that people with serious mental illness who do become homeless can obtain stable housing before their homelessness can become chronic. The department's homelessness prevention efforts are supported primarily with state-appropriated funds, and implemented in conjunction with Federal resources. Much of DMH's efforts to prevent homelessness are conducted through contractual arrangements with nonprofit and for-profit providers.

Some of DMH's activities and programs address primary prevention of homelessness; they try to avert a first episode and keep people with serious mental illness stably housed. Housing development, coupled with attending to housing at discharge, is important because many people stay in DMH continuing care units for many months. They may have been housed upon admission but lose that housing while they are in the hospital. Primary prevention involves assuring that housing is available for them once they are ready to leave.

Other DMH activities and programs address secondary prevention; quickly identifying people with serious mental illness who become homeless and supplying housing and services to assure

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<sup>36</sup> Much of this description is taken verbatim or with minor modification or reordering from documents provided by DMH.

that their period of homelessness is short and does not happen again. The study team examined both primary and secondary prevention components. These include discharge planning, housing development and the various forms of permanent supportive housing that have been created, transitional residential services (transitional shelters in Boston), outreach, and referral to housing and supportive services for people with serious mental illness found on the streets or in shelters.

The study team has ordered the presentation of these service components from the most to the least pertinent to homelessness prevention. The focus is on the Metro Boston Area because it has a more complex service structure and serves the most people. DMH also asked that we visit Western Massachusetts to learn about some particularly innovative programs such as the Tenancy Preservation Project and the housing options that have been accomplished there, both of which are described below. Each of the service components developed together and work simultaneously to prevent initial homelessness and to end homelessness quickly for those who do become homeless.

### **Mental Health Services**

Publicly funded mental health services are managed in tandem by DMH and the Behavioral Health Program of MassHealth, the state's Medicaid managed care program. Individuals who qualify for services through MassHealth, due to serious mental illness or serious emotional disturbance, are served by one of two means. Some individuals enroll in a health maintenance organization that becomes responsible for all of their care, including mental health services. Others choose a primary clinician option; in this case, services related to their behavioral health needs and the funds needed to meet those needs are separated out from Medicaid's normal reimbursement structure and managed for DMH by the Massachusetts Behavioral Health Partnership (MBHP).

MBHP is a private for-profit managed care organization that is a division of Value Options, one of the nation's largest managed behavioral health organizations. MBHP provides a comprehensive continuum of mental health and substance abuse treatment, including outpatient therapy and medication, acute inpatient and day treatment services, partial hospitalization programs, family stabilization teams, and a range of substance abuse services. Nearly all DMH clients receive MassHealth benefits as described above. The MBHP director reports directly to the commissioner of DMH.

DMH is a provider and purchaser of "continuing care mental health" services, which begin after a course of acute treatment does not achieve adequate improvement in an individual's status. DMH community services are provided, contingent upon an individual's eligibility for DMH services. Eligibility for adults, adolescents, and children is based on one or more qualifying mental health conditions (e.g., major affective, psychotic, severe personality, and eating disorders), the duration of the condition (one year or longer, observed or predicted), significant functional impairment due to mental illness, and a need for at least one service that is only available from DMH. DMH services include program- and home-based residential, wraparound services, case management, Programs of Assertive Community Treatment (PACT), homeless outreach services, supported employment, and other day and vocational services.



## **Discharge Planning**

Discharge planning assures that people leaving inpatient psychiatric facilities operated or paid for by DMH exit to stable housing and not to homelessness. The department has an explicit written discharge planning policy that includes a housing search component and the willingness to extend someone's hospital stay (i.e., to justify paying for more days than may be medically necessary) until appropriate housing is found. The policy prohibits DMH state hospitals and community mental health centers from discharging clients from inpatient wards with directions to seek housing or refuge in an emergency shelter. It directs staff to make every effort to place clients in suitable, affordable housing coupled with clinically appropriate services.

Many DMH clients with an inpatient episode, particularly those with longer stays, are at risk of homelessness because they lose their housing while receiving care due to eviction; family, partner, or sibling abandonment; and other situations. Such housing loss makes discharge planning (and developing appropriate housing resources) particularly important and a form of primary prevention. DMH has made great efforts to train staff to think that housing is one-half the job and is a critical component of mental health or clinical care. That is, people cannot respond well clinically unless their housing is secure.

DMH discharge policy has received extensive publicity as a practice model. It is formally promulgated and referenced in regulations; regular trainings and refresher courses are offered statewide; and Metro Boston has its own procedures on implementing the policy due to the high volume of clients. However, key people whom the study team interviewed in the state, particularly at DMH, noted that a do-not-discharge-to-homelessness policy is only as good as the housing options for people leaving psychiatric facilities. Therefore, DMH has been committed to creating housing options for clients with serious mental illness who would otherwise face homelessness.

## **Housing Supply and Development**

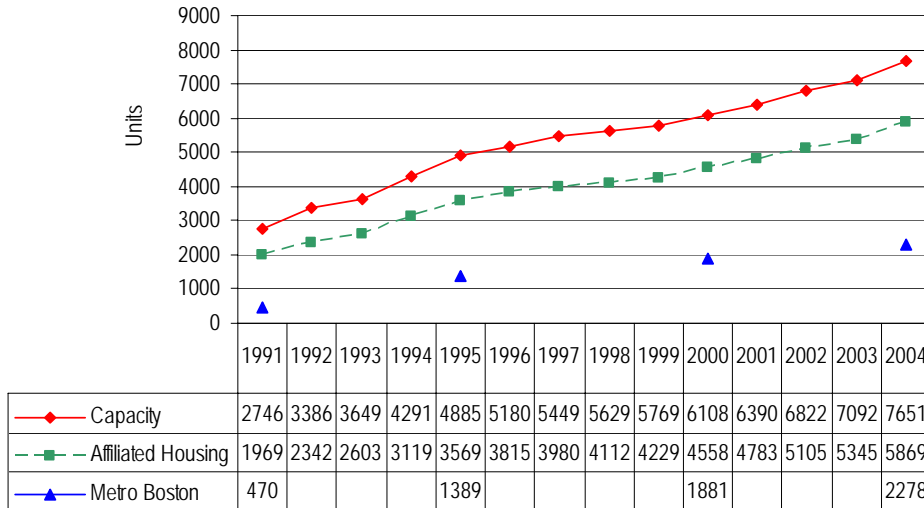
As of August 2004, DMH maintains more than 3,000 self-contained housing units of DMH-affiliated housing for people with serious mental illness and can house 5,869 people (some units have more than one person). Some of this housing is specifically targeted toward formerly homeless people. DMH-affiliated housing is any housing for which DMH or its agents have been successful in providing or otherwise proactively securing for its clients by helping to build it, providing match money for grants and other financing, or by other mechanisms. DMH-affiliated housing also includes clients living independently under their own leases.

An additional 1,792 DMH clients receive varied continuing residential community support services while living in housing that DMH did not secure. Of the total number of DMH-affiliated, self-contained housing units, approximately 1,400 are HI units. The Boston Metro Area has 2,278 DMH-affiliated housing units.

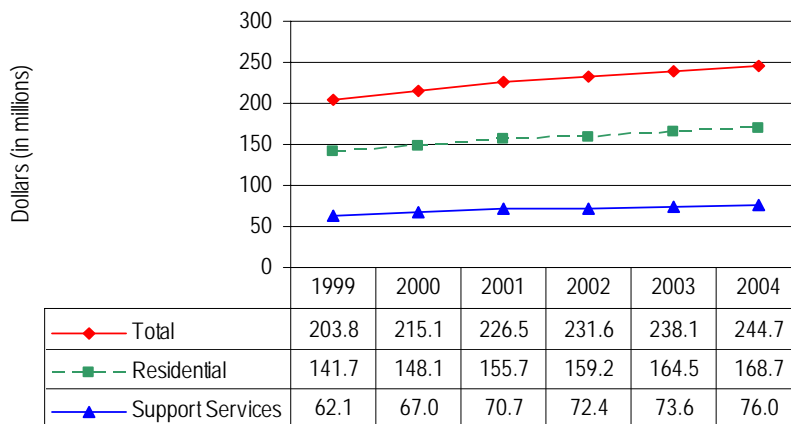
DMH has increased its housing inventory primarily since the early 1990s, and continues to add to it at every opportunity. The department's access to substantial resources through the HI and

other community services initiatives has allowed it to provide services funding for many housing units to match the housing component most commonly supplied by Federal resources (primarily the U.S. Department of Housing and Urban Development’s (HUD) McKinney-Vento Homeless and Section 811 programs). DMH’s statewide community residential capacity increased from 2,746 during 1991 to 7,651 in 2004. DMH-affiliated housing increased its ability to accommodate people from 1,969 to 5,869 people during the same period. (See Exhibit D.1)<sup>37</sup>

**Exhibit D.1. Growth in DMH Residential Housing Capacity, Affiliated Housing Statewide, and Metro Boston Capacity, 1991–2004**



**Exhibit D.2. DMH Funding for Community-Based Housing and Services, 1999–2004**



<sup>37</sup> DMH-affiliated housing is housing for which DMH has generated capital dollars, such as permanent supportive housing. DMH “capacity” includes DMH-affiliated housing and clients living on their own in the community (e.g., with family, or in their own apartments) for whom DMH supplies supportive services to help keep them from having an exacerbation of their mental illness and from losing housing. Metro Boston could only supply data for 1991, 1995, 2000, and 2004, hence the blank cells and absence of a connecting line in Exhibit D.1.

In Metro Boston, capacity increased from being able to house 470 people to the present capacity for 2,278 people (shown as separate triangles because not all data points are present). Exhibit D.2 shows DMH funding increases, in millions, from 1999 through 2004, total and separately for community-based residential and related rehabilitative supportive services. With increases running at slightly more than 5 percent each year, these funds have done better than inflation during this period, enabling DMH to sustain its community-based supports despite overall budget cuts and layoffs since SFY 2002.

### **Residential Services Other than Permanent Housing**

The HI has allowed DMH to serve and house an average of 2,400 homeless persons each year in approximately 1,400 units. In addition to extensive development of permanent supportive housing, HI has allowed DMH to enter into contracts with traditional shelters to provide supportive mental health services, to create five transitional shelters in the Boston Area, and to develop several Safe Haven projects across the state, including two in Boston. All of these programs are intended to help people with serious mental illness who have become homeless to leave that condition as quickly as possible and avoid a worsening of their mental illness. With many newly homeless people, these activities constitute secondary prevention efforts. DMH funds mental health services in the four largest traditional shelters in the state. All are in Boston and are operated by private nonprofit agencies. These services help shelter guests directly, but also make referrals to other services to help guests determine whether they are eligible for DMH continuing care services. If eligible, their prospects for ultimately becoming housed and receiving ongoing community supports through DMH increase substantially.

Metro Boston's Department of Mental Health Transitional Shelter (DMH/TS) programs, with a collective capacity of 165 beds, are affiliated with the area's mental health centers. Every effort is made to move homeless people with serious mental illness from traditional emergency shelters and the streets to more appropriate settings, such as DMH/TS facilities. DMH/TS are better prepared than generic shelters to keep people with serious mental illness safe and help them handle their mental health and other issues. Some people also come to DMH/TS from inpatient psychiatric units when a more permanent placement in the short term is not possible. DMH/TS facilities serve homeless people with serious mental illness who are waiting for permanent housing or not yet ready and willing to participate in the department's residential services programs. The goal in DMH/TS is for people to leave within 90 days, although average lengths of stay are approximately twice that goal, due in part to long stays of people who are difficult to place and the unavailability of suitable housing.

Safe Haven programs, another link in DMH's array of services, are aimed at reducing homelessness among people with serious mental illness. These programs are mostly targeted toward chronically homeless people with serious mental illness, typically with co-occurring substance abuse or other issues, and are not directly relevant to the present project's focus on primary or secondary prevention. Several Safe Havens operate around the state. Metro Boston has recently opened its second Safe Haven as an enhanced facility offering services and housing referrals typically not found in traditional Safe Havens projects. After only a few months, three

of its first eight residents are already moving into permanent housing. Another Safe Haven is under development in Metro Boston.

### **Services in Support of Stable Housing**

DMH has devoted substantial resources to sustaining people with serious mental illness in community-based living. These resources may offer primary or secondary homelessness prevention as part of treating people's serious mental illness and helping to avert housing crises. These include PACT teams, a contract with MBHP that provides behavioral health services to MassHealth clients through a behavioral health carveout arrangement, and other specialized services.

### **Programs of Assertive Community Treatment**

A collaboration between DMH and MBHP has been developing PACT teams across the state. Currently, 13 PACT teams serve approximately 750 people each year. These teams are funded with approximately \$10.4 million in state resources each year. PACT teams proactively offer outreach and highly individualized, flexible, community supports to meet each client's needs. PACT does not focus exclusively on homelessness and homelessness prevention, but it addresses and prevents first-time or extended homelessness through supporting people to stay housed. Each PACT team sponsored by DMH and MBHP has a significant number of homeless or at-risk people in its caseload. PACT teams also work to prevent people with no homeless history from becoming homeless or at risk through their comprehensive services approach. Staffing standards for PACT teams require that the teams include employment and housing specialists.

### **MBHP's Behavioral Health Care Services**

MBHP manages mental health and addiction services for all people with MassHealth coverage who choose to participate in the Primary Care Clinician Plan for their medical care. Members go to their own doctor for physical health care, and to services paid for through MBHP for their behavioral health care. MassHealth covers approximately 320,000 people, of whom approximately 120,000, mostly adults, receive behavioral health services through MBHP. These people have the most complex needs, including homeless individuals and those with both mental illness and addictions problems.

MBHP pays for services but does not deliver them. Service delivery occurs through a network of more than 1,200 credentialed inpatient, outpatient, and single-practice behavioral health providers, and is coordinated with more than 1,200 primary care clinicians. Services covered include inpatient and outpatient treatment, detoxification, medication management, and community support services.

## **Employment Services**

As the majority of DMH clients are under-employed or not working, DMH sponsors several community-based employment programs to further employment or educational objectives for all clients. DMH contracts with private vendors to supply these services, which occur across the state but concentrate in Metro Boston, where most of the state's homeless people live. The main types of services are Services for Education and Employment (SEE) and Community Support Clubhouses.<sup>38</sup> Specialized services for homeless and formerly homeless clients include Metro Boston's Employment Connections and the new Boston project, the HomeWorks Demonstration, that DMH and several partners recently won under the 2004 HUD-Department of Labor (DOL)-U.S. Department of Veterans Affairs (VA) competition to supply housing and employment services.

SEE consists of 25 projects across the state with an annual budget of more than \$6 million. This program served 2,423 clients in SFY 2003 and found 2,334 jobs for 1,064 clients. SEE helps participants secure employment in competitive settings, provides training, and addresses remedial, basic, or post-secondary education needs through flexible, individualized supports. Clubhouses offer similar types of employment-related services, as well as a "work-ordered day" in settings that include services and supports that extend well beyond employment-related activities. DMH allocates approximately \$15.6 million each year to Clubhouses, which found 2,201 job placements for 1,780 members among 880 employers. DMH clients may also receive employment supports through PACT with other types of community support.

Among DMH's homeless-specific employment initiatives, Employment Connections (EC) operates through JOB-NET, a DOL-funded one-stop Career Center. This program provides DMH clients employment-related assistance integrated with other people seeking employment help. EC is a collaboration between DMH Metro-Boston and the state Department of Employment and Training; in SFY 2003 it served 73 DMH clients and helped secure 67 jobs.

DMH partnered with JOB-NET, the Boston Private Industry Council, the Boston Office of Neighborhood Development, the Metro Boston Housing Partnership, and the Boston Emergency Shelter Commission to win support for HomeWorks in the 2004 HUD-VA-DOL national competition. The project houses chronically homeless individuals and uses the EC model to help them find and keep employment; 20 of the participants are DMH clients.

## **Specialized Services**

DMH supports other specialized services through contracts, including education services and an Aggressive Treatment and Relapse Prevention (ATARP) program to keep homeless clients with co-occurring mental illness and substance abuse disorders in housing. Most of these programs are small, each serving fewer than 100 people each year, and most would not be considered either primary or secondary prevention.

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<sup>38</sup> Clubhouses are nonresidential community programs for people with serious mental illness. They offer a major emphasis on work both in and for the clubhouse and through transitional and supported employment in regular jobs.

## **Outreach and Referral**

DMH sponsors outreach programs to streets, shelters, and other places where homeless persons may be found. These programs identify and engage individuals with mental illness and connect them to services and, ultimately, to residential programs and housing.

DMH uses Federal Projects for Assistance in Transition from Homelessness (PATH) funding (approximately \$1.3 million each year from the U.S. Department of Health and Human Services, Center for Mental Health Services, matched by \$600,000 in state funds) for its statewide outreach, engagement, and referral activities, which mostly involve visiting adult homeless shelters across the state. Clinical social workers offer eligible people on-site direct care, housing search and advocacy, and referrals to services such as housing, job training, literacy education, mental health and substance abuse services, and benefits and entitlements. Anyone with serious mental illness and a need for ongoing mental health services is referred to DMH to determine if they are eligible to enroll as a DMH client for continuing care services. During Federal fiscal year 2003, PATH clinicians screened 5,259 individuals and enrolled 3,701 as PATH clients.

DMH has also funded a Homeless Outreach Team (HOT), partially supported by PATH funding, in the Boston Area for more than 15 years. Clinicians and homeless specialists search out homeless people with mental illness who are or could become eligible for DMH services, and encourage them to accept assistance from DMH or other sources. Team members visit each shelter and known street homeless populations in Metro Boston at least once a week. They connect eligible homeless people to DMH housing and residential services opportunities, as well as medical, psychiatric, and substance abuse treatment. HOT moves appropriate people from the generic shelter environment to DMH transitional shelters, where they have more privacy and can receive more intensive services to access permanent housing and address their behavioral health needs. One HOT member is also assigned to work with MBHP to assist discharge planners to high-volume acute care facilities.

The department's Aggressive Street Outreach program supplements PATH and HOT by proactively focusing on streets, parks, and similar places. It is funded by HUD McKinney funds through the Statewide Continuum of Care, in which DMH is an active participant.

## **Department-Wide Emphasis on the Importance of Housing**

Each year, DMH serves 20,290 adult men and women over age 18 years with serious mental illness. Of this number, 2,552 are served in DMH continuing care inpatient facilities, which have a capacity of approximately 930 clients. Criteria for acceptance as a DMH continuing care client were described earlier. To be accepted for continued DMH inpatient care, clients must meet those and certain additional criteria.

DMH maintains a housing staff of three at its central office and one in each of the state's six regions, with Metro Boston being the most creative, proactive, and productive. These staff members work with DMH providers and state and local housing agencies to promote housing supply efforts; increase housing subsidies to DMH clients; and assist case managers, discharge

planners, and other DMH and provider staff to help DMH clients obtain housing or housing subsidies. The department identifies available housing resources and assists relevant agencies and providers to apply for all Federal and state homeless and non-homeless housing opportunities.

Policies and protocols emphasize the importance of housing for people with serious mental illness, adding assistance to find and keep housing as part of the services considered essential. Training for department and contract staff stresses the importance of housing, and that treatment cannot work if people do not have stable housing. The HI has been focused on establishing a comprehensive DMH service capacity dedicated to this population, and using the service funds to leverage and access transitional and affordable, permanent housing with services. DMH's \$22.2 million of HI funds are used to leverage more than \$85 million in Federal and other housing resources to develop and provide client access to housing units, mostly through HUD's McKinney Homeless Programs.

Linkages and alliances with other departments and providers, statewide and regionally, have been important to develop the current level of housing. Statewide examples include the following.

- An agreement with MassHousing ensures that 3 percent of all units developed with MassHousing financing are directed to DMH and the Department of Mental Retardation (DMR) to house people with serious mental illness or mental retardation. DMH clients now lease more than 400 such self-contained, scattered-site units. MassHousing and some local housing authorities contribute to TPP to keep their tenants stabilized and housed.
- An agreement with Massachusetts Department of Housing and Community Development (DHCD) to operate several state-funded programs includes a rental assistance program exclusively serving more than 600 DMH clients, a bricks and mortar housing development program through statewide DHCD grants to local housing authorities for DMH and Massachusetts' DMR clients (with a DMH capacity of more than 600 clients), and special project-based voucher allocations to DMH housing development projects.
- DHCD operates the Facilities Consolidation Fund (FCF) bond program, providing grants and loans to nonprofit developers for DMH and DMR housing development and housing homeless persons with serious mental illness. The FCF is an important source of capital resources for community-based housing. It originated in 1992 with bonding authority to invest capital into community-based housing instead of state hospital campuses. DMH has used it to help develop 83 housing projects for 658 of its clients. FCF was recently renewed for \$101 million over the next 10 years, with \$50 million earmarked for DMH.
- Agreements with the state's Department of Capital Asset Management ensure housing for DMH clients as a part of rental housing projects being developed on five former DMH state hospital campuses.

- Linkages with the Department of Public Health (DPH) in the ATARP efforts include a housing component.
- Area Housing Coordinators for local Continuums and DMH central office staff participate in the Continuum of Care application process through DMH.

### **Outreach to Inpatient Psychiatric Units**

The study team learned about two different activities in three sites related to identifying people just after entry into inpatient psychiatric units and subsequent interventions to prevent homelessness. One is in Metro Boston, one in Western Massachusetts, and one in Central Massachusetts.

#### ***Metro Boston***

Each private inpatient unit screens incoming patients and, for everyone identified as homeless at intake, contacts DMH's HOT to work with the unit's discharge planners to make a discharge arrangement other than homelessness. HOT members are DMH staff with extensive training and experience working with homeless people with serious mental illness. Connections made either by HOT, the unit's discharge planner, or other DMH staff usually succeed in linking the patient to housing options in the community. Occasionally, a patient in Metro Boston will have to be released to DMH/TS until more permanent housing can be arranged. People served are those with serious mental illness who experience an acute episode requiring emergency hospitalization who present at any of Metro Boston's private psychiatric facilities or private facilities elsewhere in the state that refer to DMH in Boston.<sup>39</sup>

Although most DMH and private inpatient units refer relevant patients to HOT, length of stay in these units is often short (averaging seven days) and HOT often does not get the referral until a day or two before expected discharge. The short notice makes it difficult to arrange housing by the time of discharge. To increase the speed with which referrals are made to HOT, one HOT member has been assigned to work closely with one of the major private psychiatric inpatient hospitals in greater Boston. Preliminary impressions are that this alliance has significantly improved the speed with which HOT receives referrals, and thus increased the time that the team has to make appropriate discharge arrangements for that hospital.

#### ***Western and Central Massachusetts***

A special activity of MBHP in Western and Central Massachusetts is Peer Support in Aftercare (PSIC). This project has trained consumers (individuals with mental health or substance abuse disorders) to offer support to individuals who have been hospitalized. After being notified that a patient at one of the two regional acute inpatient psychiatric units is a member of MBHP, PSIC

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<sup>39</sup> DMH contracts for acute emergency psychiatric inpatient units throughout Massachusetts.



staff interview people about discharge, offering them aftercare for 90 days to help them stabilize in housing and remain stable. Thirty to 40 percent of these patients enter the hospital homeless, and many of the remainder are at risk of homelessness upon discharge because they do not have a home to return to. Between 60 and 70 percent of those approached agree to participate. PSIC staff meet discharged patients twice a week while they stabilize, and do whatever is necessary to connect them to additional services and benefits. Data collected and analyzed by MBHP indicate that PSIC increases the number of days that DMH clients are able to remain in the community without becoming hospitalized.

### **Springfield/Hamden County Tenancy Preservation Project**

The Springfield TPP was established to help tenants threatened with eviction because their mental illness, substance abuse, or cognitive disability led to lease violations and the exhaustion of landlord ability to handle the situation. Its goals are to preserve existing tenancies or to connect households to alternate and possibly more appropriate housing. If eviction or relocation cannot be achieved, TPP refers to the local homeless outreach team for further work with the household.

TPP is an alliance among local Housing Courts, MassHousing, DMH, DMR, DPH, several local housing authorities, and the Mental Health Association, Inc. (MHA), of Springfield, Massachusetts. MHA is a major DMH provider in Western Massachusetts, offering residential, housing, and homeless services among other things.

Cases likely to be referred to TPP come into Housing Court when a landlord (either private or a housing authority) is planning to file eviction papers on a tenant after other efforts to resolve the issues have failed. The Housing Court judge, landlord, legal services staff, or other referring agency usually know or suspect that the tenant has a mental disability or other problems. They refer the person to TPP, where workers assess the situation, screen for eligibility, make referrals and establish linkages, and strive to stabilize the household through discussions and negotiations with housing managers, Housing Court mediators, relevant agencies, and the threatened tenants. The goal is to overcome problems that might otherwise result in loss of housing and potential homelessness through eviction or hospitalization.

The Springfield TPP is a pilot project of MassHousing, DMH, and their partner agencies. Similar projects now operate in three other Massachusetts communities—Northampton, Brockton, and Boston. Projects are also in various stages of development in Worcester, New Bedford/Plymouth County, Essex County, and Franklin County.

### **DATA COLLECTION AND USE**

The Massachusetts DMH prevention strategy is not as simple to describe as this study's other sites because it is an entire state rather than a city, county, or small group of counties. Its strategy has many components, and the picture is further complicated by the fact that different regions of the state customize the operation of many components to fit their own circumstances. Further,

the state has been evolving its approach for more than a decade, so some components are well established statewide, others are emerging from “pilot” or “demonstration” status to broader application, and some are just beginning the pilot stage in a few communities. The consequence of this complexity is that data on the success of homelessness prevention efforts are component-specific, and sometimes also location-specific.

### **Statewide Changes, 1992–2003, Excluding Metro Boston**

Many things happened between 1992 and 2003 that might have affected the likelihood that people with serious mental illness would become homeless in the state. Factors likely to reduce the odds of becoming homeless were significant investments in housing, supportive services, and planning to prevent homelessness by DMH and others, as well as DMH policies designed to house its clients and keep them housed. Factors likely to increase the odds included the closure of several state mental hospitals, shifts in inpatient services for others, and drastic reductions in affordable housing, especially in the Metro Boston Area.

DMH has data on admissions and discharges to its own continuing care facilities throughout the state, excluding Metro Boston, that provide a broad look at how its policies and practices might have served as primary or secondary prevention strategies. Since 1993, hospitals have recorded if someone is homeless at admission, and if people are homeless at discharge. Some people also lose their housing during a hospital stay, especially if it lasts a long time, and join the numbers who entered homeless in being at risk of homelessness at exit. Data are available for 13–15 facilities for the earlier years and six to seven facilities for the later years of the period (the difference stems from hospital closures, not from failure to report in later years).

Exhibit D.3 shows the pattern of all hospital admissions and admissions as homeless between 1993 and 2003. All admissions fell substantially during this period—later years have seen only approximately 35 percent of the admissions recorded during the early years. One would expect, therefore, that homeless admissions would have decreased proportionally. In fact, however, admissions as homeless have decreased to only 15 percent during 2002–2004 of what they were during 1993–1995 (averaging over the first and last three years). There is some question about how “homeless at admission” has been recorded in recent years; however, the data indicate that through its many activities in support of people with serious mental illness, a substantial reduction in homelessness at admission has been achieved.

**Exhibit D.3. Changes in Homeless and Total Admissions to DMH Continuing Care Units, Excluding Metro Boston, 1993–2003**

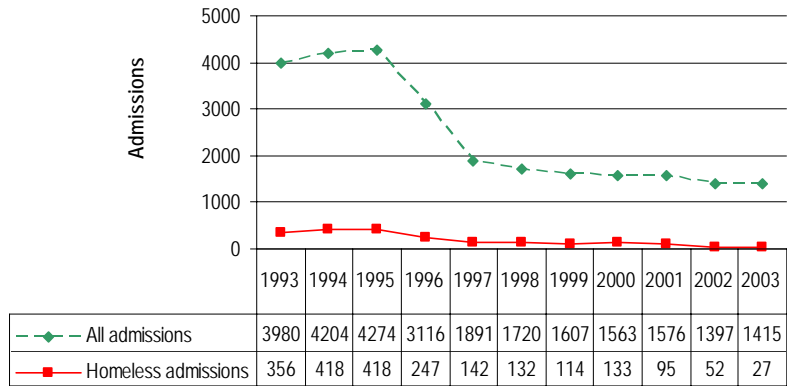
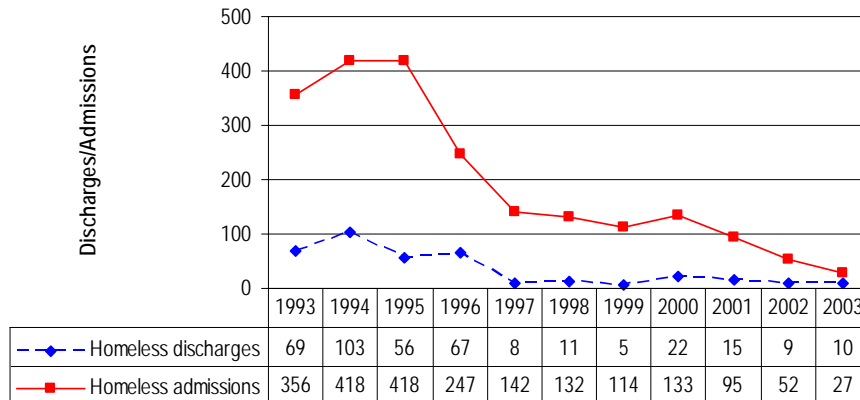


Exhibit D.4, compares admissions as homeless to discharges as homeless and illustrates that far fewer people are homeless when they exit DMH continuing care facilities than those who entered homeless. This indicates an accomplishment of secondary prevention. This figure also shows that discharges as homeless have followed the same pattern as admissions as homeless; they dropped to a level during 2002–2004 of approximately 15 percent of their level during 1993–1995. A combination of housing and community services to stabilize persons with serious mental illness at risk of homelessness may account for much of this impact, as well as an increased amount of DMH-affiliated housing to accommodate those who became homeless while hospitalized.

**Exhibit D.4. Changes in Homeless Admissions and Discharges in DMH Continuing Care Units, Excluding Metro Boston, 1993–2003**



**Exhibit D.5. Changes in Proportions of Homeless Admissions and Discharges to All Admissions in DMH Continuing Care Units, Excluding Metro Boston, 1993–2003**

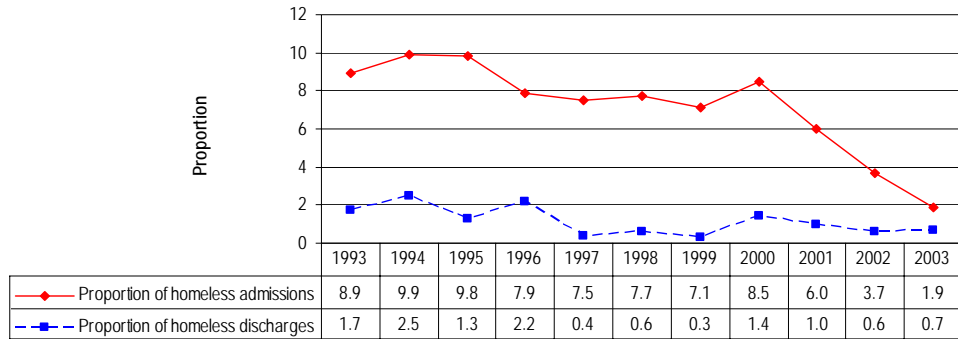


Exhibit D.5 shows ratios of homeless admissions and discharges to all admissions. The line showing the ratio of homeless admissions to all admissions indicates the same relationship as in Exhibit D.3, but presented as a proportion—homeless admissions declined over the years as a proportion of all admissions. The ratio of homeless discharges to all admissions follows the same pattern.

**Metro Boston**

The study team received data from three types of facilities—DMH transitional shelters, one DMH extended care inpatient unit, and almost all major private hospitals with acute psychiatric inpatient units. The timeframes covered for each type of facility differ, but the data show patterns of entering homeless but exiting housed, as well as how DMH-eligible clients fare compared to those who are not DMH-eligible.

***DMH Transitional Shelters***

SFY 2004 data for the 165 DMH/TS beds (in six facilities) show that of 225 admissions during the year, the average length of stay was 150 days. At entry, all were homeless—45 percent were from the streets and shelters and 47 percent were from either DMH or private hospitals and had nowhere to go at discharge. At discharge, 73 percent were *not* homeless (58 percent moved to DMH housing or their own housing, 15 percent moved in with family or friends, 12 percent entered other institutions, and 15 percent exited to the streets or shelters, after being offered housing alternatives).

***DMH Extended Care Hospitalization***

One DMH extended care facility in Metro Boston provided reliable data on annual admissions and discharges as homeless from 1992 through 2001.

- Approximately 30–32 percent of all admissions from 1992 through 1996 were homeless.
- Homeless admissions increased to 35–37 percent of all admissions from 1997 through 2001, with a peak of 42.5 percent during 1998.
- In the balance of the state, the proportion of homeless to all admissions stayed between 7 percent and 10 percent for the same period.
- Homeless discharges during the same period were less than 10 percent of admissions, with two years (1993 and 1999) dipping to 1.7–2.0 percent.
- Outside Metro Boston, discharges to homelessness from DMH extended care facilities were 0.3–2.2 percent of admissions.

The data for Metro Boston present a more challenging picture of a patient moving from homelessness to DMH extended care inpatient facilities. However, regardless of location, these facilities succeed in reducing homelessness at discharge to 20–30 percent of the number who came in homeless, acknowledging that some who entered from housing may have lost it while hospitalized. During years when much new housing was coming on line throughout the state, the ratio of homeless at discharge to homeless at admission fell below 10 percent. Beginning in 2000, it began to climb again, testifying to the need for continued system development and the inability of any state agency and its partners to overcome the housing cost and unemployment increases of the early 2000s.

### *Discharges from Private Acute Psychiatric Units*

The Metro Boston Area supplied three years of data on the housing status of people discharged from acute psychiatric units in private hospitals, where the average length of stay is seven days. As described earlier, these hospitals are all supposed to notify the HOT of people who are homeless at admission. HOT members, together with hospital social workers, then determine DMH eligibility and a collaborative effort results in comprehensive treatment planning to address the continuum of treatments and housing needs. Exhibit D.6 shows the discharge dispositions for DMH-eligible and non-DMH-eligible patients in acute psychiatric care facilities for SFY 2002–2004.

**Exhibit D.6. Discharge Destinations of People Leaving Private Acute Psychiatric Care, Metro Boston, SFY 2002–2004**

State Fiscal Year	DMH-Eligible			Not DMH-Eligible		
	2001–2002	2002–2003	2003–2004	2001–2002	2002–2003	2003–2004
All admissions for which HOT notified	820	813	513	476	276	251
Discharge Destination						
Streets or generic shelter	0%	13%	34%	23%	6%	80%
DMH transitional shelter	27%	36%	20%	0%	0%	0%
DMH community housing	43%	7%	14%	0%	0%	0%
Family or friends	0%	0%	12%	53%	55%	10%
Treatment/institution	30%	28%	21%	23%	39%	10%
Non-Metro Boston clients	0%	12%	0%	0%	0%	0%

As Exhibit D.6 shows, DMH eligibility makes a substantial difference in the discharge destination of people who are homeless and who enter private acute care psychiatric facilities. In three of the three years, the proportion released to the streets or to generic shelters is substantially lower for DMH-eligible patients. Many DMH-eligible people go to DMH/TS, so they would still be counted as literally homeless but very few leave DMH/TS and return to streets and shelters. DMH-eligible people are also moving into DMH community housing, whereas the most common destination at discharge for non-eligible people is family and friends. People not eligible for DMH continuing care tend not to be as sick as those determined to be eligible, and family and friends may be more able and willing to give them a home.

It is also clear from Exhibit D.6 that many people leaving acute psychiatric facilities need additional care, as movement to treatment or institutional settings (including DMH or other extended inpatient care, substance abuse treatment, or correctional settings) suggests.

**Effectiveness of Western Massachusetts’ TPP**

As noted above, TPP began in 1998, and since that time has opened 441 cases and closed 366 of them, with 23 households refusing TPP services. Of these cases, only 19 percent had ever been homeless, while 81 percent were potentially facing homelessness for the first time. Outcome data are from TPP case records for cases accepted and closed, and from Housing Court records for cases waitlisted but never served (our comparison group). Outcomes of cases closed between July 1, 1998 and June 30, 2004 (six years of operations) are displayed in Exhibit D.7.

Three-quarters of the people served by TPP had a non-age-related mental illness, either by itself (55 percent) or together with substance abuse (23 percent). Most of the households served by TPP did not become homeless, with approximately one-half staying in their original housing and approximately one-third moving to alternative housing. The biggest problems for homelessness prevention are with people who have both mental illness and a complicating addictions problem. More than twice as many of this group became homeless than those with only one of these problems.

**Exhibit D.7. TPP Case Status, Total Closed, by Diagnosis, and Comparison Cases**

All cases served and closed by TPP (n=366)	Tenancy Preserved	Moved to Alternative Housing	Became Homeless
		51%	34%
By Diagnosis			
Mental health (n=202)	55%	32%	13%
Substance abuse (n=43)	51%	37%	12%
Dual Diagnosis (n=83)	37%	35%	28%
Elder or Cognitive (n=24)	71%	21%	8%
Other (n=13)	38%	62%	0%

Note: Percentages run across each row; each row totals 100%.

These outcomes can be compared to cases that the Housing Court sent to TPP, but because of TPP workload the cases were waitlisted and never served. These cases had similar issues and difficulties, at the same level of seriousness or threat of eviction, and thus make a reasonable comparison group to determine what would have happened without TPP. There are 21 such cases for which outcomes were retrieved from court records. They are as follows:

- 24 percent were resolved favorably for the tenant, who retained tenancy in the original unit;
- 48 percent resulted in eviction;
- 29 percent left their original residence and subsequent location is unknown; and
- For the 76 percent that did not stay in their original housing, subsequent location is not known.

Ideally, the study team would like to assess two outcomes by comparing TPP clients served to people referred but waitlisted—retention of original housing and becoming homeless. The study team can certainly assess TPP’s effect on the first of these—TPP appears to have preserved original housing for twice as many people as would have retained it without TPP services.

Determining the proportion of people referred to TPP from Housing Court who would have become literally homeless without TPP is not as easy, however, because the court records do not contain information about ultimate homeless status. Making the most conservative assumption—of those who left their original housing, the same proportion of TPP clients and waitlist people became homeless—the study team can calculate that 23 percent of all waitlist people became homeless, compared to 15 percent of those who received TPP services. By this calculation, TPP reduced homelessness by 35 percent—at least one out of three people who would have become homeless without the assistance of TPP. TPP effects are probably even stronger than those just calculated, since the odds of becoming homeless for the waitlist people who left their original housing is higher than for TPP clients in the same situation.

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## MASSACHUSETTS ACRONYMS

ATARP	Aggressive Treatment and Relapse Prevention Programs
DHCD	Massachusetts Department of Housing and Community Development
DOL	U.S. Department of Labor
DMH	Massachusetts Department of Mental Health
DMH/TS	Department of Mental Health Transitional Shelter
DMR	Massachusetts Department of Mental Retardation
DPH	Massachusetts Department of Public Health
EC	Employment Connections
FCF	Facilities Consolidation Fund
HI	Homeless Initiative
HOT	Homeless Outreach Team
HUD	U.S. Department of Housing and Urban Development
MBHP	Massachusetts Behavioral Health Partnership

MHA	Mental Health Association, Inc.
MHSA	Massachusetts Housing and Shelter Alliance
PACT	Programs for Assertive Community Treatment
PATH	Projects for Assistance in Transition from Homelessness
PSIC	Peer Support in Aftercare
SEE	Services for Education and Employment
SFY	State Fiscal Year
TPP	Tenancy Preservation Project
VA	U.S. Department of Veterans Affairs



## APPENDIX E PHILADELPHIA, PENNSYLVANIA

With population of 1.5 million (in 2000), Philadelphia is the nation's fifth largest city. The city has been losing population and experiencing economic disinvestment for several decades.<sup>40</sup> Between 1973 and 1993, the city lost 200,000 jobs and housing vacancies soared. Although a major reinvestment effort during the 1990s slowed that decline and revitalized the downtown and many residential neighborhoods, the city still faces circumstances that generate homelessness (Kromer, 2001). Its 1999 poverty rate was twice that of the nation as a whole (22.9 percent versus 11.3 percent) and its average 2003 unemployment rate was also higher (7.6 percent versus 6.0 percent).<sup>41</sup>

Similar to four other large cities (e.g., Baltimore, New York City, St. Louis, and San Francisco), Philadelphia is its own county, with city agencies serving both city and county functions. Preventing homelessness among people with serious mental illness has been on the agenda in Philadelphia for many decades. Outreach efforts began during the early 1980s and expanded significantly during the late 1990s. These efforts have been combined with Safe Havens, permanent supportive housing, and other supports. Recent efforts have focused on preparing for an individual's release from an institution, such as jail or psychiatric inpatient setting. Such efforts build supports that will prevent homelessness, including housing. The study team's site visit concentrated on learning about these efforts as primary and secondary prevention. (An earlier study focused on the work in Philadelphia to reduce chronic street homelessness among people with serious mental illness and others, Burt et al., 2004.)

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<sup>40</sup> 1970–2000, -22.2 percent; 1990–2000, -4.3 percent; 1980–1990, -6.0 percent; 1970–1980, -13.4 percent. Calculated from data that were obtained from the U.S. Census Bureau at: [www.census.gov/population/cencounts/pa190090.txt](http://www.census.gov/population/cencounts/pa190090.txt) (accessed 3/23/03).

<sup>41</sup> 1999 poverty statistics for Philadelphia obtained from the U.S. Census Bureau at: [quickfacts.census.gov/qfd/states/42/42101/html](http://quickfacts.census.gov/qfd/states/42/42101/html); 1999 poverty statistics for the U.S. obtained from the U.S. Census Bureau at: [quickfacts.census.gov/states/00000.html](http://quickfacts.census.gov/states/00000.html); 2003 unemployment statistics for Philadelphia obtained from the Bureau of Labor Statistics at: [ftp://ftp.bls.gov/pub/special.requests/philadelphia/fax\\_9527.txt](ftp://ftp.bls.gov/pub/special.requests/philadelphia/fax_9527.txt); and 2003 unemployment statistics obtained for the U.S. obtained from the Bureau of Labor Statistics at: <http://www.bls.gov/cps/overview> (accessed 6/25/04).

During the study team's visit to Philadelphia on June 9–11, 2004, the team interviewed more than 30 people who represented city agencies providing behavioral health care and homeless services; psychiatric hospitals and inpatient units; nonprofit behavioral health and case management agencies; jails and prisons; and data managers and analysts. A full listing of persons interviewed is located at the end of this appendix.

Several meetings provided information about the system and how it works; other meetings focused on understanding the data available to assess prevention and develop strategies to document effectiveness. The service structure for behavioral health in Philadelphia (mental illness, substance abuse care, and case management); housing options for people with serious mental illness who are at high risk for homelessness upon release from inpatient care; and the structures in place or in development for assuring that institutional release does not leave a person homeless are described below. Also described are the databases available for assessing the impact of efforts to prevent homelessness.

### **PRACTICES OF POTENTIAL INTEREST TO OTHER JURISDICTIONS**

The contacts for discharge planning practices in Philadelphia are Marcella Maguire (Marcella.Maguire@phila.gov) and Rob Hess (Robert.Hess@phila.gov). Practices that are of potential interest to other jurisdictions are presented below.

1. *Collaboration between the behavioral health and corrections systems.* The Office of Behavioral Health (OBH) has developed arrangements with both the state prison system and the Philadelphia jail system to receive notification of people leaving these corrections systems. Checks to identify OBH clients who will be released allow interventions to try to prevent homelessness.
2. *Supplying case managers to OBH clients when they enter jail.* Data sharing also occurs at intake in jail, allowing OBH to re-link inmates who have been clients to their case managers, who may have lost contact with them. Mental health case managers and jail social workers try to develop an appropriate discharge plan together.
3. *Access to data across systems.* Authorized people at OBH can check child welfare and public assistance case records, as well as case records under its own aegis for mental health and substance abuse treatment and services. The access is reciprocal, so child welfare and Temporary Assistance for Needy Families (TANF) workers can check if a client is also an OBH client. Case plans can be designed with an eye to avoiding conflicting demands on clients and providers and maximizing use of appropriate resources. OBH is also able to check the management information system maintained for homeless services, and thus can determine if a client is or has been homeless.

## **DEVELOPING THE COMMITMENT TO PREVENTION**

Philadelphia has a strong public organizational structure for both behavioral health and homeless services. Creative bureaucratic negotiations during the mid-1990s established the city's Behavioral Health System, which is now formalized as OBH. The Behavioral Health System integrates agencies that offer prevention, outreach, and services for people with mental illness or substance abuse problems, primarily by contracting with nonprofit agencies.

To serve the homeless, in 1988 Mayor Wilson Goode exercised political will—supported by advocacy and coupled with control of city and county public resources—created the Office of Services for the Homeless and Adults. The office director became the “homeless czar,” a position the next two mayors maintained and expanded, and whose official designation is the Deputy Managing Director for Special Needs Housing. Through this office, and in partnership with a strong array of providers, advocates, and businesses, the city has planned for and subsequently undertaken extensive investment in programs and services to end homelessness. At the time of the study team's visit, Community Behavioral Health (CBH), the city's Medicaid Managed Care agency, was in the final stages of developing discharge planning standards that would span several agencies. These included Behavioral Health System agencies, homeless services, child welfare, and the county jail. The process began two years ago, following recognition that many clients of city agencies have serious mental illnesses in addition to the specific problems that brought them to the attention of the various agencies. Originally, the process focused on clients involved with the Behavioral Health System, as well as child welfare and juvenile justice. Under the guidance of Estelle Richman, who orchestrated the creation of the Behavioral Health System, CBH and other city practices designed to improve service delivery, representatives of these three agencies became acquainted.

Approximately 25 people regularly attended the planning and implementation meetings to develop an understanding of each other's systems and the ways in which clients were served. Department heads still attend these meetings. It became clear that these systems were not communicating well with each other. For instance, it was not uncommon for CBH to have a parent and child in its system, in separate cases, and unknown to each person's care manager, and for child welfare and juvenile justice to be unaware that a member of the family was a CBH client.

Most agencies were not doing an adequate job of ensuring that people with serious mental illness who were released from their care had a reasonable plan in place to meet their ongoing needs. The lack of communication and cooperative working relationships apparent between CBH and the child welfare system was also true for CBH clients and others with serious mental illness in several other systems—homeless assistance, juvenile justice, and the city and state correctional systems. In addition, communication difficulties plagued whole systems and how providers in each system dealt with clients. Providers tended to see an episode of care, not a whole client. If a provider served a person in an outpatient or emergency room setting, the provider frequently did not know or find out that the client had an inpatient history, the services or medications the client was using, or the options within the system for dealing with the client.

After a considerable amount of work, Philadelphia was poised to assure better communication and services to people with serious mental illness who were clients of its various agencies. This resulted from changes in the ways that staff worked with each other and in staff access to client information across several agencies' data systems. A discharge planning guide was written to prompt information exchange and collaborative case planning. It outlined the information that each system could share with each other and with other care providers, and described the procedures for getting information from each agency's data system.

## **COMPONENTS AND ORGANIZATION OF THE COMMUNITY STRATEGY**

While in Philadelphia the study team discussed how the system is set up to prevent homelessness and provide appropriate mental health care for people with serious mental illness who leave two different institutional settings: inpatient psychiatric facilities and adult corrections.

### **Philadelphia's Behavioral Health Care System**

Within OBH, the Office of Mental Health (OMH) and the Coordinating Office of Drug, Alcohol, and Addictions Programs (CODAAP) are city offices whose staff monitor and clinically manage services, shelter, and housing through contracts. CBH authorizes mental health and substance abuse treatment of many varieties for its clients. Independent of the homeless services system, OMH and CODAAP maintain an extensive network of residential settings, ranging from highly-supervised units to board and care homes and very low-demand housing that resembles Safe Havens. More than 1,900 units in these residential settings are earmarked for people with serious mental illness. These two offices also contribute to supportive housing options within the homeless continuum of care. OBH contracts with homeless shelter intake and the outreach teams under the Outreach Coordination Center run by Project H.O.M.E., as well as supporting outreach teams of their own.

### ***System Components***

CBH is the system's insurer, and hence the entity that authorizes and pays for the care its clients receive. It is funded through a Medicaid behavioral health carveout, as well as city funds for clients who are not covered by Medicaid.<sup>42</sup> CBH care managers must approve inpatient episodes and other types of care if providers are going to get paid when they treat CBH clients.

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<sup>42</sup> A carveout is one way to compensate for the fact that regular HMOs do not usually provide appropriate care for people with chronic mental illnesses and/or addictions. It takes the resources that Medicaid historically spent on a fee-for-service basis for mental health and substance abuse services and gives it to a specialized HMO that provides Managed Behavioral Health care (MBHOs). Most MBHOs are for-profit entities, unlike CBH, which is city-owned and reinvests its "profits" to provide additional services, including those related to homeless and formerly homeless people with serious mental illness.

Most components of the mental health system in Philadelphia are actually delivered by nonprofit and for-profit entities, either under contract to OMH or CODAAP or on a fee-for-service basis paid by CBH. These include:

- Five Crisis Response Centers that are similar to psychiatric emergency rooms, but reconfigured eight years ago to handle people with co-occurring disorders and conditions;
- Approximately 20 inpatient psychiatric units in various hospitals;
- Two extended acute units with 62 beds for people who may stabilize with hospitalizations that are longer than the average length of stay;
- More than 12 acute partial hospitalization programs;
- Three crisis residences for people awaiting housing placement;
- Fourteen agencies of three different types that offer case management for people with serious mental illness and co-occurring substance use disorders: coordinated community treatment, intensive case management, and resource coordination;
- At least six detoxification programs;
- Three hospital-based drug rehabilitation programs for people with co-occurring serious mental illness;
- More than 15 non-hospital residential substance abuse treatment programs that specialize in treating pregnant and parenting women;
- More than 300 progressive demand residence beds, for which an Axis I diagnosis and sufficiently high Global Assessment of Functioning (GAF) score are criteria for entry, are available under contract from private providers through OMH's Access to Alternative Services (AAS), which is the gatekeeper for residential services in the mental health system;<sup>43</sup> and
- 2,600 residential beds in programs ranging from group homes to locked facilities, available through AAS contracts.

### ***Planning and Organizing for Discharges that Prevent Homelessness***

The various agencies and systems that previously were unable to determine if their clients were involved in other systems have convened to share information and work together. The first

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<sup>43</sup> An Axis I diagnosis indicates that a person has a clinical mental disorder including psychotic, mood, anxiety, and cognitive disorders. The GAF score measures a person's psychological, social, and occupational functioning along a 100-point scale.



activities were meetings to get to know each other and identify barriers that made it difficult for clients of more than one agency to receive appropriate assistance. Each agency brought its rules, regulations, and governing legislation to document the legal framework and obligations under which they worked. The group analyzed compatibilities and incompatibilities across systems, looked for places where change could happen, and began to develop mechanisms to assure that the person or family was the focus of treatment and assistance. Mechanisms include systematic CBH assessment of its clients entering an acute care psychiatric unit, shared client lists, shared databases, co-located care managers, notification that a person has a CBH multiagency team, and regular case conferencing. Other mechanisms include the following.

- *Emergency shelter intake.* CBH staff have begun to co-staff shelter intake one day each week to screen for mental illness and divert eligible people to more appropriate care. If they are not already CBH clients, staff will enroll them and provide AAS shelter or housing options with supportive services.
- *Child welfare.* CBH staff are now co-located at the Department of Human Services to check on the CBH client status of adults and children in families involved with child welfare procedures (abuse and neglect investigations, child protective services, and foster care). At the Department of Human Services, CBH staff make assessments, conduct screenings and intake procedures, and authorize immediate care for those in need, all with access to CBH databases. A computer accessing Department of Human Services case records is now installed at CBH to cross-reference households being served in both systems.
- *Corrections.* Behavioral Health System linkages with correctional institutions for the appropriate treatment of inmates with serious mental illness are described in more detail below.

### **The System for Adults in Adult Inpatient Care**

With respect to adults in inpatient psychiatric care, OBH has established the Admissions, Discharges, and Planning Team (ADAPT) to assure appropriate care for individuals experiencing extended psychiatric hospital stays. ADAPT provides a clinical assessment specialist who determines if a client will likely stabilize in one week or two, which is the usual limit of acute inpatient care. If ADAPT judges that the client will need longer acute inpatient care, but will eventually stabilize, it recommends “extended acute” care, while still retaining the possibility that the client will do well enough in acute care not to need the extended service.

If the client requires extended acute care, the ADAPT specialist monitors progress at least once each month in case conferences, during which time treatment and discharge planning are discussed with the aim of reducing recidivism into acute care. The goal is to reach agreement on the most appropriate place for care, and for that care to be available. ADAPT and others work with clients and inpatient providers, using information from the client’s past history to assure that unsuccessful past discharge plans are not repeated (i.e., if someone has been discharged four

times to the same board and care facility that is not able to keep the person stable, a new plan is needed).

At present, providers are not held accountable for repeating discharge plans that previously have failed or for failing to assess important aspects of a discharge situation. New provider contracts with CBH will include outcome measures related to discharge planning as part of their performance requirements. Coupled with training in discharge planning, expanded knowledge of care options, and CBH's willingness to pay for providers' additional work to fulfill these requirements, CBH expects these contract changes to stimulate improvements in discharge planning.

### ***Relationships Among Crisis Response Centers, Hospital Social Workers, CBH Case Managers, and CBH Care Managers***

When a CBH client enters a Crisis Response Center, the center contacts CBH to learn the person's situation, history of care, and support system. This contact allows the Crisis Response Centers to know if the client has a crisis plan on file. Targeted case managers develop this crisis plan for each client and enter it into the CBH data system. If inpatient care is needed (approximately 60 percent of people coming to the Crisis Response Centers are hospitalized), the Crisis Response Center can send the person to an inpatient ward that has worked with him or her in the past. The Crisis Response Center also contacts the CBH case manager and follows any other recommendations for handling the client in a crisis situation, including backup plans if the primary plan cannot be followed.

When a CBH client enters an inpatient psychiatric unit, three people have responsibilities related to discharge. The first two are the hospital social worker and the person's CBH-contracted case manager. The third person is the CBH care manager, who, as the insurance representative, must approve payment for the inpatient treatment and parts of the aftercare plan. The CBH care managers are in the best position to understand the whole picture of a person's involvement with CBH, and to make judgments about what has and has not worked in the past, at least as far back as 1997. They can share this information with the hospital social worker and targeted case manager and develop a discharge plan (primary and backup) with the greatest chance for success. Because there are never enough available placements to take everyone who needs one, some people leaving inpatient care may stay in an interim placement, including extended acute care, in one of the city's crisis residences, in an OBH-supported shelter bed, or in a substance abuse treatment facility if substance abuse is an issue.

At a meeting involving social workers from three of the city's 20 inpatient units, targeted case managers from three of its 14 case management agencies, and CBH care managers, discussion focused on how placement decisions are made. The answers to a series of questions guide the decisions. The primary question is: Where was the person living immediately prior to entering inpatient care? If possible, this location is the first choice for post-release placement. The social worker and case manager explore barriers to return and offer resources to remove those barriers. If the person owes back rent or utility bills, negotiations are undertaken to resolve these bills. If personal conflicts and dissatisfactions exist, negotiations will again try to address these barriers.

If additional outside supports are needed for a family to be willing to take someone back, anything from periodic case manager visits to full-scale Assertive Community Treatment team supports may be offered.

If returning to one's earlier residence is not an option, other questions explore the range of alternatives. These questions include whether the person has income or other outside supports; what brought the person into treatment (diagnosis, medications, co-occurring substance abuse or other conditions); how often the person has been hospitalized; what the person is willing to do; and where the person is willing to go. Because a hospital stay is usually not long enough to arrange for the best housing placement (average length of stay on most psychiatric units is five to 10 days), social workers and case managers try to find appropriate interim placements, from which it is more likely that an optimal placement can follow. For instance, the presence of a substance abuse aids discharge planning because the person can enter a residential rehabilitation program while housing options are being explored.

Money is always a limiting condition. If the person has no income, every effort is made to help the person qualify for Supplemental Security Income or any other cash assistance for which she or he might be eligible. Clients do not have to pay for housing managed by AAS, but more independent living arrangements require the client to pay a portion or all of the rent. Caseworkers take advantage of all available subsidies, including project-based Section 8 and Shelter+Care vouchers.

If a CBH client entering a psychiatric ward does not already have a targeted case manager, the client applies for one, thus ensuring some continuity of support during moves from hospital and treatment settings into more stable housing situations. If the client has a targeted case manager, the case manager is often of most help to the hospital social worker due to knowledge of the client's history and housing options. CBH care managers have become a vital link among the workers assigned to work with a client's situation at and after discharge. The CBH care manager can put the hospital social worker in touch with a person's case manager, tell both people about the client's presenting situation at the Crisis Response Center, authorize care, and provide history and context.

### ***What Prevention Services Do People Get?***

A primary goal of case management is to help clients access benefits for which they may be eligible. Likewise, it is important to enroll everyone possible into Medicaid to save scarce city dollars for those without insurance. However, if the client is not eligible for Medicaid, the city will cover medical costs for enrolled clients. Case managers will also facilitate negotiations with landlords and families; food and transportation assistance; screening and referral for health, mental health, and substance abuse services; crisis care; housing location; and supportive services.

### *Staffing and Caseloads*

The social workers, case managers, and care managers involved in the efforts to prevent homelessness in Philadelphia among CBH clients with serious mental illness minimally have four-year degrees in a human services field. Social workers frequently have more education, including some clinical training. CBH requires that each person working as a case manager receive 10 weeks of directly relevant training before pursuing casework duties. The city offers this training three times each year and will not allow case management agencies to bill for work performed by people who have not completed the training. Training covers everything a case manager needs to know: housing issues, benefits and applications, involuntary commitment rules, crisis management, understanding the resources available in the community, learning how to negotiate with landlords, and how to work with families.

### *Shelter Diversion*

Many people approaching shelter intake are seriously mentally ill. Shelter intake staff have the ability to divert these individuals into behavioral health-supported shelter beds at one of three facilities, two of which are co-located with the central intake site for families and the one for singles. Services include staff trained in working with persons with serious mental illness, psychiatric care, and emergency medicine if consumers' Medicaid benefits are not active at the moment of prescription by the program psychiatrist. If this happens, the person does not appear as a homeless shelter intake in the Office of Adult Services data system, but does enter the Chronic Homeless Initiatives database and begins receiving care.

Recently, CBH staff realized that there was a need for a psychiatric triage service to co-exist with shelter intake. CBH is now stationing a person to conduct psychiatric assessments at shelter intake one day each week and to determine if there is a need for an even greater presence at shelter intake. CBH hopes that screening will identify people who have recently become homeless and who may have no idea of where to go for help. Intervention at this early stage of homelessness may help avert long-term homelessness among people with serious mental illness.

### **Special Projects for Corrections Discharges of Inmates with Serious Mental Illness**

Behavioral Health System is involved in several efforts to ease the transition of jail and prison inmates whose serious mental illness puts them at considerable risk of homelessness. Two efforts focus on inmates of the city jail (one of which also tries to assure appropriate care while in jail by working with jail social workers), while the third focuses on inmates returning to Philadelphia from the state prison system.

### *Projects with the City's Jail System*

The first project with the Philadelphia jail system was to increase communications and links to case managers. Although it was well known that many jail inmates have serious mental illness,

poor communications among jail social workers, mental health case managers, and OBH often led to inmates not receiving mental health services in jail or appropriate discharge planning to prevent their becoming homeless. This situation changed during February 2003 when jail personnel began sending daily lists of intakes and releases to OBH. OBH checks the lists against its client database to determine which new inmates are its clients (with serious mental illness or with serious mental illness and co-occurring substance use disorders) and which have assigned case managers. OBH then notifies the case managers of their clients' whereabouts and instructs them to contact the client in jail. The jail social workers determine appropriate treatment while the person is in jail and appropriate placement once the person is released.

Stakeholders felt that this increase in communication significantly increased in-jail contacts of case managers and clients, improved working relationships with jail social workers, and improved housing circumstances upon release. Workers believed that these factors have led to a reduced likelihood that the inmate will be "released to shelter" or end up homeless.

The second project was supplied with a case manager for the most severely mentally ill jail inmates with co-occurring substance abuse, but without a case manager. OMH recognized that release from jail often puts seriously mentally ill people at risk for homelessness, that co-occurring substance abuse further complicates the situation, that many such jail inmates do not get appropriate treatment while in jail, and that many do not already have a Behavioral Health System case manager or may not even be CBH clients. These circumstances prompted OMH to apply for a pilot demonstration grant to see how much difference a case manager could provide.

Two years ago, AAS applied for and received a grant from the Pennsylvania Council on Crime and Delinquency (PCCD) to test the efficacy of supplying a case manager to about-to-be-released jail inmates at the highest risk due to mental illness and lack of viable connections to housing. The grant went to the Philadelphia Mental Health Care Corporation Council (PMHCC), a nonprofit umbrella organization serving as a major human services systems management company for special programs and initiatives.<sup>44</sup> PMHCC provides critical administrative services to mental health, substance abuse, mental retardation, human services, and special health and related city offices and programs.

This PCCD Project, as it is called, includes a clinical specialist and assessor, and a behavioral health case manager. Jail personnel refer inmates to the PCCD Project for evaluation and eligibility determination. Project staff screen, conduct chart reviews and clinical interviews, determine present care needs, and make appropriate discharge arrangements. Many of the inmates who fit the project criteria have never been homeless; some have been homeless but are not chronically homeless people; and some have been homeless for years. Project staff track inmates through OMH/CODAAP data systems to learn the services they have received and learn about their treatment and family history, as well as if they received services as children. This information can be compared to what the inmate says about his or her own situation to allow the staff to assess needs. Project staff can authorize neurological, psychiatric, and substance abuse

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<sup>44</sup> PMHCC originated when Philadelphia participated in the Robert Wood Johnson integrated services grant in the late 1980s.

workups to determine if underlying neurological conditions are creating or exacerbating symptoms of mental illness.<sup>45</sup>

During its first two years, the PCCD Project has evaluated 115 people, 58 of whom have been released from jail. Inmates with serious mental illness tend to have very long jail terms—average length of stay in the Philadelphia jail is approximately 76 days, but for the 58 clients of the PCCD Project, it was approximately 300 days. Their behavior stemming from unrecognized and untreated illness usually means no “time off for good behavior,” and they tend to serve out their full sentences. Some may never even get sentenced, as they go back and forth from jail to mental hospitalization to the courts.

Getting post-release placements for people whose only problem is substance abuse is not difficult. The city supports approximately 360 recovery beds, but these facilities do not accept people who also have a mental illness, which is the case for PCCD Project clients. Nor are most of the people seen by the PCCD Project appropriate for board and care, as they do not have enough self-control to function well in a low-service environment. Project staff work with providers to adapt the rules for their clients. A new housing project, New Keys, began during March 2003 for people with co-occurring disorders, and has been an important resource for the project. Project staff believe that if enough appropriate housing were available, they could get their clients released regardless of the sentence, as jail is usually inappropriate.

Of the 58 people in the PCCD Project released so far, seven went to other institutional settings (six to state prison, one to the hospital). Forty-one (71 percent) went to known residential settings (10 to family or own residence, eight to boarding home, and 23 to AAS- or CODAAP-structured housing). Residence upon release was unknown for only 11 people (19 percent). A check of these 11 against the city’s shelter database indicated that, so far at least, only one had used the shelter system post-release.

The ability of PCCD Project staff to make a difference for imprisoned people with co-occurring disorders has stimulated the city to undertake two new projects. The Consortium Forensic Case Management Project began in April 2004 and the Mental Health Association Prison to Community Project began in July 2004. Both projects will supply case management services to jail inmates who are CBH clients but who do not have a case manager. Data documenting the progress and effectiveness of both projects should be more comprehensive than for the PCCD Project because the clients will have data in the CBH information system.

### *Liaison with the State Department of Corrections*

OBH funds the position of forensic liaison within PMHCC. The forensic liaison helps the state Department of Corrections place state prison inmates who reach their maximum sentence and will be returning to Philadelphia. The Department of Corrections tracks all inmates taking

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<sup>45</sup> For instance, temporal lobe seizures produce symptoms very similar to some mental illnesses. Such seizures are very amenable to treatment, after which the person’s “mental illness” may be cured. Serious childhood head injuries may also produce “mental illness-like” symptoms. Some neurological conditions make violent behavior more likely; they also may make it easier to qualify for SSI than would be true for mental conditions.

psychotropic medications and offers care through its Mental Health Roster (for the less severely impaired) and Psychiatric Review Team (for people receiving therapy as well). The Department of Corrections houses approximately 40,000 prisoners at any given time, of whom approximately 7,000 are on the Mental Health Roster and approximately 1,500 receive services from the Psychiatric Review Team.

Each year, approximately 120 state prisoners being released to Philadelphia are referred to PMHCC's forensic liaison to determine eligibility for housing placement services. Of these, approximately one-half have a place to live and are stable with respect to their mental illness. The remaining half, approximately five each month, do not have viable housing options other than what the city can offer. The liaison works to obtain placements for these 60 people each year. Placement will be in the most appropriate mental health residential setting available through AAS. People may not be able to enter the most appropriate residential setting immediately, either because no bed is available or the person must first establish eligibility for benefits and services. The liaison works to develop a primary and a backup plan, as well as to begin the process of establishing eligibility for medical assistance and cash benefits. Participation is voluntary on the part of the soon-to-be-released inmate because after serving a full sentence, the Department of Corrections has no oversight of the person (that is, there is no parole period).

### **Funding for Casework and Prevention Services**

CBH has a yearly budget of \$400 million and handles 70,000 of Medicaid's 395,000 beneficiaries in Philadelphia. CBH uses Medicaid to cover in-plan services (80 percent) and the remaining 10–20 percent are paid for with other funds. OMH and CODAAP provide the non-Medicaid dollars, using Federal block grants, state welfare and health department funding, and city dollars. OMH and CODAAP funding sources allow them the flexibility to serve clients whether or not they are on Medicaid, and to provide services with one funding source that another will not cover. Even so, CBH also has an interest in qualifying every client for Medicaid or other medical assistance so that city dollars can be reserved for those without other funding sources.

### **Who is Served?**

The prevention focus of this project involves people with serious mental illness leaving institutional settings. The primary population consists of people who are already CBH clients, which means that they already “qualify” for Medicaid based on a diagnosis of mental illness, substance abuse, or both conditions. Eligibility for Medicaid is determined by a standard eligibility and employability assessment. People in corrections institutions or homeless shelters with serious mental illness, with or without a co-occurring substance abuse problem, who are not yet CBH clients are a secondary population for which homelessness prevention efforts have recently focused. Enrolling them in medical assistance and getting them on the CBH rolls is a first step.

## DATA COLLECTION AND USE

1. Philadelphia has several administrative databases that, in combination, could afford an excellent opportunity to assess the impact of interventions to prevent homelessness among people with serious mental illness leaving institutional settings. *The Office of Adult Services shelter database* tracks all emergency shelter episodes dating back to 1989 and contains fields for name, age, race, gender, social security number, and other identifying information. It also records each night that each person has spent in emergency shelter and nights that people spend in some transitional housing programs funded by the city.
2. *The OBH/CBH/OMH database.* The OBH data system maintains records of care received and payments made for every client. Within OBH, the Research and Information Management Division manages much of the OBH data. This includes all of the information pertaining to CBH payments, residency in the AAS network of mental health housing, Chronic Homeless Initiatives Services including street outreach and Safe Haven residency information, case management, and emergency behavioral health services including psychiatric commitment and use of mobile emergency services.
3. *The CBH database.* CBH maintains Medicaid administrative records of all of the information pertaining to CBH payments (and therefore client services). Services include inpatient psychiatric and substance abuse treatment, detoxification services, outpatient mental health and substance abuse treatment, and case management services.
4. *The Philadelphia jail database.* The Philadelphia jail maintains its own records and recently has been informing OBH daily of the people who have entered and who have exited the jail within the previous 24 hours. The Research and Information Management Division would not be able to search this database directly, but communications between the jail and OBH are such that this division will be able to learn about jail inmates whose mental illness would qualify them for OBH services.

Philadelphia had several opportunities for creating comparison groups that were roughly equivalent to the groups experiencing some of its interventions. These opportunities placed it in a strong position to show the effects of prevention interventions, if the relevant agencies were cooperative and the databases could be brought together. Possibilities for documenting the effectiveness of efforts to prevent homelessness among people with serious mental illness discussed during the site visit included:

1. Using three of the databases listed above (Office of Adult Services shelter database, OBH/CBH/OMH database, and the jail database) to examine the effect of increased communication among jail, OBH, and case managers on the probability that seriously mentally ill jail inmates will experience homelessness within six months after release. This could be done using a sample of people released from jail in 2002, before the communication began, and 2004, when it was in place.



2. With jail inmates, compare the PCCD sample (inmates with serious mental illness who are given a case manager) to similar inmates who do not receive a case manager. Assess homelessness within one year of release using the Office of Adult Services shelter database and the Outreach Coordination Center database. This would test the effect of supplying case management to seriously mentally ill jail inmates on the probability of homelessness after release.
3. Using OMH information on its clients released from psychiatric units in private hospitals, compare the likelihood of homelessness within one year after discharge (from the Office of Adult Services and Outreach Coordination Center databases) depending on the services they received—specifically, the hospital they were in, the organization supplying each person’s case manager, what type of care they received, and their housing arrangement at discharge.

Unfortunately, merging databases from different institutional sources is a time-consuming activity, and such analyses do not take priority over routine system demands on data analysts. The OBH data managers were not able to complete any of these analyses for the present study.

## **PHILADELPHIA SITE VISIT PARTICIPANTS**

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Novenia Woodard, CBH

#### **PHILADELPHIA ACRONYMS**

AAS	Access to Alternative Services (part of OMH within OBH)
ADAPT	Admissions, Discharges, and Planning Team (part of OBH)
CBH	Community Behavioral Health
CODAAP	Coordinating Office of Drug, Alcohol, and Addiction Programs
MBHO	Managed Behavioral Health Care
OCC	Outreach Coordinating Center
OBH	Office of Behavioral Health
OMH	Office of Mental Health
PCCD	Pennsylvania Council on Crime and Delinquency
PMHCC	Pennsylvania Mental Health Care Coordinating Council
TANF	Temporary Assistance for Needy Families



## **APPENDIX F URBAN PEAK**

The population of Denver is approximately 545,000. More than 57,000 of those individuals are between the ages of 15 and 24 years. Urban Peak estimates that there are approximately 1,500 homeless youth in the state, of whom more than one-half are in the Denver area (Office of Homeless Youth Services, (2003). Most of the homeless youth seeking services at Urban Peak have a history of substance abuse and mental health issues. Further, many of the youth lack a high school diploma or a General Educational Development (GED) degree. These facts make it difficult for the youth to obtain housing in Denver even though the rental vacancy rate for 2003 was approximately 13 percent and the median rent was \$394.<sup>46</sup>

Urban Peak, which began as a storefront offering meals and counseling services, is now an umbrella organization that oversees four affiliate agencies serving high-risk youth in Denver and Colorado Springs. The agencies and their functions include:

- Urban Peak Denver provides outreach, shelter, and support services;
- The Spot provides drop-in services;
- Urban Peak Housing Corporation owns and manages permanent supportive housing for youth; and
- Urban Peak Colorado Springs provides outreach, drop-in services, medical care, education, and case management services to youth in Colorado Springs.

Through collaboration and strategic partnerships, Urban Peak offers a systematic approach of both primary and secondary prevention services to high-risk homeless and runaway youth. Services are mostly secondary and tertiary prevention services and are offered through outreach, a drop-in center, shelter, employment and education services, and housing. During 2003, 65 percent of the 762 youth who accessed case management services through Urban Peak Denver experienced a successful housing outcome (e.g., moved into own apartment, obtained permanent supportive housing, returned to family of origin). On an average night, approximately 34 youth slept in the shelter.

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<sup>46</sup> Housing information obtained from the U.S. Census Bureau at: <http://www.census.gov/acs/www/Products/Profiles/Single/2003/ACS/CO.htm> (accessed on 11/9/04).

During the study team's visit to Urban Peak on June 17–18, 2004, the team interviewed nine Urban Peak staff responsible for the management, outreach, employment, housing, and shelter aspects of Urban Peak. The study team visited an evening session at The Spot and visited the PS-1 Charter School, the outreach and educational services center located across the street. The study team also met with several youth at a monthly community breakfast where Urban Peak Denver staff and youth share a meal and experiences.

Data collection is a high priority at Urban Peak. For the past five years, the Urban Peak Client Database has stored vital information on the youth, services, and payments that are currently used to document program outcomes. The study team spoke with Urban Peak staff and outside researchers who are collecting and analyzing data to document the characteristics and outcomes of youth served. Results are available, and the data analysis addressed documenting additional prevention outcomes. A list of persons interviewed is located at the end of this appendix.

## **PRACTICES OF POTENTIAL INTEREST TO OTHER JURISDICTIONS**

The contact for all Urban Peak practices is Jerene Petersen ([Jerene.Petersen@urbanpeak.org](mailto:Jerene.Petersen@urbanpeak.org)). Because Urban Peak serves homeless youth, several practices are of potential use to other jurisdictions. These practices include the following:

- *Continuum of prevention and homelessness services.* To ensure that the needs of a diverse population are met, Urban Peak Denver provides outreach and shelter services to homeless youth, drop-in services to homeless and at-risk youth, and permanent supportive housing to youth transitioning from the streets or other unstable living environments.
- *Community relations and advocacy.* To provide innovative services for a unique population, Urban Peak advocates with the local government and other funders.
- *Innovative data collection methods.* Due to the unique characteristics of the population served by Urban Peak, the agency has been creative in the methods it uses to collect data and in developing followup data collection instruments and methods. Urban Peak has participated in several point-in-time surveys to gather information about drop-in clients' experiences, as well as to measure the prevalence of sexually transmitted infections within this population. Further, Urban Peak is considering utilizing Web-based technology to gather important followup data from the youth who have exited services.

## **DEVELOPING THE COMMITMENT TO PREVENTION**

Urban Peak opened during 1988 as a storefront office with a small annual budget, provided by the Capital Hill United Neighborhood Association, in response to the increasing number of runaway and homeless youth who gathered in the community. At that time, the agency provided food and basic counseling services. During 1992, the agency incorporated and expanded services

to include a 20-bed youth shelter—Safe at St. Paul’s—which the United Methodist Church had opened to serve youth living on the streets.

In response to a budget crisis during 1995, Urban Peak initiated a strategic planning process that incorporated consistent planning into the agency culture. Leadership and a commitment to intensive planning has provided a blueprint for the agency to respond flexibly to new opportunities, the changing needs of youth, budget realities, and necessary changes in organizational structure. Key planning goals included the construction of a new shelter facility in Denver, the development of housing for homeless and runaway youth, the expansion of programming, including education, and the development of an Urban Peak facility in Colorado Springs.

Urban Peak developed housing for substance-abusing homeless young adults in December 1997 by using a 10-year Shelter+Care grant received from the U.S. Department of Housing and Urban Development (HUD). Urban Peak developed and incorporated Urban Peak Housing Corporation—which soon opened Rowan Gardens, the first apartment facility designed to serve the unique needs of the young adults served by Urban Peak and other agencies. Urban Peak Denver partnered with the Urban Peak Housing Corporation, the State of Colorado, the Denver Department of Human Services, and HUD to provide 12 units for young adults who were addicted to drugs or alcohol, 16 units for young adults with disabilities, and 35 units for youth who were aging out of foster care. The units for youth aging out of foster care were not funded by HUD. The Urban Peak Housing Corporation also provided access to Section 8 vouchers for youth living independently in foster care at the age of 16 or older. The Urban Peak Housing Corporation currently owns and operates two apartment buildings and operates a third.

During June 1998, Urban Peak Denver designed and moved to a new shelter in South Denver. Designed for serving the needs of homeless and runaway youth, the facility included space for expanded programs—such as a room for an on-site school and increased shelter capacity from 20 to 40 beds—by replacing mats on a church floor with bunk beds. Urban Peak Denver partnered with the Denver Public Schools to open an on-site school program and computer labs.

During 1999, a group of service providers in Colorado Springs reported that youth homelessness was getting out of control. Staff from Urban Peak conducted a one-day outreach effort and identified 85 youth living on the streets during a two-hour period. Colorado Springs, raised the necessary funds and, with the help of Urban Peak Denver, established Urban Peak Colorado Springs to conduct outreach and drop-in services.

During 2002, the General Assembly of the State of Colorado established an Office of Homeless Youth Services. One of the architects of Urban Peak’s community collaboration moved into city government as the manager of the Denver Department of Human Services, reporting to the Mayor of Denver. This department has established the Mayor’s Commission to End Homelessness and is working diligently to this objective. Urban Peak serves on this commission and has been a leader in assembling Denver-area nonprofit agencies serving youth into a supportive collaboration.

During 2003, the state experienced a significant economic downturn that resulted in state and county budget reductions in youth programs. Employment opportunities for youth decreased while housing prices continued to increase. Denver also experienced an increase in gang activity. When state-funded youth services declined, there was an increase in the development of faith-based drop-in centers for street youth, offering youth survival essentials without services. It was recognized that when youth can obtain food and showers even without other services, they are able to survive on the streets. However, without these services they are less likely to achieve successful housing outcomes. Therefore, it became even more important for Urban Peak Denver to collaborate extensively with the other agencies providing services to homeless and runaway youth. Through this collaboration, youth could receive short-term services from several providers while still having contact with Urban Peak Denver, which offers a continuum of services to help youth exit the streets.

Due to the challenges of the economic downturn and the growing competition for youth services, Urban Peak partnered with a longstanding drop-in center in downtown Denver to expand services and begin to reach out to a more diverse street culture. In 2003, Urban Peak merged with The Spot, an evening drop-in center founded in 1994 by gang members, homeless youth, and graffiti artists. Accessible by public transportation, The Spot is located downtown in a gang-neutral environment. Offering a balance of positive social interaction, adult guidance and referrals, and fun- and skills-building activities, this merger created a more wide-ranging organization in terms of geography and services. Around this time, Urban Peak Denver also developed an alliance with the PS-1 Charter School through The Spot, increasing the opportunities for youth to receive their high school diplomas and GEDs.

## **COMPONENTS AND ORGANIZATION OF THE COMMUNITY STRATEGY**

Homeless and runaway youth require a continuum of support with employment, education, health care, drug and alcohol treatment, and housing issues. The continuum of services provided through Urban Peak ranges from outreach as the point of initial contact for many homeless youth to resources that provide previously homeless youth with permanent supportive housing. This continuum of services comprises the community-wide approach to address youth homelessness in the Denver metropolitan area. Urban Peak is recognized as the core service provider for the high-risk youth population. Each of these services is described in greater detail below.

### **Outreach**

Consistent with the objectives of Urban Peak Denver, the Urban Peak Outreach Team works throughout metropolitan Denver to build relationships with youth who are living on the street. The primary focus of outreach services is to build relationships with street youth as a means to remove barriers that inhibit them from accessing services through Urban Peak Denver and other agencies. The Urban Peak Outreach Team provides education about risk reduction, while distributing condoms, dental dams, hygiene products, bleach kits, food, and clothing. If appropriate, the Urban Peak Outreach Team will provide youth with information and referral to needed services.

The Urban Peak Outreach Team provides services targeted to needs of homeless and runaway youth in the locations where they gather. These locations are constantly adjusted with seasonal variations and input from collaborating partners, such as the police and the Downtown Denver Partnership, the business owners of downtown Denver. For example, the Urban Peak Outreach Team visits The Spot twice each week to offer alternative hangouts in the evening. To better understand where youth are sleeping at night, the Urban Peak Outreach Team conducts several late-night outreaches each month, mostly in one of the downtown mall areas.

Collaboration with police, downtown businesses, and other providers of services to youth is an important strategy to facilitate referrals to Urban Peak Denver and to target resources. The Urban Peak Outreach Team participates in multiple speaking engagements at junior high and high schools, as well as area businesses and agencies. The purpose of these outreach efforts is to begin the engagement process to help youth permanently exit the street.

### ***Who is Served?***

Since 1999, the Urban Peak Outreach Team has tracked contact information in the Urban Peak Denver database. These data have provided useful demographic information regarding outreach clients, as well as the types of services they most frequently access. Due to the anonymity of the contacts, it is difficult to unduplicate counts and determine when the youth had initial contact with the agency. The data reveal that the characteristics of those contacted through outreach are similar to the characteristics of others served at Urban Peak Denver.

The Urban Peak Outreach Team conducted a point-in-time survey of 215 youth on September 4, 2002. The results of this survey verified the demographic composition of the population, ranging in age from 14 to 21 years. Sixty-two percent of youth surveyed were male, 37 percent female, and the remaining 1 percent transgendered. The majority (67 percent) of those surveyed were Non-white, while the remaining youth were Latino (8 percent), African-American (7 percent), and Native American (7 percent). Most of these youth were living on the streets (32 percent) or with friends (11 percent). Some youth also reported living in motels or “couch surfing” (i.e., moving from one location to another). Survey data also indicated that the majority of the youth (greater than 70 percent) used alcohol, marijuana, and cigarettes during the past 30 days. A sizeable percentage of these youth also reported using harder drugs and some reported injecting drugs. The study also found that 11 percent of the youth admitted to participating in survival sex, defined as sex in exchange for money, food, shelter, or drugs (Van Leeuwen, 2002; Van Leeuwen et al., manuscript submitted for publication).

The expertise of the Urban Peak Outreach Team was also tapped to study an innovative way to test for and treat chlamydia and gonorrhea. Through a collaboration between the Denver Department of Public Health and Urban Peak, 414 chlamydia and 302 gonorrhea tests were conducted. The Department of Public Health and the Urban Peak Outreach Team workers met with the youth in a popular public park and arranged for the collection of urine samples, tested the samples, and provided subsequent treatment for youth with positive results. A total of 49 infections were diagnosed and 61 percent of these individuals received treatment. This activity



was not only important from a larger public health perspective, but also for increasing the documentation of the youth's needs and characteristics (Van Leeuwen, Rietmeijer, LeRoux, White, and Petersen, 2002).

### **Drop-In Services**

The Spot is an evening drop-in center for youth between the ages of 14 and 24. The Spot is influenced by the hip-hop culture and provides a place where youth may socialize, dance, and record music. The Spot provides several activities that are aimed at building youth's skills and providing positive social interactions. These activities include music recording in professional recording studios, break dancing in facilities intended for that use, Internet access, and recreation. Additional services include HIV testing, health clinic services, GED preparation at the PS-1 Charter School, and college entry assistance. The Spot has several case managers who work informally with the clients. Since merging with Urban Peak Denver, the Urban Peak Outreach Team makes contact with high-risk youth at the Resource Center located at The Spot.

### ***Who is Served?***

Any interested youth may visit or access services at The Spot, which serves from 90–100 youth each night. Point-in-time survey data indicate that The Spot serves a more diverse population in this downtown setting. The majority of youth who frequent The Spot on a regular basis are older, aged 18–24 years, and non-white, mostly African-American. Almost 17 percent of the youth identify as gay, lesbian, bisexual, or transgendered. Many of the youth (36 percent) currently live with their parents, followed by their own housing (25 percent), or with friends (18 percent). However, almost one-half (46 percent) of the youth are living in temporary living situations (Scandlyn and Grove, 2004).

### **Emergency Shelter and Support Services**

Urban Peak Denver serves youth between the ages of 15–21 years. Services include overnight shelter, case management, education and employment resources, medical services, and general drop-in services. Drop-in services consist of three meals each day, a computer lab, drug and alcohol groups, and information and referral services directing the youth to resources outside of Urban Peak.

When a youth accesses any of the services provided by Urban Peak Denver, he or she is assigned a case manager. The case manager conducts an assessment with the youth, addressing areas such as mental health, legal issues, substance use, HIV status, and education. The case manager works with the youth to determine their needs and goals and to develop a case plan. Youth may access shelter at Urban Peak Denver as long as they continue to move forward on their case plans. To facilitate that forward movement, Urban Peak Denver offers employment services including counseling and job coaching, assistance with resumes, and connections with potential employers. Urban Peak Denver's education services provide GED classes and computer training.

The typical approach to serving homeless and at-risk youth at Urban Peak Denver begins with a 30-day orientation period, during which time staff conduct an assessment of the youth, establish treatment needs, and obtain identification and other documents from the youth. Critical to this assessment is contact with the family of origin if the youth is under the age of 18—staff must obtain permission from the youth's parent or guardian for the youth to receive services. If this permission is not obtained, staff are obliged to contact the Department of Human Services. For youth younger than 15 years who are involved with Social Services and for whom living independently is not an option, Urban Peak Denver collaborates with several agencies to either reunite the families or identify additional beds available to homeless youth.

During this period of time, staff expect the youth to stay in the shelter every night. Staff believe that this stability will help the youth to exit the streets more quickly. After the youth have been involved with Urban Peak Denver and have completed the initial steps in the process, staff meet to review the client's service plan, including obtaining employment and completing education, and to determine the next steps for the youth's progress. After this team meeting, the youth will be responsible for adhering to the case plan, including employment and education, case management, and housing. Following four months of service at Urban Peak Denver, the case manager may provide some aftercare services, and upon discharge from the program, the youth and case manager will determine the services for which the youth is eligible and interested.

Education services provided at Urban Peak Denver are designed to meet the specific needs of youth. GED courses are offered through a number of vehicles—Denver Public Schools, a collaboration with The Spot and the PS-1 Charter School, and a second collaboration between The Spot and the Community College of Denver. Other educational services include financial assistance for higher education at the Community College of Denver and the Metropolitan State College of Denver. The employment program through Urban Peak Denver is funded through the Workforce Investment Act, which stems from the Mayor's Office of Workforce Development. Services provided to youth through this program include resume writing, job coaching, and employer connections.

Youth who receive services through Urban Peak Denver typically have immediate mental and physical health needs—60 percent require mental health services and 40 percent require dental health care. Due to recent cutbacks in state and Federal funding, the provision of these services was significantly reduced. Presently, Urban Peak Denver provides four hours of medical clinic staffing each week and hires a half-time clinician to work with the youth. To cover necessary services that are no longer easily funded, Urban Peak Denver identified new sources of funds and was awarded a grant through the Substance Abuse and Mental Health Services Administration to fund drug and alcohol treatment for 25 youth each year. These treatment services are provided through the Starting Treatment and Recovery (STAR) program of the University of Colorado Health Sciences Center, Addiction Research Treatment Services. Urban Peak Denver has applied for several additional grants and other funding in order to increase the level of health and mental health services provision.

### **Permanent Supportive Housing**

The Urban Peak Housing Corporation owns two multiunit buildings and manages another for the City of Denver. It performs property management for the buildings while Urban Peak Denver provides the supportive services. Rowan Gardens and STAR are located in multiunit buildings owned by Urban Peak Housing Corporation and are funded through HUD Shelter+Care grants. Each housing program serves youth with disabilities. STAR is a contingency-based housing program for substance-addicted youth enrolled in drug or alcohol treatment. Rowan Gardens is a 16-unit building that houses youth with disabilities.

The Rocky Mountain Youth Housing Program—a collaboration between Urban Peak and the Denver Department of Human Services—is a 35-unit apartment complex that houses homeless youth involved with child welfare. Two-thirds of this project is subsidized by Volunteers of America through a U.S. Department of Health and Human Services (HHS) Transitional Living Program (TLP). The state provides additional funding for this project through the HUD-funded Family Unification Program, which provides Section 8 vouchers for young people aging out of foster care. Urban Peak Denver also has a TLP grant through HHS that provides rent subsidies for youth.

Youth typically move from the Urban Peak Denver shelter to permanent supportive housing through Urban Peak Housing Corporation. Each building where permanent housing is offered has an on-site resident manager who is available to assist the resident, as well as to oversee the property. Youth receive supportive services through Urban Peak Denver and work with a case manager on their case plans.

### **Community Advocacy and Collaboration**

Collaboration with other agencies and institutions is critical to the success of a community-wide approach to serving homeless and runaway youth. The City Council, Mayor's Office, and Downtown Denver Partnership are key players in the development of the community-wide approach. Urban Peak serves on local networks and conducts a great deal of local collaboration. Urban Peak also works with a lobbyist to monitor bills in the state legislature and advocates against those that would have a negative impact for youth.

Urban Peak could not deliver wraparound services to youth without partnerships with other agencies and institutions. These partnerships help reduce the costs associated with serving youth and increase the collaboration and coordination essential to success. Key agency partners and collaborations include the following:

- The Children's Hospital provides staff for the medical clinic, HIV testing, and the on-site pharmacy;
- Denver Health and Hospitals provides street outreach and testing for sexually transmitted infections;
- Denver Public Schools provides on-site GED and title one educational services;
- Educo provides recreational outings for the youth;

- Family Tree provides transitional housing for homeless youth and families;
- Health One provides staff for the medical clinic;
- Human Services, Inc., provides transitional housing;
- Mental Health Association of Colorado provides funding for treatment services;
- Mental Health Corporation of Denver provides on-site mental health services;
- Planned Parenthood provides pregnancy prevention services;
- Rocky Mountain Youth provides staff for the medical clinic;
- State of Colorado, Department of Human Services provides assistance for youth aging out of child welfare services;
- Stout Street Clinic provides psychological evaluations; and
- Volunteers of America provides transitional housing.

A good example of Urban Peak’s community-wide advocacy, planning, and collaboration is the steps that it took to write standards to create the shelter for homeless youth. In 1997, Urban Peak advocated for the passage of the Homeless Youth Act that led to regulations that made it easier to serve this population. Urban Peak was instrumental in drafting the new state standards for youth shelter, eventually leading to Urban Peak operating the first and only youth shelter in the state. The Homeless Youth Act includes provisions for family intervention reconciliation services, as well as crisis intervention and alternative residential services. Most importantly, this Act required that the Colorado Department of Human Services license homeless youth shelters.<sup>47</sup>

### **DATA COLLECTION AND USE**

Urban Peak is dedicated to collecting data and has a Research Committee comprised of members from local universities who meet on a bi-monthly basis. Urban Peak Denver has an ACCESS database, which staff use to record data on every client served from outreach through permanent housing, with the exception of drop-in services at The Spot. Created in 1999, the Urban Peak Denver database now has more than five years of data ensuring an accurate, unduplicated count of youth served. The database includes a variety of information, including tracking services for each day that a youth presents at Urban Peak Denver (either in a drop-in or shelter capacity). This system provides tracking information needed by HHS for the Runaway and Homeless Youth Management Information System, HUD, the Workforce Investment Act, and state and city stakeholders. Street outreach youth are also entered in the database. Youth who have been discharged from Urban Peak are followed up at six months by their case manager.

Urban Peak Denver collects an important, fundamental outcome measure—the annual percentages of youth who receive services through Urban Peak Denver and then experience a successful housing outcome. For fiscal year 2004, 63 percent of the youth served at Urban Peak Denver experienced a successful housing outcome. The successful outcome dispositions were:

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<sup>47</sup> House Bill 97–1079. (1997).

- Youth moved into own apartment;
- Youth moved into other independent living (e.g., Job Corps, Youth Transitional Housing, or supportive housing with another agency);
- Youth entered an approved placement (e.g., foster care);
- Youth returned home;
- Youth moved into an Urban Peak Housing Corporation property; or
- Youth moved into Volunteers of America housing.

Dispositions that were not successful include the following:

- Youth terminated services;
- Youth went to jail; and
- Urban Peak Denver terminated services with the youth (due to age, violence, or lack of parental consent).

Exhibit F.1 lists outcomes for youth who received services at Urban Peak Denver between 2000 and 2004. With the data it collects, Urban Peak Denver has the potential to analyze other outcome measures to determine the long-term success of its clients. These potential analyses are discussed in the following section.

**Exhibit F.1. Outcome Measures for Urban Peak Denver, 2000–2004**

<b>Measure</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Number of youth with successful housing outcomes	308	343	368	426	435
Percentage of youth with successful housing outcomes	48%	52%	53%	65%	63%

### **Innovative Data Collection Methods**

To collect followup data from youth discharged from Urban Peak programs, the staff have considered innovative data collection methods. These methods include using Web-based applications, including list serves and followup data collection forms posted to the Urban Peak Web site. Urban Peak staff also discussed ways to make this type of data collection more palatable to the youth, including incentivizing data collection and involving the youth in developing this new system of Web page outreach, followup, and data collection. Staff at Urban Peak also believe that following up with clients will not only provide useful data but also an additional intervention point for the youth and will help them to maintain their stability.

### **Recommended Data Analyses**

The study team recommended several data analyses to strengthen the power of Urban Peak Denver’s outcome measures. Because Urban Peak Denver currently determines the percentage of youth with successful housing outcomes following service provision, the recommended data analyses focus on gathering additional follow back and followup data. These data would help staff to know where the youth were prior to entering Urban Peak Denver (follow back) and how they fare after leaving (followup). Descriptions of these analyses follow.

***To determine the predictive factors of youth who become homeless and receive services through Urban Peak Denver.***

By adding a 30-day followback calendar to standard intake and assessment protocols, the agency would be able to collect data to quantitatively demonstrate the path that many youth follow from homelessness to shelter at Urban Peak Denver. These data would help staff to refine the progression of service provision for youth based on their experiences prior to entering shelter. The worker conducting a client intake at Urban Peak Denver would administer a 30-day followback calendar to determine the client's housing stability for the 30 days prior to reporting homelessness. This calendar will provide variables including number of changes in living situation and types of living situations in which the client lived during the 30-day period.

***To assess the six-month and 12-month outcomes of youth who received services through Urban Peak Denver and then exited the program.***

These analyses would demonstrate the long-term effectiveness of services provided at Urban Peak Denver with the mission of preventing repeated episodes of homelessness among youth. Further, these analyses would allow Urban Peak Denver staff to more effectively target services to youth that would increase the likelihood of their having positive outcomes following exit from shelter. Urban Peak Denver would collect six- and 12-month followup data on youth who experienced successful housing outcomes after receiving services from Urban Peak Denver. Followup data would include current living situation, employment status, recidivism, and receipt of services from Urban Peak Denver following exit from shelter.

**Next Steps**

To utilize the rich data that it collects, Urban Peak Denver has developed a request for quotations to secure a contractor to help them meet three data-related goals:

- Develop an on-line followup instrument;
- Transfer the data from the agency database to a statistical package and develop a working relationship to determine the appropriate uses and analyses of the data; and
- Post previously conducted research on-line to allow public access.

Continuing its tradition of collecting timely and important data on homeless youth, Urban Peak is participating in a point-in-time survey taking place in November in seven cities across the country. This study, funded in part through a national network dedicated to the issues of homeless and runaway youth, will collect health-related data on this population and provide aggregate data as well as comparisons across sites.

**URBAN PEAK SITE VISIT PARTICIPANTS**

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**URBAN PEAK ACRONYMS**

GED	General Educational Development
HHS	U.S. Department of Health and Human Services
HUD	U.S. Department of Housing and Urban Development
STAR	Starting Treatment and Recovery
TLP	Transitional Living Program

## **APPENDIX G METHODS**

The methods involved in this study consisted of site selection, site visits, and development of data analysis plans with the selected sites.

### **SITE SELECTION**

The study team conducted a two-stage canvass to identify potential homelessness prevention programs. The first stage focused on identifying reputable, community-wide homelessness prevention programs, and the second stage consisted of in-depth screening calls with these sites.

The first stage of the process began by contacting sources identified in previous studies of homelessness by Walter R. McDonald & Associates, Inc. (WRMA), and Urban Institute (UI). In addition, the study team consulted national experts in homelessness, including national associations, state and local agencies, and mental health and homelessness consortia. These contacts included:

- Community Shelter Board (Columbus, OH);
- Corporation for Supportive Housing;
- Department of Human Services (St. Louis County, MO, and Spokane, WA);
- Housing Information Office (St. Paul/Ramsey County);
- National Alliance for the Mentally Ill;
- National Alliance to End Homelessness;
- National Association of State Alcohol, Drug, and Alcohol Abuse Departments;
- National Association of State Mental Health Program Directors, Research Institute;
- National Coalition on the Homeless;
- New York City Department of Homeless Services;
- Office of Emergency Shelter and Services (Philadelphia); and
- The Community Partnership (Washington, DC).

This first stage of the site selection process identified 28 communities for the second stage of screening to determine whether they met the study criteria. For some communities, the study team identified multiple agencies, although it was not necessary to speak with each of them to learn about the prevention efforts within that community. The team used two factors to determine the appropriateness of a site for potential study:

- Presence of a community-wide approach to primary prevention services for those at imminent risk of homelessness; and
- Adequate data to document the prevention of homelessness.



The study team’s initial discussions with each of the 28 potential sites provided a brief description of homelessness prevention efforts within a particular program as well as in the larger community. The discussions were loosely organized by a canvass discussion guide. (See Exhibit G.1).

**Exhibit G.1. Canvass Discussion Guide**

Community (State):  
Name of Agency:  
Name/Title/Contact Information of Person:  
Role of Person:  
Date:  
Discussion Person:

*My name is \_\_\_\_\_ and I work for \_\_\_\_\_, a research company based in \_\_\_\_\_. We have contacted you as part of a project funded by the U.S. Department of Housing and Urban Development to describe communities that have been successful in preventing homelessness. Our focus is on programs and services that help people at imminent risk of homelessness to avoid becoming literally homeless. We are using the HUD definition of "imminent risk" for our target population referring to those for whom homelessness is likely to occur in one or two days. We are speaking with representatives of different communities who are knowledgeable about their community's homeless assistance network and its prevention efforts. We hope to identify a small number of communities with successful prevention activities that we can study further in this project. I'd like to talk to you about your community today. The discussion may take up to 30 minutes, if your community is doing something substantial to prevent homelessness, or it could be quite short. Would now be a good time to start the discussion or is there a more convenient time we could schedule?*

1. How does your program serve those at imminent risk of homelessness? (By imminent risk we mean those for whom homelessness is likely to occur in one or two days. How imminent and how certain is the risk of homelessness?)
2. Whom do you serve? (Probes: families, individuals, special populations.)
3. Describe the locations or settings in which you provide the services.
4. Do you think that there is a community wide approach to providing services to those at imminent risk of homelessness? If so, describe the other programs or partners participating in the provision of services to those at risk of homelessness? (e.g., nonprofit emergency assistance providers, discharge planning from psychiatric hospitals or prisons, other entry points to homeless assistance services.)
5. How does your program or community document the success of these services (i.e., can you show that you have actually prevented homelessness)?
  - a. Even if you haven't actually analyzed any data to show prevention, do you HAVE any data that COULD be analyzed to show prevention? (Suggest possibilities, e.g., Does a Homeless Management Information System exist capable of providing data over several years? If yes, could it be used to track whether a household helped by your agency subsequently became homeless?)
  - b. If data exist, would you be willing, potentially, to analyze it for a HUD study?

The discussions with the 28 homelessness prevention programs identified 19 communities that met the basic study criteria—a community-wide approach to homelessness prevention and at least some data potentially available for analysis. This canvassing process found that the 28 communities with which the study team had discussions were of three types:

- Ten communities served households at risk of homelessness;
- Nine communities served specialized populations, such as people with serious mental illness, ex-offenders, and youth; and
- The remaining nine communities did not offer a community-wide approach to homelessness prevention or did not offer prevention services, and did not direct the study team to another agency in the community.

The study team recommended six sites for further study. These sites were in two categories:

- Community-wide strategies with families and individuals; and
- Community-wide strategies with specialized populations, including persons with serious mental illness and homeless and runaway youth.

Exhibit G.2 lists the sites selected for this study and indicates the type of population that their strategies target.

**Exhibit G.2. Study Sites**

		Community-Wide Strategies with Specialized Populations	
			Homeless and Runaway Youth
Hennepin County	X		
Montgomery County	X		
Mid America Assistance Coalition, Kansas City	X		
Massachusetts Department of Mental Health		X	
Philadelphia		X	
Urban Peak, Denver			X

**SITE VISITS**

The study team visited six sites. A two-person team visited Montgomery County over the course of three days; the Kansas City metropolitan area in two days; and Denver in two days. A team member visited Hennepin County for two days; Philadelphia for two days; and two separate trips to Massachusetts for a total of three days. The site visits had the following primary objectives:

- To collect more detailed information on program design to expand upon the information collected during the canvass;
- To observe the data systems in action and speak to their users at every level;
- To begin developing the data analysis plans for the communities; and
- To tour agencies and programs providing primary homelessness prevention services.

Prior to the site visits, the study team collected preliminary information from each of the six sites, including available annual and statistical reports. During site visits, the study team collected qualitative information about each effort, including the meaning of community-wide as it applies to that community, the target population, the history of the approach, current operating procedures, multiagency involvement and coordination, funding sources, data systems and documentation, and outcome measures. The study team spoke with staff knowledgeable about the approach to learn the scope of what it entails. The study team also spoke with information technology staff to learn the specific characteristics of the data systems they used, the data they collected, and how they might analyze these data to assess the effectiveness of their homelessness prevention programs.

The study team developed a site visit protocol to guide discussions with community members and program staff. (See Exhibit G.3. at the end of this appendix.) The study team adapted the discussion guide before visiting each site, confirmed the information already collected about that site, and asked additional questions. The study team wrote site summaries expanding upon information collected during the canvass calls and the site visits, including relevant contextual information. A general outline of the factors the study team examined during the site visits follows.

- Community-Wide Approach
  - Definition of “community-wide;”
  - Goals;
  - Key players;
  - Multiagency coordination; and
  - How and why the approach developed.
  
- Target Population
  - How sites determine “imminent risk of homelessness;”
  - Population focus;
  - Client identification, pathways to service, and screening; and
  - Eligibility criteria.
  
- Operations
  - Services;
  - Staff;
  - Settings and locations; and
  - Length of services (average and range).
  
- Program Funding and History of Sources

- Data Systems and Documentation
  - Data collection;
  - Homeless Management Information System (HMIS);
  - Typical analyses sites perform and report;
  - Degree to which sites prevent homelessness; and
- Outcomes Expected and Evidence That They Have Been Achieved

## **DATA ANALYSIS PLANS**

The study team worked with five sites (not including Hennepin County, which already documented the outcomes of its homelessness prevention activities) to develop data analysis plans. The study team also proposed methods to measure the effectiveness of each site's approach to homelessness prevention. The main focus of these plans was to help communities identify data elements and data sources that they could use to document their own prevention outcomes. Through this process, the study team hoped to identify a small set of measures of prevention success that could be promulgated as data standards for prevention for HMISs throughout the country.

To clearly delineate the specific types of data and analyses needed for this study, the study team collected specifications based on each site's data to develop plans with the sites to guide appropriate data analyses. Using these plans, all but one of the study communities (Philadelphia) conducted their own data analyses. The study team collected the following information about each relevant data set:

- Community;
- Name of data system;
- Agency that maintains the system;
- Purpose of system;
- Date of implementation;
- Software platform;
- Analytical software available;
- Analytical staff available;
- Key staff contact information; and
- Inclusion of fields that
  - Identify recipients of primary (or any other) prevention services;
  - Identify eligibility criteria used to determine each recipient's homelessness risk;
  - Determine start and end of primary prevention services;
  - Determine reason for ending primary prevention services;
  - Determine number of families served with primary prevention services;
  - Determine number of individual adults (including independent youth) served with primary prevention services; and
  - Match individuals and families in the service database to the recipients of shelter services in the community during the six or 12 months following receipt of

primary prevention services, or otherwise identify homelessness within a period following receipt of prevention services.

The study team worked with the agencies responsible for the community approach to define common units of measure and to develop a plan to analyze program effectiveness.

### Exhibit G.3. Site Visit Protocol

#### CHECKLIST FOR INITIAL SITE VISITS

- Complete Site Visit Discussion Guide (attached)
- Begin developing technical assistance plan
- Tour prevention program facilities (if feasible)

#### SITE VISIT DISCUSSION GUIDE

Thank you for meeting with us. As you may recall, we are from WRMA/Urban Institute and are here visiting *[name of this community]* as part of a project funded by the U.S. Department of Housing and Urban Development (HUD). The goal of this study is to describe agencies or communities that have been successful in preventing homelessness. Our focus is on programs and communities that provide services to people who are at imminent risk of homelessness, i.e., about to become homeless if services are not provided. We are also interested in the way that your agency and community collect data and how these data may be analyzed to determine the success of your efforts at homelessness prevention.

We are visiting six communities as part of this study and our report will identify each of these by name. We will *not* identify you individually without first giving you a chance to review materials and obtaining your consent. We appreciate your candor as you share your experiences and perspectives.

#### Community-wide Approach

1. What is your definition of "community-wide?"
2. What is this community's approach for preventing homelessness?
  - What is the goal of the approach?
3. Who are the key players in the community's approach to preventing homelessness?
  - What agencies or programs are involved and how?
  - What is the role of each?
  - What is your agency's relationship with the continuum of care?
4. Who coordinates and administers the community's approach to preventing homelessness?
5. How did the approach develop?
  - What were the issues or tensions, and what pushed things forward?
  - What were its steps toward getting to be the system it is today?
  - What are the perceived barriers to program effectiveness?
  - What are the controversial aspects of the approach and was there any opposition to it?

#### Target Population

6. How do your agency and your community define "imminent risk of homelessness?"
  - Do you serve only those at imminent risk of homelessness?
  - If no, who else do you serve?
  - How do your (primary) prevention activities relate to your other activities?
7. Who do you serve? Do you have any special population focus? (If this agency or approach does not serve "everyone at risk," ask question 9.)

8. How are people identified or referred to your program?
- Where do the people you serve for homelessness prevention come from?
    - Self-referrals—How do they learn about the prevention services you offer?
    - Referrals from other agencies—How do the agencies know about your services?
    - Outreach you conduct yourselves—Where, when, to whom, please describe?
  - How do you identify persons who are at imminent risk of homelessness?
    - What screeners do you use? What criteria? (get copy of screener)
    - Who would you *not* serve?
    - Do people have to meet *every* screening criterion? Are some more important than others?
    - Do you have limits on the number of times a person can get prevention help? Other limits?
    - Are the criteria the same for everyone, or are there some special criteria for different subgroups? If different, for whom, and in what ways?
9. How did you develop your criteria? Have they changed over the years? If yes, why?
- Did you establish any of your current criteria because you had a sense that people who meet that criteria “do better” (are more likely to avoid homelessness) than those who don’t meet the criteria? If yes, which ones?
10. If your agency only serves a particular population (e.g., families, singles, people with mental illness, youth), are there other systems in this community that have a focus on preventing homelessness among any of the types of people that you do not serve?
- What are they and who do they serve?
  - How does your own system relate to those other systems? (e.g., cross-referrals, shared planning, shared resources, other)

**Operations**

11. What specific services do you *provide* to prevent homelessness? To what services do you *refer* clients?
- Cash benefits
    - Emergency assistance
    - Rental assistance
    - Security deposits/first month rent
    - Moving assistance
    - Preventing utility shut-off
    - Public assistance
    - Food
    - Transportation
  - Services
    - Crisis intervention
    - Case management
    - Negotiating with landlords
    - Screening and referral for alcohol or drug treatment
    - Mental health services
    - Health services
    - Employment services
    - Domestic violence
  - Housing
    - Emergency shelter
    - Hotel/motel vouchers
    - Transitional
    - Permanent supportive
    - Affordable housing
  - Other (specify)

## Appendix G Methods

12. What type of staff provides these services?
  - Who are your staff? Background, training?
  - What is their caseload?
  - In what setting do you provide the services? (e.g., an entry point to homeless assistance services such as a family resource center, psychiatric institution, hospital, prison, a specialized court program, other)
13. For approximately what length of time does a person receive services from your organization to prevent homelessness?
14. How long has your organization been providing homelessness prevention services?
  - When you started, did you have what you have today?
  - If not, what has changed, approximately when, and why?

### Program Funding and History of Sources

15. How is your organization's approach currently funded?
16. What is the funding history for the community's approach to preventing homelessness?
17. How many other agencies are involved in terms of providing staffing or funding?

### Data Systems and Documentation

18. How does your organization document your services to prevent homelessness?
19. In addition to basic information on clients and services, have you ever checked whether the people you help with prevention services actually manage to avoid homelessness?
  - If yes, how do you do this?
  - How are data collected and analyzed? What datasets do you use?
  - Do you follow up with clients who have received prevention services? If so, how and for what length of time?
  - Have any state or local evaluations been conducted? If so, what are the findings of those studies?
20. Does a Homeless Management Information System exist capable of providing data over several years?
  - Could it be used to track whether a household helped by your agency subsequently became homeless?
  - Have you done this type of analysis?
  - What would be needed for you to do it?
21. What are barriers to data collection and analysis regarding program effectiveness?

### Outcomes

22. How does the agency know if homelessness has been prevented?
  - What outcome measures are used to determine prevention?
  - How are data analyzed to determine prevention?
  - What measure of prevention does the agency use?
23. Is the success rate the same for the different types of persons who are identified? For example, does the program have the same success rate for individuals as well as families?
24. Does the range of services or the service mix potentially influence the success rate?
25. What other outcomes are measured?

## **APPENDIX H GLOSSARY**

AAS	Access to Alternative Services (Philadelphia)
ADAPT	Admissions, Discharges, and Planning Team (Philadelphia)
ATARP	Aggressive Treatment and Relapse Prevention Programs (Massachusetts)
CAP	Community Action Program
CBH	Community Behavioral Health (Philadelphia)
CoC	Continuum of Care
CODAAP	Coordinating Office of Drug, Alcohol, and Addiction Programs
DHCD	Massachusetts Department of Housing and Community Development
DMH	Massachusetts Department of Mental Health
DMH/TS	Department of Mental Health Transitional Shelter (Massachusetts)
DMR	Massachusetts Department of Mental Retardation
DOL	U.S. Department of Labor
DPH	Massachusetts Department of Public Health
EC	Employment Connections (Massachusetts)
ESG	Emergency Shelter Grant
FCF	Facilities Consolidation Fund (Massachusetts)
FEMA	Federal Emergency Management Agency
FHPAP	Family Homeless Prevention and Assistance Program (Hennepin County)
GAF	Global Assessment of Functioning
GED	General Educational Development
HHS	U.S. Department of Health and Human Services
HI	Special Initiative to House and Serve Homeless Persons with Mental Illness Homeless Initiative (Massachusetts)
HMIS	Homeless Management Information System
HOC	Housing Opportunities Commission
HOT	Homeless Outreach Team (Massachusetts)
HSD	Human Services Department (Hennepin County)
HUD	U.S. Department of Housing and Urban Development
LIHEAP	Low-Income Home Emergency Assistance Program
MAAC	Mid America Assistance Coalition
MBHO	Managed Behavioral Health Care (Philadelphia)
MBHP	Massachusetts Behavioral Health Partnership
MCDHHS	Montgomery County Department of Health and Human Services
MHA	Mental Health Association, Inc. (Massachusetts)
MHFA	Minnesota Housing Finance Agency
MHSA	Massachusetts Housing and Shelter Alliance
OBH	Office of Behavioral Health (Philadelphia)
OCC	Outreach Coordinating Center (Philadelphia)
OMH	Office of Mental Health (Philadelphia)
PACT	Programs for Assertive Community Treatment
PATH	Projects for Assistance in Transition from Homelessness
PCCD	Pennsylvania Council on Crime and Delinquency



## Appendix H Glossary

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PMHCC	Pennsylvania Mental Health Care Coordinating Council
PSIC	Peer Support in Aftercare (Massachusetts)
RFP	Request for Proposal
SEE	Services for Education and Employment (Massachusetts)
SFY	State Fiscal Year
SHP	HUD's Supported Housing Program
SSI	Supplemental Security Income
SSO	Supported Housing Program, Services Only grant
STAR	Starting Treatment and Recovery (Urban Peak)
TANF	Temporary Assistance for Needy Families
TLP	Transitional Living Program
TPP	Tenancy Preservation Project (Massachusetts)
UI	Urban Institute
VA	U.S. Department of Veterans Affairs
WRMA	Walter R. McDonald & Associates, Inc.

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