Strategies for Reducing Chronic Street Homelessness

Final Report

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

Prepared by:
Martha R. Burt, UI
John Hedderson, WRMA
Janine Zweig, UI
Mary Jo Ortiz, WRMA
Laudan Aron-Turnham, UI
Sabrina M. Johnson, WRMA

Walter R. McDonald & Associates, Inc. (WRMA)
Sacramento, CA

The Urban Institute (UI)
Washington, DC

January 2004

ACKNOWLEDGEMENTS

Many individuals have assisted us on this project; we would especially like to thank the following:

- The researchers and program administrators who nominated potential sites.
- The on-site people we interviewed individually, in meetings and in focus groups who shared their time, information, and insights with us.
- Our advisory team members, Donald J. Baumann, Deborah Dennis, Linda Gibbs, Jean L. Hochron, Mark Hurwitz, Natalie Hutcheson, Pam Michell, Pat Morgan, Ann O'Rielly, and Robert A. Rosenheck, who have contributed their time, knowledge, and expertise.
- Marina Myhre, our project Government Technical Representative from the U.S. Department of Housing and Urban Development (HUD), who has provided us with helpful support, observations and thoughts throughout the study. Other HUD staff members who have also provided acute comments on the projects research design, data analysis and report include Paul Dornan, Marge Martin, and Kevin Neary from the Office of Policy Development and Research, and Mark Johnston from the Office of Community Planning and Development.

In addition, we would like to acknowledge the work completed by the following Walter R. McDonald & Associates, Inc. staff: Deborah Bass Rubenstein was fully involved in the early stages of this project, especially the research design and screening of sites; Charles Wheeler assisted in the report review; Gayleen Lentsch was in charge of report production; Cheryl Reed coordinated travel arrangements; Maricela Leyva-Perez and Jamie Vang provided administrative support.

We appreciate the significant contributions that the above individuals made to carrying out the research and writing of this report, and they are not responsible for any remaining errors or omissions. The findings and views herein are those of the contractors and authors.

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

TABLE OF CONTENTS

ACKNOWLEDGEMENTS II

EXECUTIVE SUMMARY XIII
Why This Study Is Important xiii
Purpose of the Research xiv
Who, What, Where, and When? xv
Findings—Key Elements of Success xv
How They Got Where They Are Today—Key Factors in History and Implementation xvii
Trigger Events and Paradigm Shifts xvii
Thoughtful, Analytic Process xix
New Strategies for Programs and Services xx
Documenting Progress xxii
How Do They Pay For It? xxiii
Implications xxiv
Implications for Policy xxiv
Implications for Practice xxvi
Implications for Research xxvii

CHAPTER 1: INTRODUCTION 1
Why This Study Is Important 1
Purpose of the Research 2
Who, What, Where, and When 3
Birmingham, Alabama 4
Boston, Massachusetts 5
Columbus, Ohio 5
Los Angeles, California 6
Philadelphia, Pennsylvania 6
San Diego, California 7
Seattle, Washington 7
Report Organization 8

CHAPTER 2: ELEMENTS OF SUCCESS 9
What Does It Take? 9
Introduction 9
Paradigm Shift 10
A Clear Goal of Ending Chronic Street Homelessness 10
Strong Community-Wide Level of Organization 11
Strong Leadership and an Effective Organizational Structure 12
The Importance of Key People Exercising Leadership 12
Effective Organizational Structure 12
Significant Resources from Mainstream Public Agencies 13
Ability to Capitalize on Trigger Events 13

Significant Involvement of the Private Sector 14
Private Businesses 14
Foundations and Nonprofit Organizations 15
Commitment and Support from Elected Officials 15
Outcome Evaluation Mechanisms for Program Support and Improvement 16
Openness to New Service Approaches 16
Strategies to Minimize Negative Neighborhood Reactions to Locating Projects 17
Conclusions 17

CHAPTER 3: NEW STRATEGIES FOR PROGRAMS AND SERVICES 19
Outreach 20
Philadelphia's Outreach Coordination Center 20
San Diego's Police-Based Outreach Teams 21
Other Outreach Efforts with Direct Housing Connections 22
Other Outreach Efforts Without Direct Housing Connections 23
New Approaches to Permanent Supportive Housing (PSH) 23
Housing First Models 25
Safe Havens 25
Low Demand—Breaking the Linkage Between Housing and Service Acceptance 26
New Approaches to Addressing Substance Abuse 26
Harm Reduction 27
Other Approaches 28
Housing Configurations and Supportive Services 29
Preventing Homelessness Upon Institutional Discharge 31
Client-Level Coordination Mechanisms 32
Databases 32
Multi-Agency Special Case Teams 34
Multi-Purpose Service Centers 34
Processes to Alter Access to Mainstream Settings 36
Co-location of Service Providers in Mainstream Agencies 36
New Roles in Old Agencies 37
Conclusions 38

CHAPTER 4: ASSEMBLING RESOURCES AND SUPPORTS 41
Assembling Resources in Communities with Long Histories of Support 41
Philadelphia 41
Columbus 43
Mobilizing Resources "From Scratch" 44
San Diego 45
Los Angeles Veterans Affairs 47
Progress Without Community-Level Commitment to Ending Chronic Homelessness 48
Seattle Program Structure Growing Out of ACCESS 48
Conclusions 49

CHAPTER 5: DOCUMENTING PROGRESS 51
Changes in the Number of People Found on the Street from Year to Year 51

Philadelphia Counts of Street Homeless Persons 52
Birmingham Street Counts 53
Seattle Street Counts 54
Boston Street Counts 55
Chronically Homeless Individuals Moved to Permanent Housing 56
Philadelphia Movement of Chronically Homeless Individuals into Permanent Housing 56
San Diego Movement of Chronically Homeless Individuals into Housing 57
Birmingham Movement of Chronically Homeless Individuals into Permanent Housing 58
Reductions in Costs of Providing Emergency Health, Mental Health, and Shelter Services 58
Reductions in Days Homeless, Hospitalized, or Incarcerated 60
Conclusions 61

CHAPTER 6: HOW COMMUNITIES PAY FOR THEIR NEW APPROACHES 63
Introduction 63
Local Funding 63
General Revenue Resources 64
Special Taxing Mechanisms 64
Use of Private Sector Resources 65
State Funding 66
California 66
Other State Funding Streams 67
Federal Funding Other Than McKinney 68
Self Support 70
Funds Blending and Access 70
Blending Funding from the Provider Perspective 70
Agencies As Funding Funnels to Ease Client Access to Services 72
Potentially Underused Funding Opportunities 74

CHAPTER 7: POLICY, PRACTICE, AND RESEARCH IMPLICATIONS 77
Implications for Policy 77
Implications for Practice 78
Implications for Research 79

APPENDIX A: BIRMINGHAM A.1
Birmingham-Brief Description A.1
Practices of Potential Interest to Other Jurisdictions A.2
History and Context–How the Current System Evolved A.3
Approach to Chronic Street Homelessness A.4
Program and Service Network A.5
Sector of Mainstream Agencies A.6
Use of Private Resources A.6
Who Is Served? A.7
Coordination Mechanisms A.9
Pathways to Housing, Approaches and Models A.10
Selected System Components A.10

Prevention A.11
Outreach/Drop-in A.11
Low Demand Transitional Residences A.12
Emergency Shelters A.12
Transitional Programs A.12
Permanent Supportive Housing A.13
Supportive Services A.13
Affordable Housing A.14
Documenting Reductions in Chronic Street Homelessness A.14
Street Counts A.14
Movement of Street Homeless into Housing A.15
Public Funding A.15
Community Relations A.16
Maintaining and Enhancing the System A.16
Site Visit Participants A.18
Acronyms A.19

APPENDIX B: BOSTON B.1
Boston–Brief Description B.1
Practices of Potential Interest to Other Jurisdictions B.2
History and Context–How the Current System Evolved B.4
Approach to Chronic Street Homelessness B.5
Mainstream Agency Involvement B.7
Selected System Components B.10
Prevention B.10
Outreach and Drop-in B.11
Emergency Shelters B.13
Low-Demand Residences B.13
Transitional Programs B.13
Permanent Supportive Housing B.14
Supportive Services B.15
Affordable Housing B.15
Documenting Reductions to Chronic Homelessness B.16
Public Funding B.17
Community Relations and Advocacy B.19
The Future–Maintaining and Enhancing the System B.19
Site Visit Participants B.20
Acronyms B.22

APPENDIX C: COLUMBUS C.1
Brief Description C.1
Practices or Potential Interest to Other Jurisdictions C.2
History and Context–How the Current System Evolved C.3
Approach to Chronic Street Homelessness C.5
Mainstream Involvement C.7
Selected System Components C.10

Prevention C.10
Outreach and Drop-in C.11
Emergency Shelters C.11
Transitional Programs C.12
Permanent and Supportive Housing C.12
Supportive Services C.16
Affordable Housing C.16
Documenting Reductions in Chronic Street Homelessness C.17
Public Funding C.19
Community Relations and Advocacy C.23
Elements of Good Neighbor agreements C.24
The Future–Maintaining and Enhancing the System C.26
Resource Development C.27
Improving Cost Efficiency C.27
Collaborative Investment Standards C.28
Evaluation C.28
Communication C.28
Site Visit Participants C.29
Acronyms C.30

APPENDIX D: LOS ANGELES D.1
Los Angeles–Brief Description D.1
Greater Los Angeles Department of Veterans Affairs D.2
Practices of Potential Interest to Other Jurisdictions D.2
VAGLAHS D.2
AB 2034 ..... D.2
Lamp Community D.3
VAGLAHS History and Context–How the Current System Evolved D.4
VAGLAHS Approach to Chronic Street Homelessness D.5
VAGLAHS Selected System Components D.9
Outreach and Drop-in D.9
Emergency Shelters D.11
Transitional Programs D.12
Employment D.17
Case Management D.17
VAGLAHS Documenting Reductions to Chronic Street Homelessness D.19
VAGLAHS Community Relations and Advocacy D.20
Los Angeles County AB 2034 Program D.21
AB 2034–Access to the System D.23
AB 2034–Housing D.24
AB 2034–Documenting Reductions to Chronic Street Homelessness D.25
AD 2034–Model of Care D.26
Program Components–San Fernando Valley Community Mental Health Center D.26
San Fernando Valley Community, Mental Health Center, Inc. D.26
Outreach D.26

Emergency Shelters D.27
Transitional Program D.27
Permanent Supportive Housing D.27
Supportive Services D.27
AB 2034–Community Relations and Advocacy D.28
Lamp Community D.28
Lamp Community History D.28
Lamp Community Model D.29
Lamp Community Components D.29
Street Outreach D.29
Low Demand Transitional Housing D.33
Lamp Community Housing D.32
Member-Operated Business and Other Employment Services D.34
Supportive Services D.34
Lamp Community–Documenting Reductions to Chronic Street Homelessness D.35
Lamp Community–Community Relations and Advocacy D.36
Site Visit Participants D.37
Acronyms D.40

APPENDIX E: PHILADELPHIA E.1
Philadelphia–Brief Description E.1
Practices of Potential Interest to Other Jurisdictions E.2
History and Context–How the Current System Evolved E.3
Mayoral Support and Public Leadership E.4
Demonstration Program Participation E.6
Turning Points and the Role of Advocacy–No Movement Without Tension E.7
The Struggle for 1515 Fairmont E.7
The Sidewalk Behavior Ordinance E.7
Approach to Chronic Street Homelessness E.9
Program and Service Network E.9
Involvement of Mainstream Agencies E.10
Who Is Served? E.13
Coordination Mechanisms E.14
Pathways to Housing, Approaches and Models E.16
Documenting Success E.17
Street Counts E.17
Movement of Street Homeless into Housing E.18
Selected System Components E.19
Prevention E.19
Outreach and Drop-in E.19
Safe Havens and No/Low Demand Residences E.20
Emergency Shelters E.20
Transitional Programs E.21
Permanent Supportive Housing E.21

Supportive Services E.21
Affordable Housing E.22
Public Funding E.23
Maintaining and Enhancing the System E.23
Developing or Adapting New Approaches E.24
Budget Cuts E.25
Community Relations and Advocacy E.25
Initial Resistance E.25
Continuing NIMBY Issues E.27
Role of Consumers in Advocacy and Shaping Policy E.27
Continued Vigilance E.29
Site Visit Participants E.30
Acronyms E.34

APPENDIX F: SAN DIEGO F.1
San Diego–Brief Description F.1
Practices of Potential Interest to Other Jurisdictions ..... …F.2
History and Context–How the Current System Evolved F.3
Approach to Chronic Street Homelessness F.7
Program and Service Network F.7
Involvement of Mainstream Agencies F.7
Who Is Served? F.8
Coordination Mechanisms F.8
Pathways to Housing, Approaches and Models F.11
Selected System Components F.11
Outreach and Drop-in F.12
Emergency Shelters F.12
Low Demand Transitional Residences F.13
Transitional Programs F.13
Permanent Supportive Housing F.13
Supportive Services F.15
Affordable Housing F.16
Documenting Reductions in Chronic Street Homelessness F.17
Movement of Street Homeless into Housing F.17
Public Funding F.18
Maintaining and Enhancing the System F.20
Community Relations F.20
Site Visit Participants F.21
Acronyms F.23

APPENDIX G: SEATTLE G.1
Seattle–Brief Description G.1
Practices of Potential Interest to Other Jurisdictions G.1
History and Context–How the Current System Evolved G.3
The Continuum of Care Plan G.5
Approach to Chronic Street Homelessness G.5

Agency Interactions at the City and County Wide Level G.6
Agency Interaction at the Case Level G.7
Selected System Components G.8
Prevention G.9
Outreach and Drop-in G.9
Emergency Shelters Focused on the Chronic Street Homeless Population G.14
Safe Havens and No/Low Demand Residences G.15
Case Management G.16
Permanent Supportive Housing G.18
Supportive Services G.22
Affordable Housing G.23
Documenting Reductions to Chronic Street Homelessness G.25
Public Funding G.27
Community Relations and Advocacy G.29
The Future–Maintaining and Enhancing the System G.31
Site Visit Participants G.33
Acronyms G.35

APPENDIX H: GLOSSARY H.1

APPENDIX I: METHODS I.1
Site Selection I.1
First Screening Round I.2
Safe Havens I.3
Veteran Affairs Homeless Programs I.3
BID-Sponsored Programs I.4
NIDA Demonstration Programs I.4
California's Integrated Services for Homeless Adults with Serious Mental Illness I.5
New York City Programs I.5
Other Programs I.5
Second Round Screening I.6
Site Visits I.7
Discussion Guide for use with Candidate Sites I.8
History/Overview/Context Discussion Guide I.13
Outreach-Caseworker Discussion Guide I.16
Data Issues Discussion Guide I.19
Program-Specific Discussion Guide 1.21
Focus Group Discussion Guide for Participants of Programs to End Chronic Street Homelessness I.25

REFERENCES J.1

LIST OF CHARTS AND TABLES

Charts

Chart 5.1: Counts of Street Homeless Individuals In Philadelphia, 1998-2003……..52
Chart 5.2: Counts of Street Homeless Individuals, Birmingham 1995-2003 53
Chart B.1: Strategic Homeless Planning Group.. .....B.6
Chart C.1: Summary of 2003 Revenue Sources for Operations and Services Costs of Rebuilding Lives C.22

Tables

Table 1: Key Elements Identified in Study Communities of Success Reducing Chronic Street Homelessness..... xix
Table 2: Evidence of Success in Reducing Chronic Street Homelessness xxvi
Table 5.1: Per-Bed Cost for Operations and Services of Franklin County Service Systems Used by Homeless Men with Long-Term Needs 59
Table 6.1: Federal Sources Invested in Ending Street Homelessness.....69
Table 6.2: Potentially Underused Funding Sources For Ending Chronic Street Homelessness.....75
Table A.1: City of Birmingham: Agencies Involved in Reducing/Ending Chronic Street Homelessness.....A.8
Table A.2: Street Counts of Birmingham Homeless Population .....…A.15
Table A.3: Local Agency Investments in Ending Street Homelessness.....A.17
Table B.1: City of Boston: Agencies Involved in Reducing/Ending Chronic Street Homelessness.....B.9
Table B.2: Boston Investments in Ending Street Homelessness B.18
Table C.1 Per-Bed Costs for Operations and Services of Franklin County Service Systems Used by Homeless Men with long-Term Needs.....C.4
Table C.1: City of Columbus: Agencies Involved in Reducing/Ending Chronic Street Homelessness.....C.6
Table C.3: Roles of Key Collaborators.....C.8
Table C.4: Rebuilding Lives: Supportive Housing Projects.....C.14
Table C.5: Per Unit Costs (Operations and Services) for Rebuilding Lives Projects.....C.15
Table C.6: Local Agency Investments in Ending Street Homelessness.....C.21
Table C.7: Summary of Operations & Services for Projects Currently Operating or Funded C.26
Table C.8: Total Estimated Funding Needs for Additional Rebuilding Lives Units.....C.27
Table D.1: Department of Veterans Affairs Network of Agencies Involved in Ending Chronic Street Homelessness D.6
Table D.2: Supportive Housing Developed by the Greater Los Angeles VA and Community Partners.....D.13

Table D.3: AB 2034 Network of Agencies Involved in Ending Chronic Street Homelessness....D.22
Table D.4: Lamp Community Network of Agencies Involved in Ending Chronic Street Homelessness....D.31
Table E.1: City of Philadelphia: Agencies Involved in Reducing/Ending Chronic Street Homelessness....E.11
Table E.2: Local Agency Investments in Ending Street Homelessness....E.24
Table F.1: City of San Diego: Agencies Involved in Reducing/Ending Chronic Street Homelessness....F.9
Table F.2: Local Agency Investments in Ending Street Homelessness....F.19
Table G.1: City of Seattle: Agencies Involved in Reducing/Ending Chronic Street Homelessness....G.10
Table G.2: Local Agency Investments in Ending Street Homelessness....G.29

EXECUTIVE SUMMARY

Why This Study Is Important

The goal of ending chronic homelessness has achieved national prominence in a very short time. It was first articulated in July 2000, when the National Alliance to End Homelessness included it as part of its ten-year plan to end homelessness altogether. The Department of Housing and Urban Development (HUD) Secretary Mel Martinez announced his agency's acceptance of this goal in his keynote speech at the National Alliance's 2001 conference one year later. Then President Bush made "ending chronic homelessness in the next decade a top objective" in his FY 2003 Budget. Also by 2003, the Interagency Council on Homelessness had been reinvigorated to guide and coordinate the efforts of Federal agencies, two *New York Times* lead editorials argued forcefully for that goal, the U. S. Conference of Mayors adopted it, and more than 100 cities and some states have committed themselves to developing a plan by 2004 to end chronic homelessness in the next 10 years.[1]

HUD's goal, and the goal of many communities, is to *end* chronic homelessness. We have titled this report strategies for "reducing" chronic street homelessness because no community has yet succeeded in ending it, and we wanted the title to indicate that we are documenting progress, not complete success. This is an experimental time for programs to reduce chronic street homelessness. The many communities that have resolved to end chronic homelessness have to learn about successful approaches,[2] construct their own strategies, and locate the necessary resources to fulfill their plans. These communities can benefit from the experiences of homeless service providers who have been willing and able to participate in developing and implementing new approaches. Given the scope of what needs to be done, integrated community-wide approaches hold the most promise of succeeding.

HUD sponsored this project to identify and describe community-wide approaches that are working in cities around the country.[3] We selected seven communities that were reputed to have made progress in reducing their chronic street homeless population and would be able to document that progress. After conducting site visits, we found that only three of the seven have developed a true community-wide paradigm, but that each of the seven communities had noteworthy strategies to reduce chronic street homelessness. We also discovered common elements in the seven communities' approaches that appear to maximize progress. This report describes these common elements and their role in approaches to reducing chronic street homelessness. Communities just beginning to develop their own plans for reducing chronic

---

[1]For examples, see State and Local Plans to End Homelessness at the National Alliance to End Homelessness webpage http://www.endhomelessness.org/localplans/.

[2] Throughout this report we use the term "approach" to indicate the set of strategies and mechanisms of coordination being employed by a community to reduce chronic street homelessness.

[3] HUD's Policy Development and Research Office funded the study, in consultation with the Office of Special Needs Assistance Programs/Community Planning and Development, which administers HUD's homeless-related programs and funding opportunities.

homelessness should be able to find illustrative practices and programs that they can learn from and adapt to their own situations.

Purpose of the Research

This project's aim was to identify successful community-wide approaches to reducing homelessness and achieving stable housing for the difficult-to-serve people who routinely live on the streets. It was also to document these successful approaches in a way that will help other communities trying to address this problem. We included as "street homeless" single adults who spend significant time on the streets, although they may also use emergency shelters from time to time. Most of the people to be helped will also be "chronically" homeless, which we defined as being disabled and either being continuously homeless for a year or more or having had at least four homeless episodes during the last three years. This definition of "chronic" homelessness corresponds to the definition recently adopted by the Interagency Council on Homelessness. Disabilities or disabling conditions often include severe and persistent mental illness, severe and persistent alcohol and/or drug abuse problems, and HIV/AIDS. To the extent that community approaches address these, they can assist a greater proportion of chronic street homeless people to leave homelessness.

This study sought to answer several questions about strategies that communities use to reduce chronic street homelessness:

- Does the community have a long-term plan for reducing/preventing chronic homelessness? What is its approach and what are the elements? What led to this approach and how was it identified? What needs of which homeless people does it address?

- How was the approach implemented? What challenges were encountered? What opportunities were used?

- How is the approach administered and coordinated? What is the role of each stakeholder?

- How is the approach funded? Do requirements of the funding sources create any barriers or promote any successes?

- Did implementation include efforts to reduce local resistance by including community members? How? How successful have these efforts been?

- Can the community document its progress, either by showing that the numbers of street homeless people have decreased or by showing that programs are accepting this population and helping them leave homelessness?

- How else do communities use data to bolster their case for making the investment to end chronic street homelessness?

Who, What, Where, and When?

In 2002, HUD contracted with Walter R. McDonald Associates, Inc. and its subcontractor, the Urban Institute, to conduct a study to answer the aforementioned research questions. We sought communities appropriate for site visits through recommendations of key informants and a literature search for evaluated projects, identifying over 120 possible programs and communities. We called community and program representatives to help us identify appropriate communities to visit. Criteria for selection included that the community *have* an approach to reducing chronic street homelessness, that it be *community-wide*, and that there be *evidence* to document that the approach actually succeeded in reducing chronic street homelessness.

HUD asked us to find community-wide approaches to reducing chronic street homelessness because its analysts suspected that such a focused commitment might be necessary for substantial progress. For our purposes, "community-wide" means that a jurisdiction such as a city or a county has made a conscious commitment to reducing chronic *street* homelessness (as opposed to all homelessness), and has mobilized resources for that *specific* purpose. We were able to find three communities that met all three criteria, and several others that met the criteria but only for specific subpopulations such as veterans, people with severe mental illness, or people with co-occurring disorders. We visited some communities that did not meet the criterion of having a community-wide approach because we reasoned that many communities throughout the country would benefit from knowing what *could* be accomplished even without a community-wide approach, as not all communities will be able to begin with a community-wide commitment. The seven communities visited were:

- Birmingham, Alabama;
- Boston, Massachusetts;
- Columbus, Ohio;
- Three projects in Los Angeles, California—one focused on homeless veterans, one focused on mentally ill offenders in the county jail system, and one focused on chronic street homeless people in the downtown "Skid Row" area;
- Philadelphia, Pennsylvania;
- San Diego, California; and
- Seattle, Washington.

We conducted site visits to each of these communities, ranging in length from two to five days depending on the complexity of the community's approach and the components we chose as the focus of our visits. We interviewed between 40 and 90 people per site, including focus groups at each site of 5 to 10 formerly street homeless people. Representatives at each site had the opportunity to review for accuracy our description of their community and its activities for reducing chronic street homelessness (which appear as Appendices A through G).

Findings—Key Elements of Success

We identified 11 key elements in the seven communities visited, shared by many approaches for reducing chronic street homelessness. Most important, we found five of these elements to be

present in the communities that have made the most progress toward reaching this goal, and have called these elements "essential."

The most important element, shown in the first row of Table 1, is (1) a paradigm shift in the goals and approaches of the homeless assistance network. The essential recognition underlying the paradigm shifts we observed was that existing approaches and homeless assistance networks were not reducing or ending homelessness, particularly chronic or street homelessness.[4] Recognizing also that they *wanted* to end chronic street homelessness, these communities adopted that goal and found new or modified existing approaches that brought greater success. We did not find any connection between having a well-established homeless assistance network and experiencing a paradigm shift; the first was not a prerequisite for a shift, nor did it guarantee that one would occur. Among the communities we visited, four (Boston, Columbus, Philadelphia, and Seattle) have extensive programs and services in every aspect of their continuum of care, run by experienced providers and developed over many years with both Federal and local funding and support. Two of the four have experienced a paradigm shift while two have not yet done so. While having a well-developed network does not produce a shift, however, once a shift occurs an established and extensive network of services and providers that work well together offers an advantage as a community proceeds with the planning and program development needed to launch new approaches. This is what happened in Columbus and Philadelphia. On the other hand, San Diego's homeless assistance network had major gaps, especially in the area of permanent supportive housing. The pre-shift system was developed by the local network of nonprofit agencies, without much focus on the chronic street population and without much participation by the public and business sectors. San Diego's paradigm shift involved both a new focus—on the chronic street population—and new players—public agencies and the business community.

The next four elements appear to comprise an important combination that, working together, turn a paradigm shift's promise into a reality. These are (2) setting a clear goal of reducing chronic street homelessness, (3) committing to a community-wide level of organization, (4) having leadership and an effective organizational structure, and (5) having significant resources from mainstream public agencies that go well beyond homeless-specific funding sources. It is important to note that these elements characterize community activities to reduce chronic street homelessness *after* a paradigm shift, but need not already be in place. Some may exist before the shift (Columbus and Philadelphia had all except the goal of ending street homelessness). We observed the most progress toward ending chronic street homelessness at the community level where these elements worked together as they did in Columbus, Philadelphia, and San Diego. Even when an organization or network experiences a paradigm shift affecting a subpopulation rather than a whole community, we found these same four elements as the engine underlying their success in building on their paradigm shift, as they did in two examples from Los Angeles (the work of the Department of Veterans Affairs with homeless veterans and the Mental Health and Sheriff's Departments' joint work with mentally ill offenders).

---

[4] The old paradigm was that street homeless individuals should be cared for more by charitable, often religious, organizations rather than by mainstream public agencies. The old paradigm relied heavily on emergency shelters, transitional housing, and sobriety-based programs. The old paradigm did not plan, or expect, to end chronic street homelessness.

The first five elements, working together, allowed several of our communities to capitalize on a trigger event or catalyst, while in at least one other, a trigger event was the catalyst for developing the first five elements. The remaining elements in Table 1 contributed to a community's ability to sustain its commitment and guide the development of its new approaches. These are (7) significant involvement of the private sector; (8) commitment and support from mayors, city and county councils, and other local elected officials; (9) having a mechanism to track progress, provide feedback, and support improvements; (10) being willing to try new approaches to services, and (11) having a strategy to handle and minimize negative reactions to locating projects in neighborhoods (NIMBY responses).

How They Got Where They Are Today—Key Factors in History and Implementation

All successful community and subpopulation approaches started from one place—key stakeholders recognized that to end chronic street homelessness, they had to focus specifically on that goal, understand the characteristics of chronically street homeless people, and plan programs and services designed to attract them. Even in communities that had a well-established homeless assistance network, stakeholders realized that they were not reducing or ending chronic street homelessness, and would have to do things differently if they wanted to succeed. As already described, they underwent a paradigm shift in the way they approached homeless assistance programs and services for the hardest-to-serve chronically homeless people.

Trigger Events and Paradigm Shifts

In most of the communities we visited, a trigger event galvanized the approach we observed. The event was impending downtown development in Columbus and San Diego, a proposed anti-homeless city ordinance in Philadelphia and Birmingham, consumer and service provider protests at the Department of Veterans Affairs in Los Angeles and municipal buildings in Philadelphia and San Diego, and an invitation to develop a pilot program for a new funding source for the Los Angeles County Sheriff and Mental Health Departments' integrated services program. The two communities that already had strong organizational structures and leadership (Columbus and Philadelphia) were able to capitalize on these trigger events with relative ease and speed. But it is important to note that several communities and public agencies that *did not* have an organized leadership structure or well-developed public agency involvement and investment before the trigger event (for example, San Diego and two of the Los Angeles programs) were able to use the event to re-examine their situation, decide to take action, organize themselves, mobilize resources, and make and carry out plans for approaches that address and reduce chronic street homelessness. Thus these four communities were able to turn these events to their advantage and gain commitments to new goals and new resources, rather than allowing the event to worsen the circumstances of street homeless people. The event itself is often perceived locally as a watershed moment—the catalyst that began the process that resulted in the current commitment to reduce or end chronic street homelessness.

Table 1: Key Elements Identified in Study Communities of Success in Reducing Chronic Street Homelessness

Type of Element	Element	Community[1]								
		Columbus	Philadelphia	San Diego	Los Angeles			Birmingham	Boston	Seattle
					Dept. of Veterans Affairs	AB 2034	Lamp Community			
Essential	Paradigm Shift	Yes	Yes	Yes	Yes	Yes	No	No	No	No
	Clear Goal Set	Yes, reducing street homelessness	Yes, reducing street homelessness	Yes, reducing downtown street homelessness	Yes, reducing veterans' homelessness	Yes, reducing homelessness among mentally ill offenders	Yes, reducing street homelessness in Skid Row	No	Yes, reducing homelessness among people with serious mental illness	No
	Community-wide Approach	Yes	Yes	Yes	No	No	No	No	No	No
	Organizational Structure and Leadership Specifically for Reducing Chronic Street Homelessness	Nonprofit lead agency with authority and resources	Government agency with authority and resources, plus a Mayor's Task Force and a voluntary association of all interested parties	Voluntary association of government agencies and business interests, with resources	VA is lead agency, with resources, of a network of VA and contracted nonprofit housing and service providers	Mental health agency is lead, works with Sheriff, directs network of contracted nonprofit mental health providers	Mini-continuum	None specifically for reducing chronic street homelessness, but starting a subcommittee that will have this focus	None specifically for reducing chronic street homelessness	None specifically for reducing chronic street homelessness
	Mainstream Agency Involvement	Strong	Strong	Strong	Strong	Strong	Weak	Weak	Strong, but not specifically for reducing chronic street homelessness	Weak
Catalyst	Trigger Event	Yes	Yes	Yes	Yes	Yes	No	Yes	No	No
Contributing	Private Sector Involvement	Strong	Strong	Strong	Weak	Weak	Weak	Strong	Weak	Some
	Local Elected Official Commitment	Strong	Strong	Strong	Weak	Weak	Weak	Weak	Strong	Weak
	Progress-tracking Mechanism	Yes	Yes	Yes	Yes	Yes	No	No	No	No
	New Approaches to Services	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes
	Strategy to Combat NIMBY	Yes	Yes	No	Some	Some	No	No	No	Yes

1 In Columbus, Philadelphia, San Diego, Birmingham, Boston, and Seattle, we sought community-wide approaches to ending chronic street homelessness. In Los Angeles, we did not look for a countywide or even a citywide approach, examining instead two systems focused on particular subpopulations of interest and one mini-continuum focused exclusively on chronically street homeless people.

Even in communities that have not, as yet, adopted reducing chronic street homelessness as a community-wide goal, some networks have developed with a focus on reducing homelessness among chronically street homeless people in response to unique opportunities or the commitment of a public agency. Seattle used the ACCESS program targeting severely mentally ill homeless people to help create a service network that still operates to the advantage of mentally ill street people, and also developed a set of programs and services targeted specifically toward substance abusing street homeless people. In Boston, the Massachusetts Department of Mental Health has committed extensive resources to programs and services for homeless people with severe mental illness, including specialized emergency and transitional shelters/housing and extensive discharge planning to avert a return to homelessness after psychiatric treatment.

It takes the change in vision—the paradigm shift in what communities are trying to accomplish—to make significant progress toward reducing chronic street homelessness within a community or for a subpopulation. Excellent individual programs will surely exist—we visited many of them—and they may have great success in helping individual homeless people leave homelessness. But without the paradigm shift, communities probably will not take the steps to develop innovative approaches and mobilize the resources that are necessary to reduce chronic street homelessness.

Thoughtful, Analytic Process

The approaches making the most progress toward ending chronic street homelessness were based on an extensive investigation of needs and options. Decision makers learned about the numbers, problems, and service needs of their chronically homeless population, through special surveys, focus groups, and "hanging out." They read evaluation reports and visited other communities that already had approaches they were considering. They invited speakers to town to discuss options. Columbus and Philadelphia provide examples of this analytical process. They each had community-wide data on emergency shelter use from which they learned that 10 to 15 percent of the people who used emergency shelters throughout the year used 50 percent or more of shelter resources (bed nights). They reasoned that if they could move these chronically homeless people into permanent housing arrangements, both they and the homeless assistance system would benefit.

Armed with pertinent information, the more advanced communities developed an approach that in all instances involved strategies to address both "opening the back door" (helping people leave homelessness) and "closing the front door" (preventing people from becoming homeless). Strategies of both types *require* the active cooperation and investment of mainstream agencies. Building this commitment occurred through various approaches, depending on the community. In Columbus, which already had a central organization and involvement of mainstream agencies, the route was through a special project, Rebuilding Lives, which included a survey of street homeless people and analysis of the results and their implications for the types of programs and

investments that would be needed. The final report addressed the whole community, explained the strategy and its rationale, and organized buy-in from many stakeholders to develop 800 units of low-demand permanent supportive housing explicitly for the chronically homeless people in shelters and on the streets, to augment the community's existing array of permanent supportive housing.

In contrast, San Diego began without an existing central organization coordinating the efforts of its mainstream public agencies. Interested parties organized informally, took their time, talked with everyone, and allowed consensus to grow as increasing numbers of public agencies and private interests were invited to participate. Ultimately the plan they developed received unprecedented endorsement and support from both city council and county board of supervisors, plus significant business commitments. Finally, communities with successful approaches set goals and timetables, put someone in charge, track their progress, make sure they get feedback on how they are doing, and periodically take time to reflect on progress and what adjustments or new commitments might be required.

New Strategies for Programs and Services

Most of the communities we visited have assessed and adopted new approaches to programs and services for the street homeless population, or have modified existing ones (as a result of the thoughtful, analytic process). They have also increased commitments to existing programs and services to better approximate the level of need among chronically street homeless people, who include many of the hardest-to-serve homeless people. They have severe mental illnesses, substance abuse disorders, HIV/AIDS, and physical disabilities, often occurring together. They have been homeless a long time, often have no ties to family, and rarely have any resources. Their skills are oriented toward survival on the streets, not to living in housing.

Most chronically street homeless people have used emergency shelter—some only briefly, but others for long periods of time. Many have been frequent users of detoxification facilities, and have had some contact with the mental health system as both outpatients and inpatients. Many will not use programs that require sobriety to enter, as they will not stop using drugs and alcohol, at least at first. In addition many are not able to comply with plans or "make progress" from the time they enter a program, as many transitional programs require them to do. The long stays of people in emergency shelter clearly indicate that emergency shelters generally do not succeed in moving these people out of homelessness.

The people on whom this project focuses are, by definition, those for whom these programs and services have not produced long-term solutions to homelessness. Their resistance to standard approaches has been a challenge to communities committed to ending chronic street homelessness. In the experience of the communities we visited, reaching that goal has required rethinking their services and offering new approaches. Most communities we visited have adopted one or more of:

- Housing First models that place people directly from the streets into permanent housing units with appropriate supportive services, including safe haven programs for people with

serious mental illness and similar programs for people whose primary problem is addiction;

- Transitional versions of Housing First that let people bypass emergency shelters;

- Breaking the linkage between housing and service use/acceptance, so that to keep housing, a tenant need only adhere to conditions of the lease (pay rent, don't destroy property, no violence), and is not required to participate in treatment or activities;

- Low demand or "harm reduction" conditions where sobriety is "preferred but not required," which often translate into a "no use on the premises" rule for projects that use HUD funds; and

- Restructuring existing activities such as outreach to increase their effectiveness at connecting street homeless people with services and housing; and

- Discharge planning from jails and mental health hospitals to prevent street homelessness among individuals leaving these institutions.

In addition, many communities have developed mechanisms for facilitating service delivery to individual clients, helping them to take advantage of what the system has to offer. Some of these are specialized versions of case management, and some are tools to support effective case management. They include:

- Database technology and information sharing that allows staff members of one agency to know what services a client might be receiving from other agencies;

- Multi-agency teams designed to include the range of expertise required to meet the broad spectrum of services needed by chronic street homeless individuals;

- Multi-purpose service centers where clients can receive more than one type of service within the same building; and

- Processes to improve access to mainstream agencies, such as locating intake workers at homeless service provider sites.

Low-demand housing approaches appear to be very successful at attracting chronic street homeless people. According to focus groups with street homeless people and outreach workers during our site visits, as well as other research (Rosenheck et al., n.d.; Shern et al., 1997; Tsemberis and Eisenberg, 2000), these low-demand programs can bring difficult-to-recruit individuals into permanent supportive housing. People *will* come in, they *do* use services even though not required to, they *do* reduce their substance use, and mostly they *do not* return to the streets. Other mechanisms facilitate the process of recruiting people into the housing programs and assuring that, with maximum efficiency and effectiveness, they get the array of services they need.

In addition to the new approaches, making a commitment to ending chronic homelessness often means increasing the availability of existing programs and services that help people to leave homelessness. Such actions might include increasing access to case managers and reducing case manager caseloads. Short-term and medium-term addiction recovery programs might be expanded to fill gaps, so that people are not left without a program when they are not yet secure in their recovery. The availability of housing subsidies might be expanded. It takes many components to create a successful system. Some will be new, others old. Birmingham, for instance, has some successful programs based entirely on sobriety and transitional rather than permanent supportive housing. But serious commitment to ending chronic street homelessness necessitates a paradigm shift, part of which involves the willingness of a community and its homeless assistance providers to consider approaches that have been proven to work even though they may, at least initially, represent a significant departure from traditional programs.

Documenting Progress

We sought out programs and communities that not only were doing important things to end street homelessness, but also had the evidence to document their progress. Collecting such evidence is not easy, and it can take many forms:

- Changes in the number of people found on the street from year to year, coming from consistently administered and analyzed street counts;
- Increases in the percentage of chronically street homeless people who
    - Move directly from street to permanent supportive housing, or other combinations of services that lead to permanent housing in the community (for example, safe havens and then PSH);
    - Receive other combinations of services that lead to permanent housing in the community (for example, transitional housing followed by moving into affordable housing with decreasing supportive services, for people in recovery where substance abuse is the primary issue);
- Costs avoided by reducing inefficient utilization by homeless people of health, mental health, shelter, and law enforcement services;
- Reductions in undesirable outcomes for homeless people (such as days homeless, hospitalized, or incarcerated);
- Increases in receipt by homeless people of entitlement public benefits (such as Supplemental Security Income, Medicaid, or food stamps); and
- No reappearance in the homeless service system (documented through a community-wide homeless management information system).

Many factors may influence the level of homelessness, including street homelessness, in a community, no matter how organized or complete the efforts to end it. In the communities we visited, interviewees attributed increases in the level of chronic street homelessness or changes in

other measures of progress to a poor economy and resulting unemployment, shutting down one or more large SRO hotels where poor single people had lived, closure of state mental hospitals, and persistently high housing costs.

Even in the face of these countervailing factors, the communities we visited were able to substantiate their progress at reducing chronic street homelessness, or helping chronically street homeless people obtain housing, in a variety of ways (see Table 2). Other communities might be able to develop the types of evidence shown in Table 2, which they could use to convince local stakeholders that investing in programs and services to reduce chronic street homelessness will produce measurable results.

Philadelphia and Birmingham street counts show reductions over a number of years, with Philadelphia's decreases paralleling increases in safe haven and permanent supportive housing units, and Birmingham's paralleling increases in both transitional and permanent supportive housing, as well as emergency shelter expansion.

As shown in Table 2, at least some programs in most communities can document progress in bringing chronically street homeless people into supportive housing and in helping them retain that housing. Lengths of stay in programs that have been in operation long enough for tenants to remain stably housed for years average three to five years. Some programs can also document the proportion of leavers who went to and remained in affordable housing in the community. In one Philadelphia program 67 percent of 90 people who left permanent supportive housing were living in "regular" affordable housing.

Columbus, Philadelphia, and San Diego have also made good use of cost data to show the most cost-effective models of providing services (Columbus) or the cost of emergency services that could be avoided through permanent supportive housing (Philadelphia and San Diego) or transitional housing and treatment for serial inebriates (San Diego). Cost avoidance studies showing that PSH does not cost much more than "doing nothing" have recently achieved national prominence (Culhane, Metraux, and Hadley, 2002; Rosenheck et al., 2003), and can be considered a more humane investment of public funds. These results are one reason why an increasing number of jurisdictions are committing themselves to ending chronic homelessness.

How Do They Pay For It?

Finding the resources to pay for new programs and services is always a challenge. The experience of these seven communities indicates very strongly that reducing chronic street homelessness requires significant investment of mainstream public agencies, bringing both their commitment and energy, and *local* dollars. The goal cannot be met if the homeless assistance network providers are the only players, and Federal funding streams the only resources.

The communities and service networks enjoying the greatest success in reducing chronic street homelessness all capture resources from many different funding streams. The local agencies that control these funding streams have made the decision to devote not only Federal resources they control, but also their own state and local resources, to achieving the goal. In addition, some communities have created special funding streams that help support permanent housing programs and supportive services. These include a housing tax levy (Seattle), tax increment

financing generated by a redevelopment agency and reinvested in permanent supportive housing (San Diego), community redevelopment bonds (Philadelphia), special state funding streams (California's Integrated Services for Homeless People with Mental Illness, and its Supportive Housing Initiative Act), and investments by Business Improvement Districts and other associations of downtown businesses and corporations (Birmingham, Columbus, Philadelphia, San Diego).

Implications

The findings from this project have some important implications for policy, practice, and research. We summarize them here.

Implications for Policy

During site visits many respondents offered suggestions for how Federal policy and Federal agencies could help them as they pursue their goal of ending chronic homelessness. Their suggestions reflect their own experiences of what has helped them, and also what they feel could continue to ease the way toward reaching their goal. These include suggestions for Federal, state, and local agencies.

- Federal agencies should:
    - Continue to prioritize community-wide planning and integrated approaches for reducing chronic homelessness in general, and street homelessness for people with severe mental illness, chronic substance abuse, HIV/AIDS, or any combination in particular;
    - Make technical assistance widely available to communities that are starting to plan an approach to reducing street homelessness; and
    - Facilitate opportunities for practitioners and planners to observe new approaches in action, speak with consumers, see results, and consider how these practices could be applied in their own community.
- Federal legislative action should increase the flexibility of Federal agencies to blend their funding to support innovative community-wide practices that integrate services to reduce chronic homelessness across local agencies.

TABLE 2: EVIDENCE OF SUCCESS IN REDUCING CHRONIC STREET HOMELESSNESS

Type of Evidence	Community								
	Columbus	Philadelphia	San Diego	Los Angeles			Birmingham	Boston	Seattle
				Department of Veterans Affairs	AB 2034	Lamp Community			
Street count reductions	Estimates of street populations do not yet show reductions	Summer counts since 1998 -6%, 1998-2003 -42%, 1998-2000 increase between 2001 and 2003 due to poor economy					Counts in 1995, 2001, and 2003 -10%, 2001-2003 -33%, 1995-2003	No reductions; only 5 of past 16 years have seen street counts over 200; 4 have been the 4 most recent years	Annual counts for 24 years, increases in street homelessness every year 1998-2002 of 10-40%, +260% between 1998 and 2002
Formerly street homeless people moved to PSH with stays of 1 year plus	Has created (to date) 370 of 800 intended PSH units and moved chronically street homeless people into them, the vast majority of whom are still there	Agency 1: of 186 people in 4 PSH programs, 73% had been in PSH for 1+ years (avg. LOS=3.2 years) Agency 2: of 146 people in 2 PSH programs, 72% in PSH for 1+ years, 44% for 2+ years	One program reports 70% (177) of current enrollees were mentally ill and chronically homeless, now in PSH; most of other enrollees are in TH				One program reports 75 (48% of leavers) went from TH to PSH, of whom 81% have stayed 1+ years	One program reports 135 (38% of leavers) went from ES to PSH, and 78 (22% of leavers) went from ES to TH	Agency 1-70-78% in 3 PSH programs remain 1+ years Agency 2-in 2 PSH programs, average LOS is at least 3 years
Formerly street homeless people moved to permanent affordable "regular" housing		Agency 1-of 90 who left PSH, 67% living in stable housing; 13% returned to homelessness; 13% unknown					Same program reports 18 (11% of leavers) went from TH to regular housing and have not returned		
Financial advantages	Estimates cost-effectiveness of different housing-service combinations	Estimates cost of chronic shelter use vs. PSH, safe havens	1. Fifteen high medical service users cost $1.5 million over 18 months 2. One arrest for a serial inebriate costs $1470 versus $977 for a *month* of TH plus outpatient treatment						
Other		Reduced emergency beds due to more PSH and Safe Havens	One program reports that after 1 year participants had 73% fewer days homeless, 35% fewer days hospitalized, 55% fewer days incarcerated	16-25% fewer homeless days (national VA evaluation study); also fewer hospital days	65% fewer days homeless, 74% fewer days hospitalized, 80% fewer days incarcerated	Reduced homeless, hospital, and incarcerated days (just for AB 2034 people)			

- State and local agencies should:
    - Adjust rules and regulations to facilitate access to benefits, programs, and services for chronically street homeless people;
    - Establish procedures and invest resources in housing and services to assure that people leaving psychiatric care, substance abuse treatment, correctional facilities or foster care do not become homeless; and
    - Facilitate state and local public agency and nonprofit provider interest in and capacity to serve clients with co-occurring disorders, by, for example, improving liaison and integrated service arrangements among mental health, substance abuse, medical care, and housing authorities; or requiring dual certification for all contract agencies and staff.

Implications for Practice

One of the primary reasons for conducting this study was to learn what different communities actually do that is effective in reducing street homelessness. The practice implications summarized here are distillations of information, opinion, and experience from many of the sites we visited. Communities desiring to advance in their efforts to end chronic homelessness, including street homelessness, should look carefully at the experiences of the places we visited and explore how they may adapt proven practices to their own situation. The body of this report includes "practices of potential interest to other communities," complete with people to contact to learn more, and contact information. Brief descriptions occur throughout the report, but details may be found in the site appendices, which begin with brief summaries and contact information. Readers should browse these appendices to learn about practices and see whether any of them might be appropriate for their own community.

- If a community is intent on reducing chronic street homelessness, it is vital that it take steps to build the capacity to work with people who have co-occurring disorders.
    - Homeless providers need to develop dual competence and dual certification—mental illness and substance abuse issues must be handled together.
    - Mainstream mental health and substance abuse agencies need to have an integrated approach to mental illness and substance abuse for chronically street homeless people. Mainstream agencies also need to accept that stable housing contributes to their clients' well being—possibly as much as medications and other official "treatments." They should consider creating positions of housing developers and coordinators, and making housing and housing stability a priority.
    - Housing providers need to understand the benefits of supportive services to their *whole* tenant base and not just to those who were homeless. In the communities we visited, some housing providers had realized the advantages of having supportive services available. The Plymouth Housing Group of Seattle reported that their tenants' average tenure increased from 18 months to 36 months, once

services were made available. Services associated with Shelter Plus Care were located at Sunshine Terrace in Columbus, a high-rise 180-unit building operated by the public housing authority, to provide support to the tenants who receive Shelter Plus Care subsidies (about one-fourth of all tenants). Other tenants may and do use these services, resulting in stabilized housing tenure for all tenants, as well as contributing to the good neighbor image Columbus cultivates for its permanent supportive housing programs.

- To develop and implement strategies for reducing chronic street homelessness, communities require strong, skilled leadership. The institutional location of the leaders is not as important as the capability and commitment of the individuals. But individuals, however good their leadership skills, must have the backing and resources of local mainstream agencies and elected officials if they are to succeed.

Implications for Research

The implications of our study for research are not as direct as those for policy and practice. They stem more from what we did not find, and what we could not document, than they do from what we were able to see and evidence we were able to collect. As we examined our findings, many gaps in knowledge appeared—types of evidence we wish we had, or wish were stronger, to establish with greater confidence which directions and practices were fruitful and should be emulated in other communities. The research suggestions presented below are those that we think will help fill the most glaring gaps in our current knowledge and provide the most useful information to show effective approaches to ending chronic street homelessness.

- Longitudinal tracking studies should be funded to document housing stability and follow people once they leave supported housing. A primary outcome to observe in this research would be housing stability and what factors contributed to it. These studies would be most relevant to conduct for formerly street homeless people with severe mental illness and co-occurring disorders. They should examine housing stability both within the homeless assistance network and after leaving it.

- Conduct research that compares the effectiveness and cost-effectiveness of different pathways into permanent housing for different subpopulations. Ideally this research should use random assignment intervention studies; if that is impossible, it *must* employ meaningful comparison groups.

    - Pathways to examine should include (1) directly from the street into permanent supportive housing, (2) transitional housing as a step before permanent supportive housing, (3) safe haven as a step before permanent supportive housing, and (4) transitional housing with expectation of movement into affordable housing in the community (no supportive services).

    - Approaches to test, within pathways, should include (1) sober versus harm reduction models, (2) voluntary versus coerced treatment (the latter through drug court or its equivalent), (3) different physical structures and service delivery

mechanisms (for example, scattered site, only-formerly-homeless single site, and mixed-use single site), and (4) if transitional housing is part of the pathway being tested, what is the optimal duration of transitional housing to increase the odds of maintaining recovery.

- Support a reasonable sample of permanent supportive housing providers to collect and maintain better data on their tenants, and assemble these data at the national level. This approach would be less expensive by far than the ideal research designs described in the first two bullets, but would still contribute significant new data on important issues, including the effectiveness of permanent supportive housing. Data would need to be collected (1) at intake about tenant histories, (2) during residence, and (3) after people leave permanent supportive housing, to document continued success or return to homelessness. 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 the follow-up interviewing, if one wanted to assure acceptable completion levels.

CHAPTER 1: INTRODUCTION

Why This Study Is Important

Today's recognition of homelessness as a social problem is about two decades old. First responses were to treat the problem as an emergency situation. Policy evolved over the years to include recognition that many of the people finding themselves homeless would need more than an emergency bed for a few nights, weeks, or even months to get themselves back into regular housing. Some communities began as early as the late 1990s to reorient themselves toward *ending* either chronic homelessness or all homelessness, and to establish action steps and a time frame in which to do so.

At its national conference in July 2000, the National Alliance to End Homelessness unveiled a ten-year plan to end homelessness altogether. A significant part of that plan is a blueprint to end *chronic* homelessness in the same time frame. The plan drew on evaluations that show we know how to create programs and supportive services to bring people in off the streets and help them retain housing, and on research that estimates the number of chronically homeless people to be few enough (between 150,000 and 250,000) to make a reasonable target for a successful policy. Two years later, additional research (Culhane, Metraux, and Hadley, 2002) showed that the policy might be close to cost-neutral in public monies as well. Since 2000, this goal of ending chronic homelessness has expanded dramatically. By 2003 the President had endorsed it and reinvigorated the Interagency Council on the Homeless to guide and coordinate the efforts of Federal agencies. Two *New York Times* lead editorials argued forcefully for that goal, the U. S. Conference of Mayors had adopted it, and more than 100 cities and states around the country had committed themselves to developing plans that would make it a reality.

These plans usually have at least two aspects—helping chronically homeless people leave homelessness for good by establishing permanent supportive housing or other supportive networks, and stopping the flow of people likely to experience chronic homelessness by offering housing and appropriate supports for vulnerable people leaving institutions such as substance abuse treatment, psychiatric, or correctional facilities.

This is an experimental time for programs to reduce chronic street homelessness. The many communities that have resolved to end chronic homelessness have to learn about successful approaches,[5] construct their own strategies, and locate the necessary resources to fulfill their plans. These communities can benefit from the experiences of homeless service providers who have been willing and able to participate in developing and implementing new approaches. Given the scope of what needs to be done, integrated community-wide approaches hold the most promise of succeeding.

---

[5] Throughout this report we use the term "approach" to indicate the set of strategies and mechanisms of coordination being employed by a community to reduce chronic street homelessness.

HUD sponsored this project to identify and describe community-wide approaches that are working in cities around the country.[6] We selected seven communities that were reputed to have made progress in reducing their chronic street homeless population and would be able to document that progress. After conducting site visits, we found that only three of the seven have developed a true community-wide paradigm, but that each of the seven communities had noteworthy strategies that were working to reduce chronic street homelessness. We also discovered common elements in the seven communities' approaches that appear to maximize progress. This report describes these common elements and their role in approaches to reducing chronic street homelessness. Communities just beginning to develop their own plans for reducing chronic homelessness should be able to find illustrative practices and programs that they can learn from and adapt to their own situations.

We found that the most successful of the study communities had experienced a paradigm shift that changed the goals and approaches of their homeless assistance network. This was especially powerful when combined with having a clear goal of reducing chronic street homelessness, a community-wide level of organization, strong leadership and effective organizational structure, and significant resources from mainstream public agencies. These and other key elements are described in detail in Chapter 2. The other chapters in the body of the report describe how the study communities implemented their strategies. The last chapter describes policy, practice, and research implications.

The site visit appendices provide descriptions of how the elements operate together in each of the study communities. These appendices also include site contact information for practices of potential interest to other jurisdictions. None of the study communities have achieved the final goal of ending chronic homelessness, but all provide examples of useful strategies. A few of our study communities have a more complete approach than the others, but all of them are working on improvements.

Purpose of the Research

This project's aim was to identify successful community-wide approaches to reducing homelessness and achieving stable housing for the disabled, difficult-to-serve people who routinely live on the streets, and to document these successful approaches in a way that will help other communities trying to address this problem. We included as "street homeless" single adults who spend significant time on the streets, although they may also use emergency shelters from time to time. Most of the people to be helped will also be "chronically" homeless, which we defined, as does the Interagency Council on the Homeless, as being disabled and either being continuously homeless for a year or more or having had at least four homeless episodes during the last three years. We use the phrase "chronically street homeless" in describing those single adults who meet both criteria. To be successful at the task of reducing chronic homelessness, community approaches must address disabilities such as severe and persistent mental illness, severe and persistent alcohol and/or drug abuse problems, and HIV/AIDS. For succinctness of

[6] HUD's Policy Development and Research Office funded the study, in consultation with the Office of Special Needs Assistance Programs/Community Planning and Development, which administers HUD's homeless-related programs and funding opportunities.

writing, often in this report we will simply use the terms "chronic homelessness" and "chronically homeless individuals" in referring to the people who are the focus of our inquiry.

This study sought to answer several questions about strategies that communities use to reduce chronic street homelessness:

- Does the community have a long-term plan for reducing/preventing chronic homelessness? What is its approach and what are the elements? What led to this approach and how was it identified? What needs of which homeless people does it address?

- How was the approach implemented? What challenges were encountered? What opportunities were used?

- How is the approach administered and coordinated? What is the role of each stakeholder?

- How is the approach funded? Do requirements of the funding sources create any barriers or promote any successes?

- Did implementation include efforts to reduce local resistance by including community members? How? How successful have these efforts been?

- Can the community document its progress; either by showing that the numbers of street homeless people have decreased or by showing that programs are accepting this population and helping them leave homelessness?

- How else do communities use data to bolster their case for making the investment to end chronic street homelessness?

Who, What, Where, and When

In 2002, HUD contracted with Walter R. McDonald Associates, Inc. and its subcontractor, the Urban Institute, to conduct a study to answer the research questions. HUD asked us to find community-wide approaches to reducing chronic street homelessness, to the extent possible, because its analysts suspected that such a focused commitment might be necessary for substantial progress.

We sought communities appropriate for site visits through recommendations of key informants and a literature search for evaluated projects, identifying over 120 possible programs and communities. Screening phone calls to community and program representatives helped us identify appropriate communities to visit. Criteria for selection included that the community *have* an approach to ending chronic street homelessness, that it be *community-wide*,[7] and that there be *evidence* to document that the approach actually succeeded in reducing chronic street homelessness. (The selection methods are described further in Appendix H.)

[7] For our purposes, "community-wide" means that a jurisdiction such as a city or a county has an effective cross-agency collaborative approach. See Chapter 2 for a fuller discussion of this term.

We were able to find three communities that met all three criteria, and several others that met the criteria but only for specific subpopulations such as veterans, people with severe mental illness, or people with co-occurring disorders. We also visited four communities that did not meet all criteria. We reasoned that many communities throughout the country would benefit from knowing what could be accomplished even without a community-wide approach, as not all communities will be able to begin with community-wide commitment. The seven communities visited were:

- Birmingham, Alabama;
- Boston, Massachusetts;
- Columbus, Ohio;
- Three projects in Los Angeles, California—one focused on homeless veterans, one focused on mentally ill offenders in the county jail system, and one focused on chronic street homeless people in the downtown "Skid Row" area;
- Philadelphia, Pennsylvania;
- San Diego, California; and
- Seattle, Washington.

We conducted site visits to each of these communities, ranging in length from 2 to 5 days depending on the complexity of the community's approach and the components we chose as the focus of our visits. We interviewed between 40 and 90 people per site, including focus groups at each site of 5 to 10 formerly street homeless people. Representatives at each site had the opportunity to review for accuracy our description of their community and its activities for ending chronic street homelessness. Below we present a short introductory sketch of our sites in alphabetical order. The complete descriptions are in Appendices A through G.

Birmingham, Alabama

Metropolitan Birmingham Services for the Homeless, the entity orchestrating most of the homeless network planning and development that occurs in Birmingham, is a membership organization with no formal authority or control over its members. The network of programs and services developed to encourage people to move from the streets into housing includes outreach, emergency shelter, and transitional and permanent supportive housing. A safe haven[8] is just being developed, with an anticipated opening date of December 2003. Employment and community

[8] Safe havens are very low cost or free housing programs for homeless persons who, at the time, are unwilling or unable to participate in mental health treatment programs or other supportive services. Safe havens provide low demand housing with no limits on length of stay. The Stewart B. McKinney Homeless Assistance Act, as amended in 1992 by Public Law 102-550, authorized the Secretary of the Department of Housing and Urban Development (HUD) to make grants for such housing, but not all the programs we refer to receive these grants.

service are important emphases in programs working with people whose homelessness is complicated by chronic substance abuse. Birmingham has been the site of an ongoing research project funded by the National Institute on Drug Abuse that has had considerable success in treating homeless addicts. Agencies have developed some innovative ways to blend the interests of property owners and poor people to create affordable housing with very little government funding, and have involved the business community in other ways to address street homelessness.

Boston, Massachusetts

Boston has mayoral-level community-wide planning and program development, extensive involvement of mainstream agencies and funding from state and local general revenues, and an extensive and committed community of service providers and advocates working with homeless people. Through a collaborative network of programs and services, the city moves several thousand individuals out of homelessness each year through services such as street outreach and drop-in centers, emergency shelter, substance abuse and mental health treatment, medical services, educational programs, career development and employment services, transportation, and transitional and permanent housing programs. The city has a highly developed approach to discharge planning and homelessness prevention for people with severe mental illness, and is very focused on affordable housing production and preservation.

Columbus, Ohio

The lead agency for the homeless service system in Columbus is the Community Shelter Board (CSB), an independent nonprofit agency founded in 1986 by a group of civic leaders, business associations, local government leaders, and representatives from a variety of foundations. CSB does not provide any direct services within the community, nor is it an original source of money for homeless assistance services. Its main responsibilities are resource development and investment, service delivery coordination and planning, program accountability, and systems change and public policy reform. The Community Shelter Board currently allocates $7.5 million annually to 14 partner agencies for programs serving homeless individuals and families in Columbus.

The community's main strategy for ending chronic homelessness is embodied in an initiative known as "Rebuilding Lives." It is a community-based initiative developed by the Scioto Peninsula Task Force in response to problems created by downtown redevelopment along the part of the riverfront known as the Scioto Peninsula. The task force was charged with developing a coordinated, targeted, cost-effective method of providing shelter and services to homeless individuals and families. Launched in July 1999, the Rebuilding Lives initiative focuses on ending homelessness and "rebuilding lives" by meeting the short-term needs of homeless individuals through an improved safety net of emergency shelters and by establishing 800 units of permanent supportive housing programs for homeless individuals with long-term needs. It includes opportunities for people with severe mental illness, addictions, HIV/AIDS, and combinations to leave the streets for permanent housing with supports in a "housing first" approach that can be as short as three weeks from first contact on the streets to lease signing.

Los Angeles, California

Unlike the other cities we visited, Los Angeles does not offer a single coordinated system for reducing chronic street homelessness, although the Los Angeles Homeless Services Authority (LAHSA) provides funding and guidance for local nonprofit agencies with programs that address homelessness and coordinates the county's Continuum-of-Care applications, in which most of the county's 88 entitlement jurisdictions participate. What Los Angeles does offer, because of its immense size, are several specialized continuums to meet the needs of frequently underserved subgroups of homeless individuals. We visited three such networks that have been working diligently to end chronic street homelessness—the Veterans Affairs Greater Los Angeles Healthcare System (VAGLAHS), Lamp Community, and a state-funded program known as AB 2034 after its legislative bill number. AB 2034 offers integrated services to mentally ill homeless people, and is administered in Los Angeles by the Los Angeles County Department of Mental Health (LAC-DMH). The Department of Veterans Affairs and Lamp Community both offer comprehensive services for homeless individuals, while the AB 2034 program is primarily a funding and coordinating mechanism for service delivery to prevent homelessness upon release for mentally ill offenders in the county jail population. Although these programs do not all work in concert with each other, there is significant overlap among the systems. For example, Lamp Community is a funded program under AB 2034 and at least one VA partner agency collaborates with Lamp Community to provide housing for Lamp guests. Another organization, Shelter Partnership, collaborates with both the AB 2034 program and Lamp Community by providing technical assistance in many areas including housing development, funding, and grant writing. Shelter Partnership also touches many agencies through its advocacy for homeless individuals and its shelter resource bank, which provides surplus merchandise to homeless agencies.

Philadelphia, Pennsylvania

Mayor Wilson Goode in 1988 created the Office of Services for the Homeless and Adults. The office director eventually became a "homeless czar," a position that the next two mayors have maintained and expanded. The current "czar's" official designation is the Deputy Managing Director for Special Needs Housing. Having someone in this position means there is a single person whose obvious job it is to resolve issues about homeless services. This is the Mayor's point person on homeless issues, held responsible for emergency shelter directly but also expected to interact with mainstream systems and coordinate activities more broadly to address homelessness. 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.

A major focus of Philadelphia's efforts has been people experiencing chronic street homelessness. The network of programs and services developed to encourage people to move from the streets into housing includes extensive outreach, entry-level safe havens and other low demand residences, emergency shelters, transitional housing programs, permanent supportive housing programs of various configurations, and supportive services purchased or supplied directly by city agencies. These latter services include outreach, mental health and substance abuse treatment and intensive case management, and primary health care. Community development corporations (CDCs), including several created and run by homeless assistance

providers, have been active in creating affordable housing that may be occupied by formerly homeless and other persons.

San Diego, California

The Ad Hoc Committee on Downtown Homelessness is San Diego's lead entity for planning and developing resources to end street homelessness in the downtown area. Important differences about San Diego's approach from the community-wide approaches in Philadelphia and Columbus include the informal nature of its lead entity, extensive involvement of the downtown redevelopment agency, Centre City Development Corporation, the Downtown San Diego Partnership, and local law enforcement and the courts in addressing street homelessness, along with the more expected city and county agencies. San Diego's downtown area has undergone redevelopment in recent years, adding a convention center, considerable waterfront development, office buildings, and both market rate and affordable housing. With development of each major downtown section, the homeless street people who frequented the area found themselves displaced. As downtown revitalized, the issue of street homelessness became a focus of discussion. Two police department programs to address street homelessness were already under way when the decision was taken to build a new major league ballpark downtown, in an area that had become the most recent center of street homelessness. The impending ballpark development galvanized San Diego businesses and government agencies to get serious about reducing street homelessness in a responsible way. The network of programs and services developed to encourage people to move from the streets into housing includes outreach, much of which is linked to multi-agency team community policing strategies, emergency shelter, safe havens, and transitional and permanent supportive housing.

Seattle, Washington

Seattle does not have one authority responsible for community-wide strategies to address chronic homelessness. Yet over time, the region has developed an approach to this population as homeless service providers, low-income housing providers, and other agencies involved with chronic street homeless people have cultivated working relationships and capitalized on Federal and local funding opportunities to expand programming. No community-wide coordinating entity controls and manages the full spectrum of resources and services targeting chronic homelessness. Instead, individual nonprofit service providers and government agencies have taken it upon themselves to tackle the problem of chronic street homelessness through specialized service offerings. Some of these agencies work together to meet the needs of their clients while others operate service structures representing the full continuum of care under their own umbrella. Local government leaders—primarily from Seattle and King County—have sponsored various coalitions and task forces over the years that have brought these agencies together to analyze needs, establish priorities, and plan for specific projects and system improvements. Seattle has also responded to Federal funding guidelines concerning programming strategy and initiatives to reduce chronic street homelessness.

Report Organization

We have tried to make this report accessible and practical in several ways. First, we have analyzed the information gathered from the seven communities in cross-cutting chapters that give an overview of a particular topic, including:

- Chapter 2. Elements of Success
- Chapter 3. New Strategies for Programs and Services
- Chapter 4: Assembling Resources and Supports
- Chapter 5. Documenting Progress
- Chapter 6. How Communities Pay For Their New Approaches
- Chapter 7. Policy, Practice, and Research Implications

Second, we present full descriptions (in Appendices A through G) of the seven communities we visited and the ways they have approached the job of ending chronic homelessness. These chapters are structured similarly, beginning with a brief community overview followed by a section recapping three to six practices of potential interest to other jurisdictions, including contact information for each practice and a community contact. So readers can go directly to the source to find out more about practices they might want to examine more closely. Each appendix then has sections for the history of the community's approach, a description of that approach, documentation of progress, details of selected system components, funding, maintaining and enhancing the system, and community relations.

Third, the report's final chapter discusses the implications of the findings for policy, practice and research concerning approaches to reducing chronic homelessness.

CHAPTER 2: ELEMENTS OF SUCCESS

What Does It Take?

This chapter introduces the elements that made efforts to reduce chronic street homelessness successful in the study communities. The following chapters elaborate on important aspects of the elements and their interactions, and end with implications for policy, practice, and research. Although we provide examples in the report chapters, the site report appendices provide a more complete description of how the elements of success work together in a specific community.

Introduction

We identified 11 key elements shared by many of the approaches successfully reducing chronic street homelessness. Five of these elements, in combination, are essential for the strongest approaches. In addition to these five elements, trigger events were an important catalytic element for four of our study communities. Five other elements when present contributed to making an approach stronger. The elements were:

Essential Elements:

- A paradigm shift;
- A clear goal of ending chronic street homelessness;
- Community-wide level of organization;
- Strong leadership and an effective organizational structure; and
- Significant resources from mainstream public agencies.

Catalyst Element:

- Trigger event--capacity to capitalize on triggering events.

Contributing Elements:

- Significant resources from the private sector;
- Commitment and support from elected officials;
- Outcome evaluation mechanisms for program support and improvement;
- Openness to new service approaches; and
- Strategies to minimize negative neighborhood reactions to projects.

Paradigm Shift

Of the five essential elements the most important was a paradigm shift away from traditional homeless program goals and approaches. The old paradigm was that street homeless individuals should be cared for more by charitable, often religious, organizations rather than by mainstream public agencies. The old paradigm relied heavily on emergency shelters, transitional housing, and sobriety-based programs. The old paradigm did not plan, or expect, to end chronic street homelessness.

The new paradigm emphasizes reducing and eventually ending chronic street homelessness through an integrated community-wide approach that includes substantial participation by mainstream public agencies. Part of the paradigm shift was the adoption of an explicit goal to end chronic street homelessness. A second part of the shift was communities recognizing that their existing homeless assistance network was not reducing homelessness and that they had to do something different. Permanent supportive housing programs had to expand, they had to be structured to accommodate people with co-occurring disorders, and clear and simple pathways from the street into housing had to be available. The general homeless service programs may remain, but the new programs, supported with new resources, contribute the most to reaching the goal of ending chronic street homelessness.

The paradigm shift to low-demand permanent supportive housing on a broad scale affects policymakers, funders, program planners, and service providers. The new approaches can be especially challenging for traditional housing developers and social service providers. For mental health and social service providers, low-demand environments mean they cannot require tenants to use services, and they have to deal with both mental health and substance abuse issues, and do so simultaneously. In addition, tenants may not use their services consistently, thus reducing reimbursements on which the providers may rely. For housing providers, a low-demand residence means that tenants may not act as predictably as the property managers might wish. For both, the challenges are as much philosophical as financial, in that the new model demands that they conduct business in ways that had formerly been considered not just impractical but wrong (Grieff, Proscio, and Wilkins, 2003).

A Clear Goal of Ending Chronic Street Homelessness

The most successful community-wide approaches have an explicit goal of ending chronic street homelessness. Two communities, Columbus and Philadelphia, have adopted the goal of ending chronic homelessness, which has turned their priorities away from emergency and even transitional programs. They invest heavily in permanent supportive housing and have stabilized (Columbus) or actually reduced (Philadelphia) the number of emergency shelter beds they support as they work to move persistent shelter stayers (Philadelphia) and street homeless people (both cities) into permanent supportive housing. Columbus follows a “housing first” model for chronic street homeless people, moving them directly from the streets into permanent supportive housing, still with low demands. Philadelphia also tries to bypass emergency shelter for street homeless people, but has focused more on safe havens as an intermediate step toward permanent housing and has only recently begun to develop its first “housing first” program.

San Diego has set itself the goal of ending downtown street homelessness, which is a paradigm shift from the city's earlier ways of dealing with street homeless people. It has some unique ways of addressing street homelessness among chronic inebriates and those with severe mental illness and co-occurring disorders, thanks to a police department that has long been in the forefront of community-oriented and problem-solving policing. San Diego developed several safe havens and is working on developing more permanent supportive housing, with active involvement of the local redevelopment authority and the business community.

Strong Community-Wide Level of Organization

A community-wide level of organization exists when agencies are working together to end chronic street homelessness. As we describe organizational approaches, it helps to think about three levels of contact or working together for two or more agencies—communication, coordination, and collaboration (Konrad, 1996; Melaville and Blank, 1991).[9] These levels are hierarchical—agencies cannot coordinate without communicating, and cannot collaborate unless they both communicate and coordinate. The hierarchy reflects the extent to which agencies pay attention to other agencies, perhaps change their own ways, and make a joint effort to reach shared goals. We use these hierarchical terms very carefully throughout this report and define them as follows:

- **Communication.** Agencies are at the level of communication if they have accurate knowledge of each other's existence, service offerings, and eligible clientele. They will also know how to access each other's services, and may refer clients to each other. They may have shared involvements through meetings, committees and task forces, but they do not have mechanisms in place to support each other's work.

- **Coordination.** Agencies are at the level of coordination if in addition to communicating they support each other's efforts to obtain resources for clients. However, they do not deliberately work to develop shared goals and structure their operations to meet these goals.

- **Collaboration.** Agencies are at the level of collaboration if they work with each other to articulate shared goals, analyze their operations to determine how they may achieve those goals, and make the changes dictated by this analysis.

Of course agencies may relate to each other *below* the level of communication—that is, they do not know these things about each other, do not interact in any way, interact negatively, and/or hold inaccurate views of each other. In most communities at most times, most agencies operate toward each other at the level of communication or worse. This is "business as usual"—it takes work to get beyond it.

Collaboration may mean that agency staff members fulfill new roles or restructured roles; co-locate, team, or otherwise work together with staff of other agencies; merge money, issue joint

[9] Some may prefer the term "cooperate" to "coordinate." We think they mean the same thing in the context of the levels we are describing, and use "coordinate" because it was used in previous work.

requests for proposals, apply together for new money to do new programs in new ways; actively support each others' work; have mutual feedback mechanisms to assure continued appropriate service and program delivery; and/or other mechanisms and activities that reflect a purposeful, well-thought-out commitment to work together to reach common goals. Collaboration can occur between two agencies, or among several agencies. When it extends to include all or most agencies in a community focused on the same population with the same goals, we call it a strong community-wide level of organization.

Strong Leadership and an Effective Organizational Structure

Strong leadership within an effective organizational structure was crucial in the development of successful community-wide approaches.

The Importance of Key People Exercising Leadership

Ultimately, it is people and not systems that make things happen—especially in the beginning. Individual personality and devotion played an extremely important role in the development of the homeless assistance systems we visited. In most of these communities, a few people have been such essential players that it would be hard to imagine that without them the system would be what it is today. They have not all played the same roles. Some have been idealistic inspirers who brought public and private resources to focus on the issue of chronic street homelessness and stick with it, although their role in the actual organization of services might have been slight. Some have been socially and politically skilled organizational masterminds who knew what it would take to get an aggregation of programs and personalities to become a system focused on chronic street homelessness. Some have occupied vitally important positions in government agencies and persisted over many years in bringing those agencies to the table, keeping them there, and seeing that agency resources were applied to homeless issues, including chronic street homelessness. And some have been instrumental in bringing about a significant meeting of minds because they insist on cooperation and accountability, yet have a high tolerance for tension and the ability to channel it toward useful outcomes. It is vital to recognize the role played by people who really care, and who have the ability to translate that caring into structures of cooperating individuals, programs, and agencies. Without them the homeless assistance systems in their communities would look far different.

We cannot describe the actions and effects of all the leaders in all the communities we visited. However, in the Appendices we describe a few leaders and the effects of their leadership, to show the range of positions in which communities have found leadership, and the capacity of people operating in any position to offer leadership and make a difference.

Effective Organizational Structure

The seven communities we visited for this project have very different structures through which they have developed assistance networks for chronically street homeless people. Most of the communities we visited did not begin their endeavors in the homeless arena with a focus on reducing or ending chronic street homelessness. These focused structures evolved, some over

decades, with varying degrees of local political support and local funds. Consequently, they emerged in diverse forms. In Columbus a nonprofit lead agency received strong authority and resources from city, county, business, and philanthropic interests some years before the new initiative. In Philadelphia a combination of a city agency with authority and resources, a Mayor's Task Force, and a voluntary association of all interested parties each play their roles. San Diego developed an informal but well organized group of leaders from relevant positions in the city and county governments and a downtown business association.

What these organizational structures had in common were strong links to elected officials and mainstream governmental and private sector resources. They were not working only in the context of programs for homeless persons. The organizational membership also crossed over city, county, and private sector boundaries. While always coordinating with service providers, the lead organizations did not always include them as full members.

Significant Resources from Mainstream Public Agencies

Ending chronic street homelessness requires resources far beyond those commanded by agencies, programs, and networks exclusively focused on working with homeless people. Major commitments of resources are needed from mainstream public housing, health, mental health, substance abuse, welfare and other agencies.

Mainstream public agencies have four roles to play with respect to ending chronic homelessness. These are facilitating homeless people's access to their services, developing specialty approaches, establishing funding priorities, and contributing leadership of various types.

All of the communities we visited for this study have significant involvement of mainstream public agencies; some have major, sustained commitments and participation in leadership to end chronic homelessness. Most communities in the nation enjoy considerably less mainstream agency involvement, and could benefit from increasing the effectiveness of such partnerships.

Getting mainstream public agencies to the "homeless" table takes planning, persistence, and sometimes power. It also often takes being able to present the case for their involvement as a mutually beneficial situation in which mainstream agencies are able to serve "their own" clients better by joining forces with the local homeless assistance network. The mainstream agencies whose own missions coincide most closely with the goal of ending chronic homelessness, and hence the ones that will have the greatest incentive to work with homeless assistance networks toward that end, include housing and community/neighborhood/economic development agencies; health, mental health, and substance abuse agencies; and to an increasing extent, corrections agencies.

Ability to Capitalize on Trigger Events

In several of the communities we visited, "trigger events" stimulated re-examination of the community's approach to chronic street homelessness. The experiences of these communities in turning trigger events with potentially disastrous consequences for homeless people into

opportunities for growth and change provide examples for other communities seeking to develop new approaches to chronic street homelessness.

In two communities the trigger event was proposed development on land that was "home" to many homeless people. In Columbus it was prospective redevelopment of the Scioto Peninsula along Columbus' riverfront; in San Diego it was the prospect of a new downtown ballpark. In two other communities the trigger event was a proposed city ordinance to criminalize street homelessness. One city, Philadelphia, actually passed such an ordinance but not before it had undergone considerable revision and resources had been appropriated to ameliorate its harshest conditions. In the other city, Birmingham, the ordinance was defeated but mobilizing to be sure that happened stimulated some significant forward movement in addressing street homelessness.

Significant Involvement of the Private Sector

In addition to governmental agencies, we found that private businesses and foundations were often mainstream organizations making significant contributions to reducing street homelessness. Their involvement is described more fully in Chapter 4 on assembling resources and supports, but we note a few examples here.

Private Businesses

Many of the communities we visited have been promoting central city redevelopment. In the past many downtown businesses and developers have had a kneejerk reaction against providing services to their neighborhood's street homeless people, fearing that services would attract more homeless individuals. However, in four of our communities, businesses and their associations took leadership roles in programs providing services to help end street homelessness. These were Birmingham, Columbus, Philadelphia, and San Diego.

In the late 1990s the Birmingham City Council was considering an ordinance that would have banned "urban camping," a measure clearly aimed at street homeless people in the downtown area. The proposal galvanized support for an alternative—active outreach programs to bring people off the streets without criminalizing them. Advocates of the ordinance complained that street homeless people were creating problems such as panhandling, litter, poor sanitation, and safety concerns. Advocates for the homeless population wanted to develop a more constructive and less punitive approach. The mayor created a Task Force on Homelessness to address the issue. As an outgrowth of the Task Force, the City Action Partnership (CAP)—the city's Business Improvement District—funded an assistance-oriented uniformed patrol. CAP officers provide services downtown that range from directing shoppers to stores to helping case managers locate homeless individuals when they need to deliver medications or other services. CAP prepares pamphlets listing resources by needs with addresses and maps for food, shelter, clothing, and employment services. CAP officers routinely coordinate with outreach workers from several programs to facilitate assistance to street homeless people.

Columbus businesses play a major role in Community Shelter Board (CSB) fundraising and strategic planning. Business leaders predominate on the CSB's governing board of trustees and have led it to adopt an outcomes-based funding model that has won the respect of agencies and

the general public. CSB leverages public grants with corporate fund raising, and private dollars make up over 20 percent of CSB's annual revenue. The private funding helps support innovative programs that have brought Columbus national recognition as a community with creative and effective homeless assistance programs.

Foundations and Nonprofit Organizations

Organizations such as the United Way, which address a wide range of community needs, have the potential to make significant contributions to a community's efforts to end chronic homelessness. In Columbus the United Way helps fund supportive housing for Rebuilding Lives. In Columbus United Way also supports emergency shelter and other CSB initiatives including Rebuilding Lives. The total United Way commitment to the CSB is $1.0 million. In Boston the United Way funded $4 million of emergency shelter, transitional housing, and support services; cash, and in-kind donations from businesses, religious and civic organizations totaled over $3.6 million; and over 50 foundations contributed over $7 million. Cash donations from individuals to programs were also substantial, totaling an additional $12.5 million.

Commitment and Support from Elected Officials

Commitment and support from mayors, city and county councils, and other elected officials can be a significant contributing element in the progress of community-wide efforts toward reducing chronic homelessness. In at least three of our sites, mainstream city officials and business leaders played a seminal role in initiating collaborative programs to end homelessness. Philadelphia's Mayor Goode created an Office of Services for the Homeless and Adults and appointed a de facto "czar" of homeless assistance programs who orchestrated planning and implementing a wide set of services; subsequent mayors maintained and expanded these efforts. Boston's Mayor Menino placed ending homelessness high on his agenda, created a homeless planning committee and pressed mainstream city agencies to become involved. In San Diego mainstream business leaders and city officials involved in mitigating the potential displacement of street homeless persons expected from the construction of a new baseball stadium were among the founders of the interagency Ad Hoc Committee on Downtown Homelessness, which is developing solutions involving housing and services for the special needs homeless population.

State and national political environments also have a significant impact on community approaches to reducing chronic street homelessness. This may be especially true at the state level, which requires a wider mobilization of support than city or county initiatives. Many state assemblies and governors would not follow the examples of California and Massachusetts in making large fiscal commitments to programs to end homelessness. Winning support from elected officials for state and other mainstream funding of programs to end homelessness is greatly facilitated by demonstrations of positive outcomes and cost effectiveness. The potential savings from innovative programs may be demonstrated by developing good estimates of how much homeless persons are costing the public through conventional emergency services and law enforcement programs.

Outcome Evaluation Mechanisms for Program Support and Improvement

Agencies and planners in the communities we visited use data to demonstrate that programs are operating as designed and having successful impacts. The primary types of data we found to document progress in ending chronic street homelessness were:

- Changes in the number of people found on the streets from year to year;
- Increases in the number and percentage of chronically street homeless people who have moved into permanent housing;
- Reductions in costs of providing emergency health, mental health, and shelter services;
- Reductions in days homeless, hospitalized, or incarcerated; and
- Less recidivism in the homeless assistance system, as documented by street counts, program operations and outcome data, and interagency homeless management information system (HMIS) data.

Some street counts were greatly enhanced by asking the homeless individuals background questions. We found examples of communities maintaining information on services provided to individuals in linked emergency shelter and outreach databases, which help in monitoring program activity, evaluating impacts, assessing needs, and planning programs. Some communities also used information systems to demonstrate the incurred costs of providing mainstream emergency services to chronic street homeless individuals—money that could be saved by effective programs to end homelessness. Good administrative record information on homeless-related program operations and outcomes also provide support for program planning, policy design, and system development. In addition, a good homeless management information system can facilitate case management by providing workers access to better case history information and knowledge of what other programs may be serving the client. Finally, some agencies and communities are using analyses based on sound data to support community relations and program advocacy work.

Openness to New Service Approaches

Contributing to the progress of the study communities was their openness to new service approaches. Ending chronic street homelessness requires new approaches to homeless service delivery. It requires new ways of helping people (such as harm reduction), new ways of providing old services (such as housing first), new agency relationships (such as joint provision of mental health and substance abuse services, or agency mergers), and new investments in effective approaches (such as permanent supportive housing). It can also involve redesigning service systems to create better matches between people's needs and the services they receive. One such shift involves reserving emergency shelter and other forms of short-term assistance for those with acute needs who are homeless for the first time or as the result of a crisis, while those with chronic needs receive longer-term supports (including effective treatment for co-occurring mental illness and substance abuse) and permanent housing. (Columbus and Philadelphia are

using this strategy.) Reducing chronic street homelessness also results from effective outreach and engagement strategies, especially those that are able to link people directly to housing. Finally, new approaches to prevention can prevent people with chronic disabilities from becoming homeless in the first place.

Strategies to Minimize Negative Neighborhood Reactions to Locating Projects

Frequently, some neighborhood residents resist locating projects for homeless persons in their neighborhood—the "not in my backyard" (NIMBY) reaction. Communities can minimize NIMBY by establishing standards that include looking for favorable locations, planning appropriate structures and activities, and involving the neighborhood in planning. However, the success of these mitigating activities is affected by economic, cultural, and political factors beyond the control of programs. Planning and opening new sites are especially volatile activities that require agencies to establish good communication with neighbors and work to mitigate potential adverse effects. Public meetings with frank descriptions of the project, testimony by neighbors of similar projects, and opportunities for people to express their concerns are essential. (Columbus, Philadelphia, and Seattle employ the strategy of using testimony by people who had seen past projects start up in their neighborhoods.) Forming advisory committees with neighbor representation that address how to resolve problems is also crucial. A good practice is to select locations where rezoning is not necessary and where facilities can be built that improve the neighborhood by removing eyesores and trouble spots. Our sites were able to implement this practice without concentrating their projects in the lowest income areas.

Communities should also have policies that ensure programs are good neighbors once a facility opens. Good neighbor agreements can help promote community relations in the areas of property maintenance, neighborhood codes of conduct, community safety, communication and information, and agreement monitoring and compliance. Agencies can foster better community relations through open houses, making meeting rooms available to neighborhood organizations, participating in neighborhood watch projects and involving the public in fix up and fund raising activities. Staff members can educate neighbors on ways of interacting with homeless individuals and ways of addressing issues they create as a group.

Homeless and formerly homeless individuals can be effective spokespersons to call public attention to their concerns and help develop programs to remedy their problems. These individuals can personalize and associate a human face with the issues by speaking at public meetings.

Conclusions

This chapter focused on the elements of success separately to provide a clear portrayal of each, however, the combined effects of the elements are what power the greatest community progress toward the goal of ending chronic street homelessness. Of particular importance is the paradigm shift toward a community-wide focus on eliminating chronic street homelessness through mainstream public agency programs including permanent supportive housing.

As we repeatedly stress, this is an experimental time for programs to reduce homelessness, new approaches are being tried and the evaluations of their success are still in emergent stages. Nevertheless, our analyses of the seven study sites, as well as information gathered about other locations during the site selection process, suggest that certain elements are essential for a community to make significant progress toward the goal of ending homelessness. The essential elements were: the paradigm shift; a clear goal of ending chronic street homelessness; community-wide level of organization; strong leadership and an effective organizational structure; and significant resources from mainstream public agencies. At most of our sites, catalytic trigger events combined with a capacity to capitalize on the event led to significant improvements in the community's approach.

We also found the following elements contributed to making a community's approach more effective: significant resources from the private sector; commitment and support from elected officials; outcome evaluation mechanisms for program support and improvement; openness to new service approaches; and strategies to minimize negative neighborhood reactions to projects. Our list of elements emerged and changed over the course of the study, and we do not view it as exhaustive and immutable. It is a snapshot of what we saw happening at this time. The next chapter of the report presents some specific strategies that the communities were incorporating into their approaches for reducing chronic homelessness.

CHAPTER 3: NEW STRATEGIES FOR PROGRAMS AND SERVICES

The number and variety of homeless assistance programs has grown tremendously since the late 1980s and early 1990s, becoming a $2 billion a year endeavor today (National Alliance to End Homelessness, 2000). Yet chronic homelessness remains a serious problem in many communities across the country, despite the system that has been developed to date. As communities come to recognize this reality, they may abandon their old paradigms of what works and shift to new approaches. We described in Chapter 2 how some communities have made this paradigm shift in terms of their general goals and methods. In this chapter we discuss more specifically some successful strategies for reducing chronic homelessness.

Looking at the characteristics of most chronically homeless people, it is obvious that most have serious mental illnesses, substance abuse disorders, HIV/AIDS, or physical disabilities. Many have more than one of these major problems, any one of which frequently results in their being turned away from many traditional homeless assistance programs. Further, they have been homeless a long time, often have no ties to family, and rarely have any resources. Their skills are oriented toward survival on the streets, not to living in housing.

Any effort that expects to reduce chronic homelessness to any significant degree must attract and hold the target population—something that traditional approaches have often failed to do, or the people would not still be homeless. First and foremost, there have to be effective ways to contact and recruit chronically homeless people into programs. Equally important, there must be something to offer them that they will take—the programs need to fit the people, rather than the reverse.

Outreach, housing, and supportive services are obvious components of a solution, but as existing versions of these elements are not doing the job, or not all of the job, new versions have had to be developed. Preventive efforts are also increasingly part of the picture, in the form of planning and providing housing and supports for people at high risk of homelessness on being discharged from institutions. More and more communities have recognized that their outreach, housing, supportive services, and discharge planning must incorporate the following abilities if they are going to be part of the solution to chronic homelessness:

- The ability to attract people with addictions. Many chronically homeless people are initially unwilling to commit to sobriety. If programs cannot work with people who are still using alcohol and drugs, they cannot attract the hard-core street homeless people.

- The ability to attract people with serious mental illnesses. Many chronically homeless people have serious mental illnesses that have affected their willingness to use shelters. They often find shelters intolerable because of overcrowding, or feel vulnerable and threatened by fellow residents, or the shelters themselves will not serve them because their symptoms are too disruptive.

- The willingness and ability to accept and work with people with co-occurring disorders. Too many chronically homeless people have been caught in the demands of single-focus

agencies, within both homeless-specific and mainstream systems. Many agencies will not work with people's mental illness until they stop using substances, or will not work with their substance abuse until their psychiatric symptoms are under control.

At the same time communities have been seeing the advantages of interagency databases, multi-agency teams, multi-purpose service centers, and processes to increase access to mainstream agencies. In this chapter, we examine the ways that programs and services can reduce chronic homelessness by accommodating to the needs of the people they want to reach.

Outreach

Outreach and engagement are the first steps involved in connecting with street homeless people, bringing them off the streets, and linking them with other portions of the service system. Most chronically homeless people are unlikely to connect with even the best housing programs unless these first contacts are effective. Our study communities provide several examples of new strategies to make outreach more effective.

Philadelphia's Outreach Coordination Center

Philadelphia's Outreach Coordination Center (OCC) developed in 1998 as part of the city's commitment to develop systematic approaches to ending street homelessness following enactment of a Sidewalk Behavior Ordinance. Its innovative aspects include outreach teams from several agencies working together and coordinated through a single entity, the OCC; daytime rather than nighttime outreach; direct access to safe havens and other low demand residences that were developed simultaneously; full cooperation and backup from city health, mental health, and substance abuse agencies; and a comprehensive database. The OCC also operates in an environment with existing and increasing permanent supportive housing resources.

The OCC offers a coordinated point of contact for street homeless people. Outreach workers linked to the OCC are able to offer a wide array of services. Even more important, at a meeting of 17 outreach workers, all said they felt confident that the people they contact will receive the services if they are willing to accept them. One does not always find such confidence among outreach workers in other cities, as the services often are not sufficient to meet demand, or not geared to street homeless people.

The OCC coordinates most of the city's outreach efforts, including a 24-hour homeless hotline, one comprehensive response team, two mental health specialty teams, two substance abuse specialty teams (one peer and one professional), and emergency backup from city agencies. The teams cover center city and west and southwest Philadelphia, where the majority of chronically homeless individuals who avoid shelters are found. In addition to these regular street "beats," OCC outreach workers respond to hotline calls from businesses, civic and neighborhood associations, and private citizens about homeless people in need. OCC has a case management component and access to the city's list of available shelter beds. Representatives of all outreach teams meet monthly to review activities and needs. Through radio contact with teams, the OCC facilitates resolution of the immediate needs of any homeless person in contact with an outreach worker on the street that the worker cannot handle independently. OCC workers have also

conducted street counts of homeless people every quarter since 1998, and are now doing it monthly.

Since its inception, OCC has maintained a database of all persons contacted by the participating outreach teams, averaging about 2,000 unduplicated individuals annually. OCC teams repeatedly see about one-fourth of those they contact over a span of years. These are the chronic street homeless people the teams try hardest to induce off the streets. The database provides a history of their service receipt and an excellent picture of who they are and what their needs are. Through common identifiers, the OCC database can be linked with the city's database that chronicles most emergency shelter and some transitional housing stays. Using this link, OCC workers can see whether any of their consumers have used shelter, and how much. Conversely, the city's analysts can assess the proportion of people making heavy use of emergency shelter who are also well known to outreach workers.

San Diego's Police-Based Outreach Teams

San Diego city has two innovative outreach programs developed by and located in the San Diego Police Department—the Homeless Outreach Team (HOT) and the Serial Inebriate Program (SIP). Both can offer housing options that bypass emergency shelter, connecting street homeless people directly to safe havens, transitional housing programs, or residential treatment settings.

HOT combines a police officer, a mental health worker, and a benefits eligibility technician in outreach teams operating during the day and evening hours to engage mentally ill street people and connect them to services. It also has access to "dedicated" safe haven beds to which it can bring people if they are willing to leave the streets. The team approaches people on the street or at homeless services. Each HOT team member's skills and agency affiliation enhances those of the others, to make the combination more effective than any one or two acting without the others. Because they combine police and mental health expertise and authority, they are the only outreach teams on the streets that have the ability to remove people either voluntarily or involuntarily, in addition to building rapport and making referrals. The mental health worker opens up options for care that the police officer could not access, the police officer adds an element of protection and authority that the mental health worker could not command, and the eligibility technician offers connection to or reinstatement of benefits that serves as a positive inducement for street people to accept services. HOT focuses on people who are likely to have mental illness as a primary problem and are not likely to get arrested. HOT gets them into treatment facilities, safe havens, board and care facilities, and skilled nursing facilities, depending on their level and type of need. When HOT encounters alcoholics or other substance abusers it offers rehabilitation and help getting into appropriate care for those who are interested.

SIP comes into play for chronic inebriates who do not voluntarily accept treatment. SIP is a collaboration of four city and five county agencies, including law enforcement, the city attorney's office, the public defender, the Superior Court, health care, and homeless agencies working as a team in a court context. Mental Health System, Inc. is contracted to coordinate the program. SIP follows the Drug Court model in offering addicts a choice of jail or treatment, after assuring that the community was willing to pay for treatment if requested. SIP's focus is on chronic alcoholics who populate the downtown streets of San Diego. Police officers arrest

chronic street alcoholics for public drunkenness, and bring them to jail and subsequently to court. Once arraigned, caseworkers approach each person, conduct assessments, and offer treatment plus transitional housing as an alternative to six months in jail (the maximum allowed under California state law) to those who pass the assessment. Many people eventually accept the offer, although they may first serve a full jail sentence or even two before they are convinced to try. The court monitors treatment compliance; leaving treatment means returning to jail. This approach is "something different" for this population, for which the revolving door of arrest and detoxification was not working. The approach is also designed to reduce the impact of public drunkenness on the community.

Other Outreach Efforts with Direct Housing Connections

In Los Angeles we also found innovative outreach efforts focused on well-defined subpopulations of chronically homeless people—veterans, and mentally ill criminal offenders. Both efforts were part of larger programs that included housing and supportive services as well as health, mental health, and other types of care. Their involvement in a collaborative network of public and private agencies and their connection to housing should make them interesting to other communities.

The Veterans Affairs Greater Los Angeles Healthcare System has used Health Care for Homeless Veterans programs to conduct outreach to severely mentally ill veterans to link them with VA clinical services, contracted residential treatment programs, and contracted transitional or permanent supported housing programs. The VA operates some of these programs on its own campus, and has developed an elaborate system of contracts with nonprofit agencies to supply a variety of housing and service options. Also in Los Angeles, the County Sheriff's and Mental Health Departments and nonprofit mental health providers collaborate in a partially state-funded program to prevent first or repeat homelessness among inmates of the county jail who have a serious mental illness. The program begins with integrated outreach focused on individuals who are homeless, at risk of homelessness or incarceration, and who have a serious mental illness.

In Seattle, the Downtown Emergency Service Center (DESC) operates many programs and services that make it a mini-continuum in its own right, all focused on street homeless people. One of its programs is outreach, which is able to connect street homeless people to the various DESC offerings including transitional and permanent supportive housing. DESC's Homeless, Outreach, Stabilization, and Transition Project (HOST) has Outreach and Engagement Specialists who work within specific geographic regions or in other targeted programs or facilities such as drop-in centers for women, local hospitals, and jails to find chronically street homeless people and help them connect to services and housing. Sometimes they approach potential clients directly and other times they develop an engagement plan with staff members from other agencies who have had interactions with the person. HOST staff members receive referrals from concerned citizens, jail, the Department of Social and Health Services, the mental health court, hospitals, the Harborview Medical Center Crisis Triage Unit, the Seattle Public Library, family members, and other mental health professionals, shelters, and drop-in centers.

Other Outreach Efforts Without Direct Housing Connections

Every community we visited has outreach and engagement programs that are less fortunate than those already mentioned, in that they have no direct access to housing options for the street people they contact. However successful the outreach to people living on the streets, its value is limited in terms of ending chronic street homelessness if the community does not have adequate permanent supportive housing or safe haven resources. Large congregate emergency shelters are unlikely to succeed in breaking the cycle of chronic street homelessness among people with multiple disabilities. Traditional shelters also tend to be places where chronically homeless street people are not willing to go and stay for extended periods of time. During a focus group discussion of formerly chronically homeless men who were housed in various PSH programs, the group was asked what they would do in the absence of the program. Interestingly, several commented that they would never want to go back to a shelter—they were more willing to return to the streets than to a shelter.

Nevertheless, many outreach programs are able to help street homeless people in a variety of ways even when they are not able to offer them a home. In addition to providing a regular contact and a reliable friend on the street, they are able to ease the difficulties of street living. We describe one such program here, of several we encountered during site visits—Seattle's Mental Health Chaplaincy.

The Mental Health Chaplaincy provides an outreach and engagement program for the most difficult and most vulnerable mentally ill street homeless people. Its outreach strategy involves long-term engagement with clients until they receive benefits and are comfortable entering into service or housing programs. The Chaplaincy program helped to develop and uses the Relational Outreach and Engagement Model currently promulgated by the National Health Care for the Homeless Council.[10] This model has four phases to working with homeless individuals: approach, companionship, partnership, and mutuality, which revolve around building and shaping a relationship with the client. The focus is to build trust with street people until they are ready to access services on their own terms. The Mental Health Chaplaincy typically will link its clients to other Seattle service providers such as Harborview Mental Health, local emergency rooms, the Downtown Emergency Service Center, and the Health Care for the Homeless Network.

New Approaches to Permanent Supportive Housing

The ultimate solution for ending homelessness of any type is housing. For chronically homeless people with disabilities, though, simple housing is not enough. Most people who have been living on the streets for many years have multiple barriers to independent living and are likely to need various treatment and support services for many years. A major innovative step in reducing chronic homelessness among people with disabilities was taken in the early 1990s (and even earlier in some places such as Philadelphia), when models of permanent housing with attached supportive services were developed. Demonstration studies sponsored by NIMH (Shern et al., 1997) showed that permanent supportive housing (PSH) was very successful at stabilizing its

[10] The curriculum can be found at: http://www.nhchc.org.

tenants in housing, with retention rates at about 85 percent after two years or more. As PSH programs evolved, they embodied most or all of a set of principles since articulated by the Technical Assistance Collaborative as:[11]

- The housing is affordable for people with SSI level incomes (residents usually pay 30 percent of income or about $160 per month);
- There is choice and control over living environment;
- The housing must be permanent (tenant/landlord laws apply, but refusal to participate in services is not grounds for eviction);
- The housing is "unbundled" from but linked to services;
- The supports are flexible and individualized: not defined by a "program"; and
- There is integration of services, personal control, accessibility, and autonomy.

Although it is not a principle, in the past a characteristic of many PSH programs has been that prospective tenants had to be "housing ready." This almost always meant "clean and sober," stabilized on medications if mental illness was an issue, and familiar with the rudiments of housekeeping. As a consequence, very few people entered these programs directly from the streets. The usual routes could be long, through emergency shelter and transitional housing programs. Another consequence is that as of 2002, a surprisingly small proportion of PSH units appear to be occupied by people that we would consider to have been chronically homeless—only about 20 percent, according to a recent Corporation for Supportive Housing estimate.[12]

Thus, although some chronically homeless disabled people are being served in the PSH programs developed during the past decade, the people on whom this project focuses are, by definition, those for whom traditional programs and services have not produced solutions to homelessness. One group in particular, people with co-occurring mental illness and substance abuse, has traditionally been seen as "resistant to treatment." They have been beyond the reach of many traditional homeless service providers, in part because they are "difficult" but also in part because providers have not been interested in trying to serve them, having enough easier people to serve. But as they comprise a significant share of street homeless people, communities committed to reducing street homelessness had to find ways to serve them. Their resistance even to PSH as it was being offered, and also the resistance of many providers to serving them, has challenged communities to develop permanent supportive housing operating on some new, or additional, principles. In the communities we visited, these include:

- Housing first models that place people directly from the streets into permanent housing units with appropriate supportive services;

---

[11] These are drawn from "Affordable and Accessible Housing: A National Perspective," presentation by Emily Cooper, Technical Assistance Collaborative, Inc. to the Regional Housing Forum, November 13, 2002.
[12] Wilkins, Carol. Presentation at Ending Long-Term Homelessness: Taking Supportive Housing to Scale conference, Columbus, Ohio, May 13-15, 2002.

- Safe havens, a variation of Housing First that offers "as long as you need it" accommodation but that nevertheless is not intended to be permanent;
- Low demand—breaking the linkage between housing and service use or acceptance; and
- Harm reduction or "abstinence encouraged" approaches to sobriety.

Housing First Models

Housing First models place people directly from the streets into permanent housing units with appropriate supportive services, with no requirement that they be "housing ready." The sole requirements are those that are usually expected of any renter—pay the rent, do not destroy the property, and refrain from violence. Housing is provided immediately, with few, if any, demands with respect to abstinence or accepting mental health treatment or other types of care, although these are offered and available. As one advocate for PSH and Housing First puts it, "we give them a key to their own door; they don't have to leave it open, but we knock often." Proponents of this approach argue that it is much easier to work on substance abuse and mental health issues when clients are stably housed than when they are on the streets or in a shelter. More and more communities are attempting to offer chronically homeless street people Housing First. Among the communities we visited, Columbus, San Diego, Seattle, and two of the Los Angeles sites offer Housing First programs, and Philadelphia is just starting to do so. Also, a growing body of research documents the success of Housing First models at keeping even the most disabled homeless people housed, and also saves some public costs for crisis emergency services (Anderson et al; 2000; Culhane, Metraux and Hadley, 2002; Martinez and Burt, 2003; Tsemberis and Eisenberg, 2000).

Housing First programs are very popular among outreach workers, case managers, and their clients. Those we interviewed as part of this study reported that they could easily fill their permanent supportive housing programs with chronic street homeless people, and the tenants in such programs are very positive about them. Of course, slots in permanent housing programs are not always available. In Columbus, Ohio, recruitment for these programs tends to happen when a program first opens for occupancy. Turnover among tenants has been much lower than expected, so the most common way in is at start-up. Also in San Diego, efforts to recruit chronically homeless people directly from the streets into PSH (or safe havens when no PSH unit is immediately available) are ongoing and successful.

Safe Havens

"Safe haven" is a term used by HUD and others to describe a special type of housing program for chronically homeless people with serious mental illness, often with co-occurring substance abuse. A safe haven program usually takes a Housing First approach, and it may be either transitional or permanent housing. Most safe haven programs we talked with will let residents stay "as long as it takes" for them to feel comfortable moving on. Data from Philadelphia's four safe havens indicate that the average length of stay is 1.3 years, and that most residents move on to PSH or to housing in the community, either independently or with family. Three of the

communities we visited, Philadelphia, San Diego, and Seattle, have safe havens, and Birmingham will open one in December 2003. In both Philadelphia and San Diego, capacity and turnover appear to be such that a safe haven bed is usually available when a street homeless person is ready and willing to take it. Seattle's safe haven is usually full, however, and not able to accommodate the many more people on the streets who could and would use this type of program.

Low Demand—Breaking the Linkage Between Housing and Service Acceptance

A key component of Housing First and safe haven models is their willingness to accept tenants without requiring that they participate in services. As already mentioned, the only demand placed on tenants in these programs is that they adhere to the conditions of their lease (Housing First), or the equivalent without a lease (safe haven). An example of a restrictive condition that remains is that projects funded by HUD bar the use of illegal drugs on the premises. Another restriction is that some projects require clients to participate in a representative payee program for the purpose of assuring that the rent is paid. In many ways, the low demand concept entails significant changes that affect policymakers, funders, program planners, and service providers. The new approaches can be especially challenging for traditional housing developers and social service providers. For mental health and social service providers, low demand environments mean that a tenant does not have to use services, or use them consistently. Providers have to *attract* tenants to services, so the services, and the providers, have to be attractive *to the very resistant people* they are trying to serve. In addition, service providers may not be able to count on a predictable level of reimbursements for services, upon which their budgets may depend. For housing providers, low demand programs may mean that tenants may not always act as predictably as property managers might wish, and that housing managers may have to deal directly with tenants rather than going through service providers. For both, the challenges are as much philosophical as financial, because low demand housing sometimes means that they must now conduct business in ways that had formerly been considered not just impractical but wrong.[13] Much of the debate surrounding Housing First and safe haven models concerns how substance abuse and mental health issues are handled, to which we now turn.

New Approaches to Addressing Substance Abuse

A central tenet of low demand housing is not requiring sobriety. These sobriety "preferred but not required" conditions often translate into a "no use on the premises" rule for projects that use HUD funds. The terms "low" or "no" demand housing describe programs where abstinence may be encouraged but is not required or enforced. This is one aspect of a more general movement known as "harm reduction" within the broader health treatment community of which programs for disabled homeless people are a part.

[13] Grieff, Debbie, Tony Proscio, and Carol Wilkins, "What Systems Change Is and Why It Matters to Supportive Housing," A preview from an upcoming CSH publication, Corporation for Supportive Housing, January 2003, p. 13. Accessed July 7, 2003 online at http://documents.csh.org/documents/Communications/SystemsChangePreview.pdf.

Harm Reduction

Harm reduction may guide the operations of either permanent or transitional supportive housing. Harm reduction is a set of practical strategies designed to reduce the negative consequences of drug use by promoting first safer use, then managed use, and finally abstinence if people can do it.[14]

In their position statement on housing options for individuals with serious mental illness, the American Association of Community Psychiatrists advocates a full range of community-based housing types, including the following:

- **"Abstinence-expected ("dry") housing**: This model is most appropriate for individuals with substance disorders who choose abstinence, and who want to live in a sober group setting to support their achievement of abstinence. Such models may range from typical staffed group homes to supported independent group sober living. In all these settings, any substance use is a program violation, but consequences are usually focused and temporary, rather than "one strike and you're out."

- **Abstinence-encouraged ("damp") housing**: This model is most appropriate for individuals who recognize their need to limit use and are willing to live in a supported setting where uncontrolled use by themselves and others is actively discouraged. However, they are not ready or willing to be abstinent. Interventions focus on dangerous behavior, rather than substance use per se. Motivational enhancement interventions are usually built into program design.

- **Consumer-choice ("wet") housing**: This model has had demonstrated effectiveness in preventing homelessness among individuals with persistent homeless status and serious psychiatric disability (Tsemberis and Eisenberg, 2000). The usual approach is to provide independent supported housing with case management (or ACT) wrap-around services, focused on housing retention. The consumer can use substances as he chooses (though recommended otherwise) except to the extent that use-related behavior specifically interferes with housing retention. Pre-motivational and motivational interventions are incorporated into the overall treatment approach."[15]

Not surprisingly, the last two options are controversial, and projects that use HUD funds cannot permit illegal drug use on the premises. Nevertheless, for people with long-term deeply rooted problems, these options appear to be among the ones that work best, in part because they are the ones that this group of people is willing to try, and in part because the approach to services is one they can live with. Participants in focus groups for this project repeatedly stressed the importance of having control over their own service uptake, and that staff respect their right to move at their own pace. Harm reduction programs have been the last type of PSH to appear in many

[14] Drawn from the Harm Reduction Coalition's website http://www.harmreduction.org/prince.html, accessed July 7, 2003.

[15] See Kenneth Minkoff, MD, "AACP Position Statement on Housing Options for Individuals with Serious and Persistent Mental Illness (SPMI)," June 18, 2001. Accessed on July 7, 2003 at: http://www.wpic.pitt.edu/aacp/finds/Housing-Revised.pdf.

communities, and in many areas programs using this approach are not available at all. Yet it has great potential for preventing and ending homelessness, especially among people who have "failed" sober group living.

The fundamental belief underlying Housing First and most other low demand housing strategies is that individuals should not be left homeless simply because they are unable or unwilling to maintain abstinence. Among the communities we visited, Columbus and Seattle have extensive harm reduction-based programs, Lamp in Los Angeles was an early Housing First and harm reduction developer, Philadelphia's safe havens and many of its PSH programs operate on a harm reduction model, as will the Housing First program it is getting ready to open, and San Diego has similar housing opportunities.

Other Approaches

In addition to harm reduction programs, we observed a number of other innovative intervention strategies for homeless chronic substance abusers during our site visits for this project. Two are expansions and enhancements of traditional detoxification programs, while a third combines community service and employment expectations with traditional clean and sober requirements. A fourth approach, San Diego's Serial Inebriate Program, has already been described in the Outreach section of this chapter.

The two examples of expanding traditional detoxification programs are Maryhaven Engagement Center in Columbus, Ohio and the Dutch Shisler Sobering Center in Seattle. People may walk into these programs on their own, or be brought by outreach workers or law enforcement officials. Once there, they are strongly encouraged to stay and sober up and then to move on to longer residential treatment programs. These communities have made an effort to develop extended residential treatment, recognizing that without it detox is usually just a revolving door.

Several programs for homeless chronic substance abusers in Birmingham take a very different tack. They require sobriety, community service, and employment, as well as attendance at regular meetings related to staying clean. Community service begins immediately, at a level of 10-20 hours a week, and clearly functions as much more than a way to keep participants occupied. In a large focus group held in Birmingham with people who had been chronically homeless, most said that being required to perform community service was the first time in their lives that anyone had treated them as if they had something to contribute, and as if they had a community that would care what they gave. This was the turning point and beginning of self-esteem for most people at the focus group. Community service continues even after employment begins, which occurs as soon as a person's sobriety indicates it is feasible. Programs have developed extensive networks of employers willing to hire program participants, and several programs said finding work for people was not a problem. Working continues the self-esteem boost begun by community service, and puts people on the road to self-sufficiency. Program graduates often help locate jobs, and some have become employers themselves, as well as organizers of community service opportunities. Noting that participants frequently could not sustain sobriety after residential treatment if they went back into the community, several Birmingham substance abuse programs developed transitional housing and affordable private housing. One has become the biggest affordable housing developer in the area, serving formerly

homeless and never homeless low-income people alike. In Birmingham, PSH is reserved largely for those with serious mental illness, with or without co-occurring disorders, and people with AIDS. Chronic substance abusers are expected to work from very early in their recovery, to contribute to the cost of their program (they pay for both emergency shelter and transitional housing as soon as they are working), and ultimately to become self-sufficient.

Housing Configurations and Supportive Services

PSH housing configurations vary a great deal, which in turn affects decisions about how to offer supportive services and whether it is also possible to create a supportive community of tenants. Completely scattered-site configurations (program participants occupy apartments wherever they can find them, usually no more than one or two in any single building) make demands on service delivery that are quite different from the opportunities offered by operating a dedicated building (one in which all tenants are part of the program). Other housing configurations include "clustered scattered" and mixed-use buildings. "Clustered" programs may operate a six- or eight-unit building completely occupied by program participants on a block with no other such buildings. Mixed-use buildings are usually large (100-300 units), with 20 to 25 percent of units set aside for program tenants. Other tenants may be never-homeless disabled singles, as is the case at Sunshine Terrace in Columbus, a public housing authority 811 building.[16] Or they may be "regular" low-income households, as in the unit set-asides in the San Diego buildings developed by Centre City Redevelopment Authority. Set-aside units may be master-leased by a PSH program or accessed through an understanding with landlords that on average, every fourth vacant unit will go to a program client. Another variation on "mixed" use is a building occupied entirely by formerly homeless people, in which tenants may include both singles and families.

Support services in these programs may include case management, service referrals, instruction in basic life skills, alcohol/drug abuse treatment, mental health treatment, health care (medical, dental, vision, and pharmaceutical), AIDS-related treatments, income support, education, employment and training assistance, communication services (telephone, voice mail, e-mail, Internet access), transportation, clothing, child care, and legal services. The exact mix of services and who provides them can vary greatly from one community to another, and even from one program to another in the same community. This variation is partly a result of who does what in different communities, and partly due to the "piece-it-together-as-best-you-can" nature of assembling the many types of people, agencies, and funding streams needed to create a successful supportive housing program. However, the variety is also partly deliberate, as programs and communities sort out the most effective distribution of responsibilities among housing developers, property managers, on-site program service staff, and services delivered on and off site by staff of other agencies. And it is always influenced by housing configurations.

Issues mentioned during our site visits that affect supportive services structure include:

[16] The HUD Section 811 program provides "funding to nonprofit organizations to develop rental housing with the availability of supportive services for very low-income adults with disabilities, and provides rent subsidies for the projects to help make them affordable." (From a HUD web page program description accessed on October 26, 2003 at http://www.hud.gov/offices/hsg/mfh/progdesc/disab811.cfm.)

- **The appropriate division of labor between property management and case management**. Most programs we visited have decided to separate these two functions, either by assigning them to completely different entities (such as a housing management company for the first and the program for the second) or by dividing their own staff into distinct property management and services teams. This eliminates the conflict of interest that arises in handling nonpaying tenants or other issues relating to lease conditions.

- **Whether to bring services into the residential site or encourage tenants to navigate community service systems**. This is not a major issue in scattered-site programs, but it is in mixed-use and dedicated buildings. Program staff members say tenants often prefer that services come to them. As they use services more when the services are convenient, staff members have some motivation to accommodate the tenants. This is especially true as these are PSH programs where tenants are not expected to be working toward self-sufficiency, and the demand that they deal directly with service systems may be enough to prevent them from getting the services they need.

- **The extension of services to tenants of mixed-use buildings who are not part of the program, and who were never homeless.** Several communities (Columbus, at Sunshine Terrace; Seattle, through Plymouth Housing) have found this to be both useful and cost-effective.

- **How to attract tenants to services when they are free to choose to use them or not.** Housing First and safe haven programs need to make effective *offers* of service, as they cannot require tenants to use services. Program staff in many of the communities we visited characterized their role as making friends, being available, making suggestions, checking up, hanging out, creating and then attending social events such as barbeques or monthly birthday parties, either not having an office or never closing the door, and other similar measures. Tenant word-of-mouth is the best referral; acting in ways contrary to tenant free choice will quickly be known and compromise one's ability to assist tenants. For many service professionals, this is really a whole new way of life.

- **How much the on-site program staff should know about what services tenants are accessing.** Some programs arrange for sensitive issues such as mental health and substance abuse to be handled by contract service providers who offer their services on site but independent of the program staff. Tenants make their own arrangements to see these service providers, and information of what they wanted and what they got is never conveyed to the program staff. Strict confidentiality is maintained. Other programs handle these issues with program staff, still maintaining strict confidentiality and voluntary use of services.

- **How to maximize service dollars, which may also be related to facilitating tenant access to services**. To facilitate client access, many homeless assistance programs use program staff, supported by grant monies, to provide health, mental health, substance abuse, as well as case management. Medicaid might be able to cover these services, freeing up grant monies, but the programs are not set up to maintain the records Medicaid requires, to do Medicaid billing, or to underwrite costs during what may be long lag times before reimbursement occurs. San Diego addresses many of these issues

simultaneously through contracts with nonprofit and for-profit behavioral health companies—see Chapter 6 for a description.

Preventing Homelessness Upon Institutional Discharge

One of the most effective ways of ending chronic street homelessness is preventing it from happening in the first place. This often involves commitment of resources to assure housing and services, and effective discharge planning from the many institutions that interface with chronically homeless people and those at risk of chromic homelessness: hospitals, treatment facilities, psychiatric institutions, correctional facilities, and sometimes foster care. In the absence of effective policies and practices around discharge, many of these institutions simply release people into local homeless shelters. Even discharge planning without commitment of resources to assure stable housing, is not sufficient to prevent homelessness. Discharge plans adequate to prevent homelessness typically include an estimated discharge date, collecting medical records, and making arrangements for post-release housing, medical and mental health care, and other community-based services. In some states this planning is the formal responsibility of the agency releasing the individual back into the community, while in other places it is done more informally by agency staff or community-based social service providers (Community Shelter Board, 2002). Our study discovered many examples of important prevention efforts, but did not focus strongly on them because we knew that HUD has two other studies focused specifically on prevention. One is on discharge planning to prevent street homelessness among ex-offenders, and the other is a more general look at the workings of successful community programs to prevent homelessness of all types.

Philadelphia's Housing Support Center (HSC). The HSC has a primary prevention focus for individuals (and families) at imminent risk of homelessness. It began operations in winter 2003, and when fully operational will bring together resources from Adult Services, Department of Human Services (child welfare), Community Behavioral Health, the County Assistance Office (cash assistance), the Philadelphia Housing Authority, and other public agencies whose clients face challenges to housing stability. It will serve as the city's central referral point for all households needing help because they are facing or experiencing homelessness. Because Philadelphia has a homeless management information system that covers all emergency shelter and another that covers the street population, the city will be able to track whether people assisted by the HSC do indeed avoid becoming homeless.

Psychiatric Institution Discharge Planning. A number of communities, including Boston and Columbus, have policies and structures in place to prevent people leaving public psychiatric facilities from becoming homeless.

Correctional Institutions Discharge Planning. Boston and Los Angeles (County Sheriff's Department), and at least some other California cities have programs to prevent homelessness among mentally ill offenders leaving correctional institutions. The Los Angeles program, funded through California state revenues in the AB 2034 program, involves careful interagency coordination as part of making discharge planning work. The Program Evaluator links the client with an agency in the area where he wishes to reside after discharge. If no housing is available in the client's desired area, he is placed close by and has the option of receiving outpatient

treatment in the program of his choice until housing becomes available. Once in the program, the individual may transfer between programs as the need arises. Even though the jail does not have a policy requiring housing upon release, the agencies participating in the AB 2034 program are required to locate housing and provide transportation to wherever the client will be living upon release. Checks are in place to assure that incarcerated AB 2034 clients are not discharged to the streets.

Leaving Substance Abuse Treatment. In some communities, individual agencies such as the Community Psychiatric Clinic in Seattle and Aletheia House in Birmingham have created a continuum of housing options, starting with residential treatment and including transitional, permanent supportive, and affordable independent housing, because they perceived that many such clients became homeless without these options. Both programs serve people who have never been homeless as well as those who have. They offer primary prevention to the former, and secondary prevention to the latter.

Client-Level Coordination Mechanisms

In addition to strategies involving new types of programs and new treatment philosophies, we encountered quite a number of mechanisms for assuring that individual clients get the services they need. These client-level service coordination mechanisms are the grease that makes the wheels go round for the new strategies and philosophies. Without them, clients would not have the same chance of getting the services they need, especially when they have many and complex needs that require assistance from many types of agencies. These client-level coordinating mechanisms include databases, various multi-agency team and co-location mechanisms.

Databases

One way that community agencies can promote appropriate service delivery to individual clients is to share information about the services that each provides. A number of communities use database technology to do just that. Some communities have created databases specifically for the homeless population and services while others use existing databases to track their clients' use of mainstream services or systems. Using databases allows staff members of one agency to know what services someone might be receiving from others, and plan their own service delivery accordingly. Shared databases also help agencies avoid unnecessary service duplication. Databases are useful at each level of community interaction and can be forms of communication, coordination, or collaboration, depending on how agencies related to each other overall.

King County's Mental Health Information System is a database used for both communication and coordination purposes. King County's Mental Health System has a Mental Health Information System logging any person's use of county mental health services. This database has become a source of useful information for Seattle's homeless service providers that are also certified mental health providers such as the Downtown Emergency Service Center. Individuals who have used system services have a record in the shared database and get a rating, or tier, for their service needs. To enroll a new client, he or she must first be on or eligible for Medicaid. Then the agency serving the client will apply for a tier based on medical necessity and treatment

intensity. The county will review the tier request and grant or deny the tier. Once tiered, the person can begin to receive ongoing publicly funded treatment.

The Mental Health Information System serves a communication function related to service duplication. The database logs the person's tier and the agency that provides care within the mental health system; two agencies cannot serve the same individual and both receive reimbursement for the care. The database thus prevents mental health service duplication and encourages some interaction among agencies to provide the most appropriate services. For example, if an outreach worker begins to provide outreach and engagement services to a street homeless individual who already gets services from another agency, the worker will reconnect the person to the original agency to continue services. Or if the person seems to need the specific services of the agency doing outreach, the staff will contact the other agency and ask them to stop providing services to the individual so they can begin to.

The Mental Health Information System also serves a coordinating function in Seattle between mental health service providers and local hospitals and jails. Once a person is logged in the database, a countywide agreement assures that local jails and hospitals notify the mental health provider if its client becomes incarcerated or is admitted for services. Then the mental health provider is encouraged to contact the client to re-establish or refine service linkages.

Other communities use database technology as part of their collaborative work. The San Diego REACH Project (Reaching Out and Engaging to Achieve Consumer Health) makes use of an existing database to assist its clients. This program, operating under the aegis of the San Diego County Mental Health Services Department, contracts with the San Diego County Probation Department to have a probation officer assigned to work directly with the REACH team. The officer is able to access the Department of Corrections database and helps many REACH clients clear up outstanding legal issues (e.g., warrants, criminal background checks) in her role as liaison between clients and the courts.

The Greater Los Angeles Department of Veteran Affairs (VAGLAHS) created a database to assist with its work with agencies in its collaborative network. Staff members developed a discharge/service history database that provides the ability to track the service-use patterns of individual veterans. The discharge/service history database logs individuals' use of services throughout the whole homeless services network. VAGLAHS program and partner agency staff members contact the VAGLAHS database coordinator to provide client data and the database coordinator also periodically contacts partner agencies to ensure that all data have been submitted. Partner agencies also contact the database coordinator to learn about a new enrollee's history of service receipt and use the information to develop an appropriate service approach. VAGLAHS staff liaisons to partner agencies also use this database to review veteran status and to ensure appropriate referral and service plans.

Philadelphia's OCC, which was discussed above in this chapter's section on outreach, is a particularly strong example of a collaborative service network using an integrated database. The agencies collaborate to integrate outreach efforts so that different teams cover different areas of the city and/or different issues of immediate concern. The collaborative has created a database to log the outreach and case management contacts. Outreach workers can also access shelter and

transitional housing information by linking into the database maintained by the city that tracks this information.

Multi-Agency Special Case Teams

In addition to the multi-agency teams that collaborate on a day-to-day basis, such as those discussed in this chapter's outreach section, there are teams that collaborate on a case-by-case basis or for a particular subset of the client population. Multi-agency special case teams may work for agencies that recognize the utility of combining approaches and integrating services, but may not have the resources to address the needs of all clients so they focus on cases meeting particular criteria.

An example of a multi-agency special case team is Seattle's High Users of Crisis Public Services team. Every two weeks staff members from the Crisis Triage Unit in the Harborview Medical Center Emergency Room, the REACH project (an outreach and case management project for chronic public inebriates), the emergency room, the Sobering Center, the detoxification center, the Emergency Service Patrol (a transport system for chronic public inebriates) and other relevant service providers meet to discuss high service users. These are people who have used the Crisis Triage Unit four times in three months, of which 52 percent are homeless. Together the agencies create integrated service plans for clients that each provider commits to following. This system allows service providers to think together creatively about client needs and the types of services that would be helpful to particular individuals, focusing especially on services designed to reduce their reliance on expensive public services. Clients sign information releases so agencies can coordinate in this way. At times the Triage Unit may also involve the client, family, friends, or police representatives.

In Los Angeles, the VAGLAHS collaborative network is another example of a multi-agency special case team. The VA has an administrative requirement that a homeless veteran is only eligible for three complete treatment episodes in residential programs. If a person requires more than three episodes in housing, then the VA is required to seek a waiver for the person. The network uses the discharge/service history database just described to see whether a person has reached his service limit. When that happens, staff members from the VAGLAHS and relevant collaborating programs, as well as the veteran, come together in a clinical case conference to develop an approach to care to meet the person's needs at that point. The group develops a service plan and integrated service approach that the participating agencies commit to following. If necessary, the VAGLAHS staff will apply for a waiver for a client.

Multi-Purpose Service Centers

Another way that agencies collaborate around services for chronically homeless people is to develop multi-purpose service centers where clients can receive more than one type of service within the same building. The goal of such "one stop shopping" arrangements is to increase a homeless person's access to services. Homeless individuals may need, but not seek, more than one service, or be willing to go to more than one location. By offering multiple services at one site, agencies are better able to comprehensively meet the needs of clients.

VAGLAHS's Comprehensive Homeless Access Center. The VAGLAHS operates the Comprehensive Homeless Access Center for homeless veterans. VAGLAHS staff realized that homeless veterans had multiple needs and designed the Access Center to co-locate primary medical care, mental health, and homeless services. The structure of the access center dramatically changed "business as usual" for VA medical services. Now, a nurse conducts a complete bio-psycho-social assessment on clients including medical, treatment, and housing needs. The nurse will also review the person's history of using VA medical and homeless services within the LA system and the larger VA network. The veteran receives a comprehensive treatment plan addressing all bio-psycho-social issues including referrals to appropriate services. Referrals to services are then prioritized according to need.

Access Center clients receive same day appointments and immediate medications, which is very important to homeless individuals who may have difficulty keeping appointments. Homeless veterans can receive emergent, urgent, or routine medial care (such as physicals) the same day they access the center. Those needing emergent or urgent care are transferred to the VAGLAHS hospital on campus and those needing routine care are sent to the second floor of the building where the primary care facilities are based. The veterans shower and receive clean clothes before receiving medical care. Homeless veterans now have physicals the same day they come into the center as opposed to waiting six to eight weeks for a physical as they did before the center opened.

VAGLAHS staff members realize housing increases stability and stability increases the likelihood that veterans will follow up with additional medical services and appointments. Therefore, in addition to immediate medical care, homeless veterans accessing the center are directly linked to housing. Staff members find homeless veterans temporary housing in transitional programs that have openings in their collaborative network and are appropriate to the needs of the particular veteran.

Veterans experiencing severe psychiatric problems such as delusions or suicidal ideations are sent to the psychiatric emergency room. Otherwise, psychiatrists conduct same day assessments for those experiencing less emergent psychiatric problems. The clients are then referred to the mental health clinic's orientation program given provided weekly.

After the triage process described above, about 80 percent of the clients are referred to a social worker for more detailed assessments of complex issues. Together the veteran and social worker develop referral plans to address other needs, such as substance abuse treatment and social service needs. The social worker continues to provide case management and follow-up services with the Access Center clients as long as necessary. The Access Center also provides the first time user with a hot lunch from the campus cafeteria. There are plans to begin providing dental care to homeless veterans in summer 2003.

- **Seattle's Dutch Shisler Sobering Support Center.** The Sobering Support Center was built and is owned by Community Psychiatric Clinic and co-locates three connected programs collaborating to provide services for chronic public inebriates: the Sobering Support Center itself; the Emergency Service Patrol; and the REACH Project. The Sobering Support Center, funded by King County, cares for people as they sober up. Another county program, The Emergency Service Patrol, operates a van that picks up

vulnerable homeless people from the streets and brings them into services. Sobering Support Center staff members refer clients to REACH, which provides case management services. REACH staff members target the most vulnerable and difficult to serve, who are likely to make heavy use of the Sobering Center. REACH workers assist clients to apply through the Department of Social and Health Services for state Alcohol Drug Abuse Treatment and Support Act funds, eligibility for which opens the door to all chemical dependency services in Seattle. This fund provides cash assistance to people who are disabled due to addiction as long as they are in treatment and have a payee. REACH also provides its clients direct links to housing, a good part of which grew out of CPC advocacy. A number of Seattle housing providers are more willing to take REACH clients because the project is well respected.

- For a person in King County to receive public mental health services, he or she must first be entered into the county's mental health database. The database, an outgrowth of ACCESS, tracks every client's mental health service use and also logs the agencies that provided the care. Several agencies dealing directly with street homeless people are part of this system. Because two agencies serving the same client cannot both receive reimbursement, the database is also used to prevent service duplication and encourages some service coordination. Any agency interviewing a prospective new client will check with the database to see if the person is already in the system. If yes, staff will reconnect the person to the original agency or, if the person seems to prefer the new agency steps are taken to reassign the service responsibility. The database also provides opportunity for coordinating mental health services with local hospitals and jails, as these latter institutions can check the database and, if there is a provider of record, connect a person to that provider.

Processes to Alter Access to Mainstream Settings

Homeless individuals require many services and supports beyond what homeless service providers offer (Burt et al., 2002). Many of the services and supports are provided through mainstream agencies that do not specifically have a focus on homelessness, including mental health, substance abuse treatment, and social service agencies. HUD encourages communities to use mainstream agencies when serving homeless people. Mainstream agencies have increased involvement in serving the chronically street homeless population through new roles in old agencies and co-location of services.

Co-location of Service Providers in Mainstream Agencies

One way that mainstream agencies have increased access to their own services and supports or access to other agencies' services for their own clientele is through co-location. Co-location is when staff members from one agency are located within the building of another agency to reduce barriers to services. For example, Seattle's Downtown Emergency Service Center has outreach staff located at the Department of Health and Social Services one day a week so eligibility workers can refer clients directly to the person for services if necessary. The Los Angeles County Sheriff's Department has created the Community Transitions Unit to empower jail inmates to be

successful once they leave custody. Homeless veterans are one of the unit's target populations. The unit staff members contact VAGLAHS to verify veteran status of inmates prior to placement in the veteran portion of the facility. (Offenders can be in the veteran portion of the facility as long as they are not mentally ill or are not charged with murder or sex offenses. Mentally ill inmates are housed in a different portion of the facility). The VAGLAHS, US Vets, and the Salvation Army each have staff located in the facility to provide services and classes to veterans. Services include assessments for treatment, drug and rehabilitation classes, parenting classes, personal relationship classes, computer training, job skills, and resume building.

New Roles in Old Agencies

Some mainstream agencies in the communities we visited have altered their philosophy by accepting greater responsibility for serving chronic street homeless people. These agencies have reduced barriers and increased access to their services.

Philadelphia. The city Office of Emergency Shelter and Services (OESS) maintains two central intake systems, one for single men and one for women with or without accompanying children. Emergency shelter occupancy went from about 80 percent to 97 percent once the central intake system was fully operational. While it does not run any shelters or transitional programs itself, the city pays for shelter for all people that OESS places into emergency or transitional programs. The intake databases link to a management information system that can provide an unduplicated count and other information about people served, going back to 1989.

The Housing Support Center is a new program just getting under way within the city Office of Adult Services (AS). When fully operational, it will bring together resources from AS, Department of Human Services, Community Behavioral Health (CBH), the County Assistance Office (cash assistance), the Philadelphia Housing Authority (PHA), and other public agencies whose clients face challenges to housing stability. It will serve as the city's central referral point for all households needing help because they are experiencing homelessness or facing homelessness, including families whose involvement with child welfare arises chiefly from their lack of housing.

Agencies under Philadelphia's Behavioral Health System offer prevention, outreach, substance abuse, and mental health services through their own staff and by contracting with nonprofit homeless assistance programs. The Coordinating Office of Drug and Alcohol Abuse Programs and the Office of Mental Health are city offices whose staff provides care directly and who also pay for services and shelter/housing through contracts for people meeting their eligibility criteria. Both work closely with the outreach teams under the Outreach Coordination Center run by Project H.O.M.E., as well as supporting outreach teams of their own. Direct mental health and substance abuse treatment is also supplied through CBH, the city's nonprofit managed behavioral health care entity covering poor people with behavioral health disorders, whether Medicaid beneficiaries or not. All are components of Philadelphia's Behavioral Health System (BHS).

Los Angeles. The Department of Mental Health (DMH) Adult Systems of Care administers the AB 2034 program in Los Angeles County. AB 2034 is a state-funded program to address the

mental health needs of persons whose illnesses have led them to homelessness and incarceration. In Los Angeles, these funds focus on providing appropriate supports to incarcerated people with serious mental illness, to prevent (return to) homelessness upon release. They thus link DMH and the County Sheriff's Department in a new and important partnership.

Several mainstream agencies cooperate in providing outreach for the program. Most AB 2034 clients enter the program from jail. When jail staff members identify a prospective AB 2034 client, they contact the Program Evaluator who begins the intake process into the AB 2034 program to determine program eligibility. At this point, the agency initiates the engagement process and remains connected with the client during incarceration. While in jail, the inmate is followed by one of two AB 2034 case managers who advocate for the client and work with the sheriff's department to produce an effective discharge plan. Referrals can also come from the courts, prosecutors, parole officers, county mental health programs, self-referrals and referrals from family members. The AB 2034 Program Evaluator works with police departments, prosecutors, and parole officers to negotiate alternative sentencing programs for inmates who qualify for the AB 2034 program.

The Adult Systems of Care's Housing Coordinator provides technical assistance to the agencies in leasing and purchasing housing and in completing applications for Section 8 housing vouchers. The Housing Coordinator also works with the Los Angeles City Housing Authority on a case-by-case basis to apply for exemptions for clients with criminal histories.

AB 2034 funds give Housing Specialists the flexibility to overcome property owner resistance by employing such innovative strategies as paying the rent until the client receives his/her housing voucher and placing an early deposit on a housing unit so the property owner will have funds available to make necessary repairs to bring the building up to Section 8 standards. The Housing Specialists can also intervene if an eviction is imminent or use AB 2034 funds to repair any damage done by the client. To recruit more landlords willing to rent to AB 2034 clients, the Department of Mental Health hosted a landowner/property owner breakfast for which they brought in speakers to speak on such topics as how to become Section 8 landlords and how to obtain low interest loans.

The Housing Specialists have made such an impact that some landlords have taken their names off the HUD Section 8 list and only rent to AB 2034 clients. Not only do the housing specialists provide technical assistance and temporary financial relief for Section 8 landlords serving their clients, but the AB 2034 clients come with case managers who resolve problems between tenants and landlords.

Conclusions

Housing First, safe haven, low demand, and harm reduction approaches, which usually occur in combination, appear to be very successful at attracting chronically street homeless people. Focus groups of street homeless people and outreach workers interviewed during site visits attest to their attractiveness, as do these communities' evidence of successful recruitment into permanent supportive housing and publicly available reports (Anderson et al., 2000; Rosenheck et al., n.d.; Shern et al., 1997; Tsemberis and Eisenberg, 2000). Chronically homeless disabled people *will*

come in, they *do* use services even though not required to, they *do* reduce their substance use, and mostly they *do not* return to the streets.

In addition to the new approaches, making a commitment to ending chronic homelessness often means increasing the availability of existing programs and services that help people to leave homelessness. These might include increasing access to case managers, reducing case manager caseloads, expanding short- and medium-term addiction recovery programs (for those who will accept them) that fill gaps so people are not left without a program when they are not yet secure in their recovery, increasing availability of housing subsidies, and so on. It takes many components to create a successful system. Some will be new, others old. Birmingham, for instance, has some successful programs based entirely on sobriety and transitional rather than permanent supportive housing. But serious commitment to ending chronic street homelessness necessitates a paradigm shift, part of which involves the willingness of a community and its homeless assistance providers to consider approaches that have been proven to work even though they may, at least initially, represent a significant departure from traditional programs.

A number of agencies in the communities we visited have found innovative ways to address client needs. Some agencies do this within their own structure, such as through mini-continuums. Other agencies have accessed resources through other organizations in the community and developed structures where they interact to provide services to chronically street homeless clients. Many of the communities have collaborative relationships between agencies to serve this population such as those working in multi-agency teams, multi-agency special case teams, and multi-purpose service centers. Others have at least developed communication and coordination mechanisms to try to improve services for the chronically street homeless population. Many communities have also taken advantage of database technology to increase their interactions and knowledge flow perhaps thereby improving services for clients.

CHAPTER 4: ASSEMBLING RESOURCES AND SUPPORTS

Once communities recognized that existing programs and services were not reducing or ending chronic homelessness, committed themselves to that goal, and identified potentially successful strategies, they still faced the task of assembling the resources and supports needed to implement their plan. In Chapter 2 we identified the sources of those supports—commitment and investment from mainstream agencies, the business community, local elected officials, and the general public. Each source may contribute interest, leadership, funding, staff, collaboration, and willingness to change.

Previous chapters have been organized by topic, illustrated by examples from several communities. In contrast, this chapter is organized by community to show how each community drew together the elements necessary to succeed. We first describe developments in two communities with long histories of cooperative investment in homeless programs and services—Philadelphia and Columbus. As will be seen, even these communities still had to make their case for new strategies and gather resources and supports. We then present two examples of developing new goals and strategies in the absence of any previous structure or commitment—San Diego and the Veterans Affairs Greater Los Angeles Healthcare System. Finally, we give an example of what has been accomplished in Seattle to assist chronically homeless people with mental illness and substance abuse problems, even without a change in the larger community toward a commitment to end chronic street homelessness.

Assembling Resources in Communities with Long Histories of Support

Philadelphia and Columbus are two communities with a very long track record of organized commitments to homeless assistance programs and services. Each already had an effective organizational structure, the commitments of local elected officials, extensive mainstream public agency involvement and investment, and general public support. Yet each still had to mobilize resources once it defined a new direction.

Philadelphia

Trigger Event. In 1998 a City Council member introduced a bill to criminalize many of the behaviors and actions of homeless street people. The proposed legislation galvanized the homeless advocacy community and brought a great deal of pressure to bear on the Council. The city ordinance eventually passed, but not before it had been changed in major ways and carried with it significant new funding to provide alternatives to street homelessness.

The response to the sidewalk behavior legislation was a remarkable example of what Philadelphia respondents mean when they say there is no progress without tension, “as long as we all still talk with each other.” Downtown businesses wanted to do something to decrease the odds that people coming downtown to shop, do business, attend conventions, or visit tourist attractions would encounter panhandlers or people living on the streets. Advocates countered with two tacks—1) arresting people would just add a criminal record to their other difficulties in leaving homelessness, and 2) if you want to get people off the streets, you have to offer some

alternatives that they are willing to take. The Open Door Coalition, a group formed in 1997 to develop viable plans for permanent long-term supportive housing for homeless individuals, solicited support from the media and community residents to protest the Sidewalk Behavior Ordinance in its original form. After a good deal of controversy, and conversation, the results were:

- An ordinance passed, and is still city law.
- Proscribed sidewalk behavior is not criminalized, however. Instead, police may issue a ticket similar to a parking ticket, and then only after making several attempts to offer shelter or other assistance themselves, calling an outreach worker, and having the individual refuse any type of assistance from the outreach worker.
- New services were authorized to provide alternatives to living on the street, and about $5 million annually in new money was authorized to pay for them. The services include:
  - The Outreach Coordinating Center (OCC), its management and oversight activities, and its outreach teams (see Chapter 3);
  - Four new safe haven residences, comprising 85 new low demand beds for substance abusers, mentally ill individuals, and those with co-occurring disorders;
  - New commitments to PSH.
- The police department established a special Homeless Outreach Team to work with OCC outreach and respond to street emergencies.

Mainstream Agency Involvement. As a conscious part of Philadelphia's approach to ending chronic street homelessness, many city agencies serve this population. Most use their resources to fund homeless assistance programs or supportive services and case management; many also offer some programs and services with their own staff. All participate in weekly and monthly meetings of city agency heads, and in one or more of Philadelphia's three citywide coordination mechanisms—the annual Strategic Planning Committee, the Blueprint to End Homelessness, and the Mayor's Task Force on Homelessness. Philadelphia's history in the homeless arena attests to its willingness and ability to entertain new ways of doing things when the situation warrants. The city began developing PSH in the early 1980s, long before McKinney funds became available for this purpose. In the early 1990s it served as a model and one of the sites for the Program on Chronic Mental Illness, a national demonstration of supported housing funded by HUD and the Robert Wood Johnson Foundation. Over the years the city has thoroughly changed its approach to outreach (from night to day, and much-increased coordination), and developed targeted responses to street homelessness in its no/low demand programs.

Private Sector Involvement. The Center City District, Philadelphia's downtown Business Improvement District, has been active since at least 1991 in addressing street homelessness, including providing jobs for homeless and formerly homeless people. Earmarking funding in response to the Sidewalk Behavior Ordinance to expand street outreach was in part a response to concerns of the business community. Street outreach has been crucial in helping homeless individuals move off the street; which met a business community objective to improve downtown visiting attractions. The Center City District's concern for street homelessness translated directly into funding and running an outreach team; its daytime outreach approach proved so useful that it became the model that Philadelphia outreach efforts now follow.

Committment from Local Elected Officials. The City Council supported and passed the revised Sidewalk Behavior Ordinance and approved additional funding for all of its provisions. The current mayor established the Mayor's Task Force on Homelessness even before he took office as another response to street homelessness. With almost 70 members representing every possible interested party, the Task Force addresses issues related to street homelessness, especially in the center city area. These issues include outreach, access to shelter resources, police/community/ homeless person relations, differentiating between panhandling and homelessness, running public education campaigns, services delivered "on the street," and similar issues. Members include representatives from the city council, businesses, faith communities, neighborhood and civic associations, homeless services providers, relevant government agencies, the Chamber of Commerce, legal and housing advocates, universities, the Convention Center and Visitors Bureau, the Center City District, and private foundations.

Role of Consumers in Advocacy and Shaping Policy. Homeless people themselves have been involved from the beginning in advocacy and actions to bring attention to the needs of people without shelter for the night. Homeless advocates have been very successful in rallying community support on the issues of homelessness in the political arena. For example, during the 1999 election of Philadelphia's mayor, homeless advocates formed a nonpartisan coalition called "Election '99: Leadership to End Homelessness," which educated the community through forums and workshops on the issues of homelessness, publishing and distributing more than 10,000 copies of the Voters' Guide on Homelessness and Housing, and registering over 2,000 homeless and low-income individuals to vote. Members of the coalition also organized a forum with the mayoral candidates, attended by more than 800 people, to examine the candidates' strategies for creating additional affordable housing units as well as obtaining their commitment to find solutions to end homelessness. The coalition has also been active in statewide senatorial and gubernatorial elections.

Columbus

Trigger Event. The Rebuilding Lives initiative grew out of a request by the City of Columbus in August 1997 for a plan to address the needs of people experiencing housing crises who were being affected by the development of the Scioto Peninsula, a riverfront corridor in downtown Columbus where many street homeless people congregated. In response to that request, the Community Shelter Board, with the support of the Franklin County Board of Commissioners, the City of Columbus, and United Way of Central Ohio, established the Scioto Peninsula Relocation Task Force, which issued the Rebuilding Lives plan in October 1998. The letter introducing the Task Force's report is addressed "To the Franklin County Community." Columbus views ending homelessness the responsibility of the entire community, not some smaller group such as the Community Shelter Board, homeless service providers, or elected officials. Launched in July 1999, the Rebuilding Lives initiative focuses on ending homelessness and 'rebuilding lives' by meeting the short-term needs of homeless individuals through an improved safety net of emergency shelters and by establishing 800 units of stable supportive housing programs for homeless individuals with long-term needs.

Mainstream Agency Involvement. A major focus of the original Rebuilding Lives plan was identifying and securing the resources needed for implementation. The plan outlines several options for new financial resources: establishing dedicated local revenue sources for broad-based

affordable housing activities; encouraging innovative, entrepreneurial businesses tied to programs serving homeless individuals; and generating private, state and Federal funding for specific projects. Resources for Rebuilding Lives are managed through a specially created "Funder Collaborative" that allows individual funding agencies to pool their resources to achieve mutually agreed-upon goals, establish common expectations about what outcomes are to be achieved, and specify what reporting requirements are needed to document progress towards those goals. Funder Collaborative members include elected representatives of city and county government, all of the major public agencies, private agencies such as the Corporation for Supportive Housing, and philanthropic organizations such as the United Way and various local corporate donors. Key members are the Alcohol, Drug and Mental Health Board of Franklin County (ADAMH), which coordinates all community-based alcohol, drug addiction, and mental health services in Columbus; the Columbus Metropolitan Housing Authority; and the Departments of Job & Family Services and Health.

Mainstream agency commitment to the larger goals of Rebuilding Lives is clear from many actions, of which we describe only one here. Recognizing a gap in services for people with addictions who were not also mentally ill, the Maryhaven Engagement Center was designed and developed to improve on existing detoxification facilities and offer a more inviting entrée to services for male and female public inebriates. This is a population whose treatment is vital to the success of Rebuilding Lives. Funded by the Community Shelter Board, the ADAMH Board, and HUD support for safe havens, the Center has an overall capacity of 54 beds and provides overnight accommodations and services. Clients may remain in the Engagement Center for three days without receiving substance abuse treatment, or ten days if they participate in Maryhaven's outpatient detoxification program, which is right next door. Individual inebriates, however, can be admitted to the engagement center as often as needed. The usual stay is for one night. Once someone enters the Engagement Center, attempts are made to engage him or her in substance abuse treatment and other services working towards the goal of permanent housing.

Private Sector Involvement and Local Elected Officials Commitment. Rebuilding Lives has a great deal of community support and political backing, building upon the same elements in Columbus' long-standing commitment to addressing the issues of homelessness in a unified way through the Community Shelter Board. The executive director of the Community Shelter Board explained that both Columbus and Franklin County have high quality elected officials and the community has a long-standing tradition of caring about people, not just homeless people. The message is "bipartisan and very moderate— you don't have to support us because you like homeless people, you can just not like homeless people on the street in front of your business." Also, the business and political leadership mentors itself and ensures that this tradition of caring for and helping others continues over time.

Mobilizing Resources "From Scratch"

Two of the communities we visited provide examples of how resources and supports were mobilized when no prior structure of commitments or relationships existed that had a primary focus on homelessness. San Diego mobilized business community, mainstream agency, and ultimately political support for a commitment to end street homelessness in the downtown area, overcoming a long history of government disinterest and lack of cooperation between city and county government agencies and elected bodies. In Los Angeles, the history of the current

collaborative network of public and private agencies serving homeless veterans reveals the roles of advocacy and political commitment in demanding a new goal and stimulating a public agency to devote the resources needed to reach it.

San Diego

The Role of Trigger Events. As downtown San Diego revitalized during the 1990s, the issue of street homelessness and what to do about it became a focus of discussion. In 1998, a camp-out by homeless advocates in front of the municipal building grew over the course of a few months from a few people to more than 300. Initially sent to remove the campers, the police department drew upon its problem-solving, community-oriented approach and sought a positive resolution. After interviewing campers, officers realized that the issues raised required responses beyond anything the police could muster, and began a process that ultimately produced San Diego's Homeless Outreach Team (see Chapter 3 and Appendix G).

Also in 1998, the decision was taken to build a new major league ballpark downtown, in an area that had become the most recent center of street homelessness. Anticipating displacement, residents in nearby areas began raising concerns about where homeless people would move next, while downtown businesses expressed concerns about "doing something serious" to reduce street homelessness. The impending ballpark development galvanized San Diego businesses and government agencies to get serious about reducing street homelessness in a responsible way.

Mainstream Agency Involvement. Interested parties from public agencies and the business community began meeting and soon constituted themselves the Ad Hoc Committee on Downtown Homelessness. The Committee serves as the major coordination mechanism for planning, assembling resources, and developing programs related to ending street homelessness. From the beginning of this response, the downtown redevelopment agency (Centre City Development Corporation—CCDC), businesses (the Downtown San Diego Partnership), the San Diego Police Department, and the courts were extensively involved, as were the city's housing authority (San Diego Housing Commission) and its Department of Community and Economic Development/Division of Homeless Services.

The Committee has no formal existence, which members say is its strength. Members described their initial process as "our approach was to sit around the table and ask ourselves what should our approach be." Committee members think their success is due to the many conversations they had, and their commitment to seeking information until they felt they knew what they wanted to do and something about how they wanted to do it. New agencies and stakeholders were invited to participate as it became clear to the first organizers that their roles were vital to success. The Committee's unbureaucratic and unofficial nature allows each participating agency and organization to be frank about its issues and tensions, as well as about its resources and abilities. Attendance by agency heads means that the power is present to make decisions, commit agency resources, and see that plans are carried to completion. Peer-to-peer accountability once commitments have been made keeps things moving forward, and peers can help troubleshoot bottlenecks and barriers and offer their own resources to help regain momentum if things do not work as expected.

A very significant addition to the San Diego effort was the opening of a regional office of the Corporation for Supportive Housing (CSH). It provides a team member that has full time staff focused on the issue of supportive housing. Courting the CSH to open an office in San Diego was an important achievement of the Ad Hoc Committee, and in turn the CSH presence adds strength and stability to the Committee's work.

Private Sector Involvement. CCDC works closely with the business community. The portfolio of one staffer includes responsibilities to "solve problems" in the downtown area, so homelessness fell into her bailiwick. In addition, the chair of the CCDC Board of Directors became very interested in the issue and provided essential leadership. The President of the Downtown San Diego Partnership, who was also an advocate for mentally ill homeless people and a political activist, played a key role in educating the business community and bringing it to the table. Guest speakers educated both Partnership and Ad Hoc Committee members about homelessness, the relation of mental illness and co-occurring disorders to homelessness, and best practices elsewhere in the state and country to address the needs of chronically homeless people.

Two people more than any others spearheaded San Diego City's activity on the Committee—one was a planner from the City Manager's office, and one was a private developer who was in charge of the ballpark development. The former, who estimates she spent about half her time for a year on the effort, is described as "the glue that kept it all together." They attribute their success in their roles to their neutrality—they started the process knowing nothing about homelessness or homeless programs, but being willing to learn and having no preconceived ideas. They went everywhere, asked endless questions, brought fresh perspectives to existing programs, and thought about "why couldn't we do X?" rather than "we've never done it that way." The combination of their politics also helped—one was a liberal public servant, the other a conservative businessman. When both of them agreed on a course of action, they tended to carry the day with audiences across the political spectrum. By December 1999, the Committee's five-part program to assist the special needs homeless population had been presented to and approved by the San Diego City Council. Its parts included:

- Creating a centralized intake and referral system and locating a facility;
- Building transitional housing beds for special needs homeless people;
- Building permanent supportive housing units for special needs homeless people;
- Expanding residential alcohol and drug treatment programs for substance dependent and dually diagnosed homeless people; and
- Evaluating and expanding the Police Department's Serial Inebriate Program.

Commitment from Local Elected Officials. Part of the Ad Hoc Committee's success lies in drawing in players from both the city and county, in a spirit of cooperation that was unprecedented in San Diego up to that point. When the Committee was ready it asked for, and got, an historic, first-time joint meeting of the City Council and County Board of Supervisors. These two bodies committed themselves to the plans offered by the Committee and to working together to make them happen. This public commitment was an important policy progress. The City Council and Board of Supervisors created a Joint City-County Homeless Program

Committee and appointed two members from each body to serve on it. These members in turn assigned staffers to work on the committee, which held regular meetings at which staff of city and county agencies reported progress toward various goals and discussed ways to reduce any barriers that arose. This Joint Committee became an important avenue through which city and county agencies could talk to each other and develop collaborative plans.

Los Angeles Veterans Affairs

The history of how the Veterans Affairs Greater Los Angeles Healthcare System (VAGLAHS) developed its current system is a dynamic example of how advocacy stimulated political commitment, which in turn changed public agency leadership and resource commitments. The result is a greatly changed and expanded system addressing the needs of many chronically homeless veterans who were not being served before. Developments began with increased communication—initially adversarial but changing to information gathering and open dialogue. The final system is fully collaborative, with each partner working together in newly developed ways to achieve the goal of ending homelessness for many disabled veterans.

Role of Advocacy in Developing Political Commitment. During the late 1980s and early 1990s, even the health services available to homeless veterans through VAGLAHS were limited, and only about six transitional housing beds were available. Homeless service providers and advocates appealed to the VAGLAHS administration and demonstrated on VAGLAHS' Los Angeles campus to obtain more services for homeless veterans. The group met resistance locally, which inspired them to go to Washington, DC to inform congressional leaders about the lack of services for homeless veterans. This movement resulted in a congressional hearing on the Los Angeles campus grounds, with representatives of VAGLAHS and community agencies giving testimony.

During the same time frame, staff from a community based organization, New Directions, wanted to begin providing services to veterans in one of the many empty buildings on the LA campus, but met great resistance to this idea. The organization worked to get an act of Congress to acquire a building on the campus, which occurred in 1989/1990.[17] The building is now the site of the New Directions South program.

Mainstream Agency Involvement. After the congressional hearing, VAGLAHS began to respond. The VA established a new administration at VAGLAHS in the early 1990s, and created a department focused on homeless services (McGuire, et al., 2001). VAGLAHS leadership began to communicate with agencies about what veterans needed and how to develop a collaborative to address those needs. To further complicate the VAGLAHS situation, the West LA Health Care Center was downsizing its inpatient health care services because of lowered resources at the same time that the VAGLAHS was trying to expand its homeless service approach.

Recruiting Partners. VAGLAHS leadership recognized that it needed community organizations to adequately serve chronically homeless veterans, who face many barriers to service. The VA

[17] The lease was eventually signed in 1995, until then the program provided services to veterans living in housing in the community.

proceeded to develop partnerships with community agencies from 1992 through 2000, creating a network that now includes 11 private and 7 public agencies in Los Angeles city and county. The network's goal is to assist veterans to leave the streets and lead productive lives by addressing four needs: (1) access to health care and treatment; (2) income from benefits and/or employment; (3) stable housing; and (4) support networks. The collaborative network approach is based on the premise that no single agency can provide comprehensive services to meet these four needs. The network includes programs that range from unstructured drop-in centers to treatment facilities. Private agencies have developed a total of 930 new transitional housing beds for veterans—up from the 6 beds that were available in 1992 and the largest number in the country connected to a VA facility.

Progress Without Community-Level Commitment to Ending Chronic Homelessness

We encountered some examples of important developments for the street homeless population even in communities without a central guiding vision at the community level of ending street homelessness. Some of these examples used Federal funding opportunities to promote significant service development and interagency cooperation. We give one example—Seattle's service structures that capitalized on participation in the Center for Mental Health Services' Access to Community Care and Effective Services and Support (ACCESS) demonstration program that began in 1993.

Seattle Program Structure Growing Out of ACCESS

A Federal funding opportunity had an important impact on Seattle's programs for the chronically street homeless population. Federal guidelines for the five-year ACCESS project, in which Seattle's Community Psychiatric Clinic and Downtown Emergency Services Center (DESC) participated, emphasized cross-agency systems and services integration. This gave strong impetus to Seattle providers and government agencies to develop outreach and engagement services for chronic street homeless individuals. Through its assertive outreach, ACCESS found new pockets of homelessness and helped chronic street homeless persons through the eligibility process for health and human services. It helped spark system innovations in Seattle and King County services, such as the merger of the mental health and chemical dependency divisions of county government and adding a housing specialist to this staff (now called the Mental Health, Chemical Abuse, and Dependency Services Division, King County Department of Community and Human Services). The demonstration findings persuaded county government that it should continue to fund programs such as those operated through ACCESS, which would avert public outlays for back-end services such as jail and hospital costs.

Service Development and Mainstream Agency Linkages. The Systems Design Workgroup formed within ACCESS to examine and recommend changes in system functions related to homeless mentally ill people. A Chronic Public Inebriates workgroup formed at the same time in response to a county executive request, and developed an action plan to create appropriate services and housing. When the mental health and chemical dependency divisions of county government merged in 1998, the two groups also merged, renaming the new entity the Chronic Populations Action Council (CPAC) in 2002. These groups pushed with ultimate success to develop a number of specialized services for the chronically street homeless population. These

include the Harborview Medical Center Behavioral Health Crisis Triage Unit, the Mental Health Court, the Dutch Shisler Sobering Support Center, the REACH Project, the mental health detoxification enhancement project, the Emergency Service Patrol, and pre-recovery and recovery-oriented housing projects such as the Archdiocesan Housing Authority's Wintonia project and a new DESC housing project.

The Dutch Shisler Sobering Support Center operations and the mental health database, already described in Chapter 3, illustrate the complex inter-agency relationships that had to be developed to make these programs work, and that still continue to serve chronically homeless people today.

Private Sector Involvement. The Downtown Seattle Association, a local business association focused on downtown business community concerns including social service policy, provides leadership in the area of chronic street homelessness. This group helps garner support from neighbors and improve community relations for projects serving this population. Specifically, it supports DESC's work and has been instrumental in the development of the new pre-recovery housing project being designed by DESC.

Conclusions

The examples described in this chapter show how a central guiding commitment has helped the communities that have one to mobilize the resources and supports needed to fulfill their goal of ending street homelessness. They also show that mobilization is necessary whether or not a community habitually invests generously in homeless assistance programs and services. Changing one's paradigm means changing one's goals and adopting new strategies to achieve them. Either communities must find new resources to develop these new strategies, or they must redirect old resources. As no one likes to take money away from functioning programs, the price of political support from existing programs almost always means finding new resources. Communities with a history of strong support for homeless assistance may have a somewhat easier time convincing potential funders that the new direction is the right one, because their track record of responsible system management makes them a credible source of new information. But they still have to make the case, just as did people in San Diego and the Los Angeles VA once they had convinced themselves of the direction they wanted to follow. It is certainly possible to develop good programs, and even good cross-agency cooperation, without a central guiding vision, as some of the Seattle programs demonstrate. But it is not as easy, and the pieces may have a harder time retaining their "systemness" when the pressures that brought them together disappear.

CHAPTER 5: DOCUMENTING PROGRESS

We sought out programs and communities that could document that their approaches were achieving progress in reducing chronic street homelessness. This evidence took several forms:

- Changes in the number of people found on the street from year to year;
- Increases in the number of chronically street homeless people who have moved into permanent housing;
- Reductions in costs of providing emergency health, mental health, and shelter services; and
- Reductions in days homeless, hospitalized, or incarcerated.

In presenting the evidence we gathered from the study, we do not want to create the impression that success was under community control if it only tried hard enough. Many factors may influence the level of homelessness in a community, no matter how organized or complete the efforts to end it. Interviewees in the communities we visited noted that factors tending to increase chronic homelessness included a poor economy and resulting unemployment, shutting down one or more large SRO hotels where poor single people had lived, closure of state mental hospitals, and persistently high housing costs. Furthermore, the study communities' were generally more successful than most at tapping into Federal and, to a lesser extent, state programs reducing chronic street homelessness. Non-local resources have played a significant role in supporting integrated, community-wide approaches involving mainstream agencies and permanent supportive housing. Spreading such approaches nationwide will entail Federal and state commitments.

Changes in the Number of People Found on the Street from Year to Year

Counts of street homeless persons are a basic method of determining changes in the number of people found on the street from year to year. A difficulty in such counts is ensuring that the numbers do not change because of variations in definitions and completeness of coverage. Street counts are much more valuable if they are done regularly using the same methods. If the territory covered changes from year to year, it is also most useful if analysts report a time series of data for the same area. For example, Seattle has extended the geographic coverage of its annual street count, but also reports changes over time within a fixed core area. Street counts are also more valuable to a community when they gather data that will help with service planning, such as individuals' characteristics and needs, and cover homeless individuals residing in shelters or other program housing.

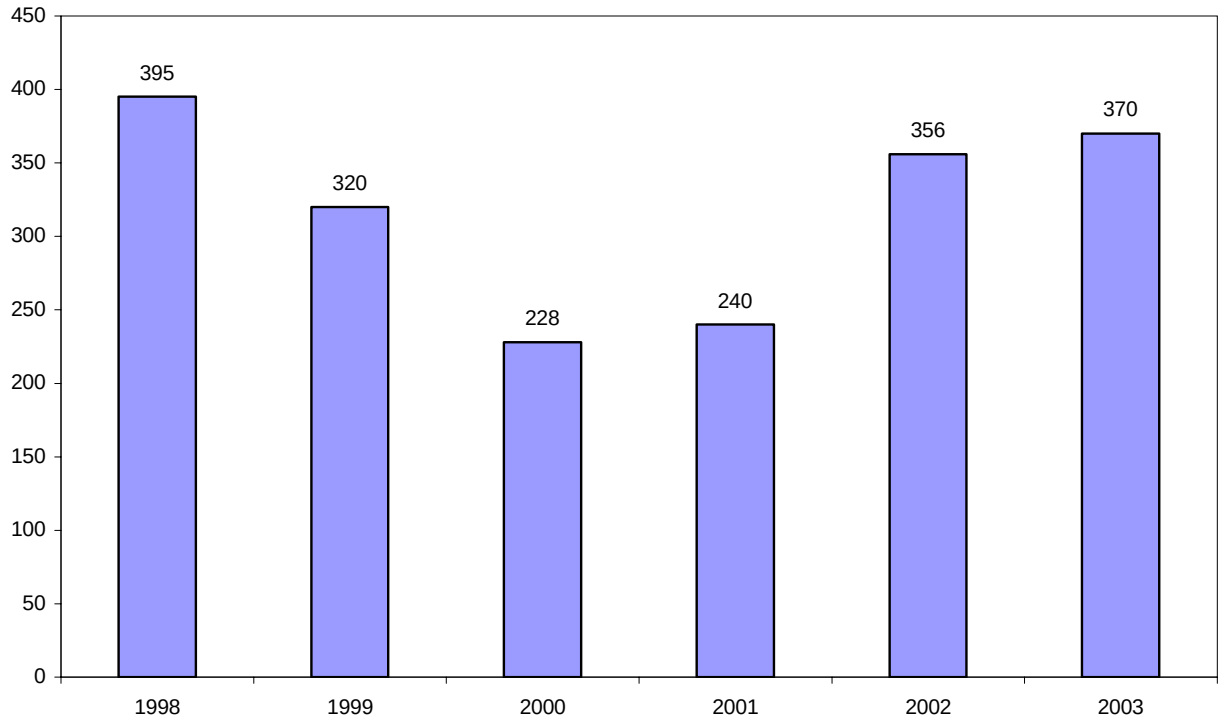
Despite the difficulties in maintaining consistency of coverage, street counts are the most direct measure of reductions in chronic street homelessness. Philadelphia, Birmingham, Seattle, and Boston have all conducted a series of street counts that we judged to have sufficient coverage and consistency to allow comparisons over time. One of our standards was that persons in emergency shelters should be counted as homeless, but not persons in permanent supportive housing. These four communities collected and presented their data in a manner that met this

standard, or from which equivalent statistics could be calculated. We also checked to see that there were consistent guidelines in place for dealing with situations such as people sleeping in cars and abandoned warehouses. Finally we were concerned that attention was paid to the issue of whether there were changes in the geographic area of coverage. While recognizing that these communities do not have perfect coverage or consistency in their street counts, we think they are useable, direct measures of street homelessness.

Philadelphia Counts of Street Homeless Persons

Street counts conducted by Philadelphia's Outreach Coordination Center between 1998 and 2003 indicate positive outcomes from developing alternatives to living on the streets, including safe havens and permanent supportive housing (see Chart 5.1). Since 1998, outreach workers coordinated through the OCC have conducted quarterly street counts over an area that includes all of downtown and west and southwest Philadelphia. Summer counts declined from 395 in 1998 to 228 in 2000. Since 2000 the count has increased, reaching 370 in 2003. Interviewees at the site attributed the increased street homelessness to a downturn in the city's economy. Also since 1998, however, over 300 PSH beds have been created which presumably kept the street count from going even higher as the economy worsened.

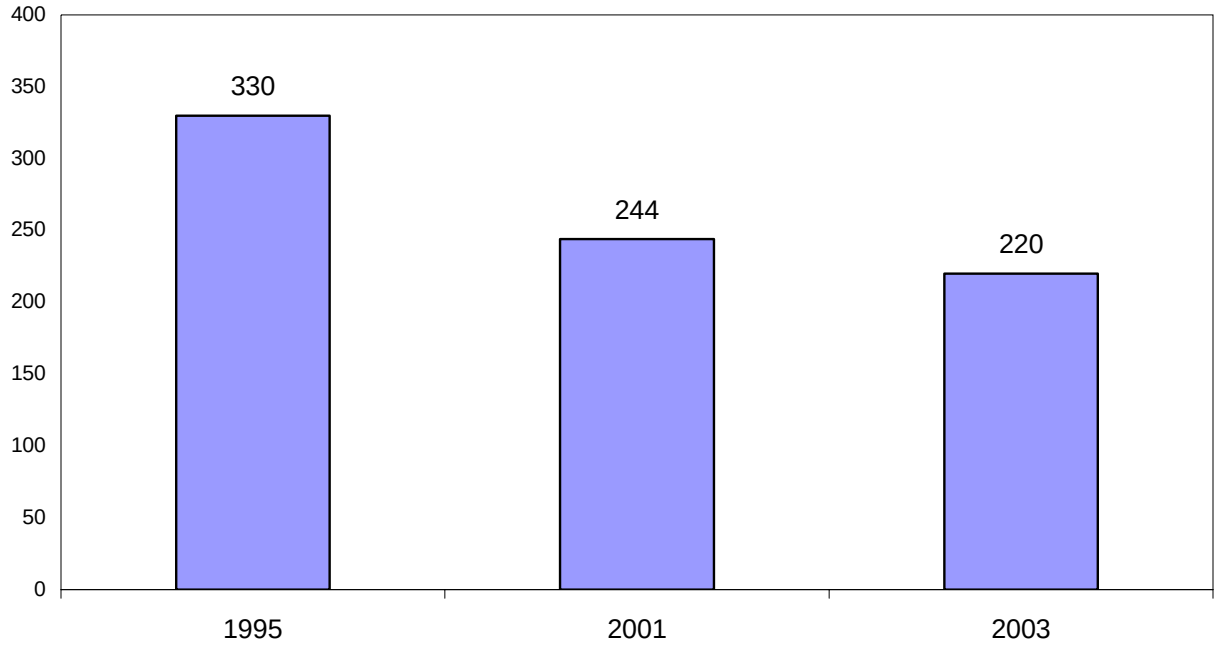
Chart 5.1
Counts of Street Homeless Individuals in Philadelphia, 1998-2003



Birmingham Street Counts

Birmingham has done periodic counts of homeless persons complemented by a sample survey of the people counted. To provide a complete profile of the chronic homeless individuals in a community, a "street count" needs to go beyond the people on the street and include homeless individuals housed in emergency, transitional, treatment. Birmingham's counts provide a good example of the scope necessary. The number of homeless living on the street declined by one-third from 330 in 1995 to 220 in 2003, with most of the decline occurring between 1995 and 2001 (see Chart 5.2). This decline was achieved by "sheltering" and "housing" more people, because the sum of street homeless persons and homeless persons in programs providing shelter or housing increased from 1,404 in 1995 to 1,667 in 2001. By 2003 the sum of street homeless and persons in programs had declined slightly to 1,616.

Chart 5.2
Counts of Street Homeless Individuals, Birmingham 1995-2003



Street counts are a valuable tool for examining whether the total CoC system is succeeding in lowering homelessness, however, unless background history is collected one cannot determine what is behind the trends. A rising street count could be from many causes such as fewer individuals moving into housing, increasing migration of homeless individuals to the community, reduced state mental hospital beds forcing people with severe mental illness onto the streets, a new epidemic of substance abuse, declining housing for very low income individuals, increased job layoffs, or some combination of these and other factors. Birmingham's 2003 Homeless Survey included questions to shed light on the causes of homelessness. The survey also gathered information on age, sex, race, ethnicity, family status, education, income, veterans

status, disabilities, health care, and homeless services being received. However, complete data on these other items are not yet available.

Seattle Street Counts

The Seattle/King County Coalition for the Homeless oversees an annual one night street count and survey of homeless shelters and transitional programs that have been conducted for 24 years (Seattle/King County Coalition for the Homeless, 2003). The survey of shelters and transitional programs is conducted the same night as the street count and produces unduplicated numbers of people using homeless services at the time of the count. The coalition returns annually to the same areas of the city and county to count street homeless individuals and also adds new neighborhoods to the count periodically. When comparing numbers of street homeless year after year, however, the coalition does some analyses that use a constant geographic area to avoid increases in numbers being attributable to the increase in area. From 1999 to 2002 the One Night Count of street homeless individuals went up 81 percent in "traditional count areas" from 983 to 1,779. From 2001 to 2002 the total count of street homeless individuals went up 40 percent from 1,454 to 2,040, but a substantial portion of that was from adding three new areas to the count. From 2001 to 2002, restricting the analysis to the 2001 geographic area, the number of street homeless individuals increased 23 percent in one year. From 1998 to 1999, during better economic times, a same geographic area count of street homeless individuals still went up 16 percent in one year.

During the 1999 to 2002 period, these increases in street homelessness occurred despite a 21 percent increase (from 4,917 to 5,940) in the survey count of the number of homeless individuals in shelter or transitional shelters. The community is losing ground while making improvements in resources for homeless individuals. One explanation is that homeless individuals are drawn to or sent to Seattle from surrounding communities. Our focus group of homeless individuals indicated that Seattle was known to be a relatively "good" place to be homeless. In the October 2002 One Night Count survey of shelters and transitional housing, 46 percent of the respondents indicated that their last permanent address was outside the City of Seattle. In the late 1990s there were skyrocketing housing prices in Seattle and some tearing down of single room occupancy buildings, and these economic pressures probably pushed more people on to the streets because they could not afford the available housing. More recently the job market has soured, and our interviewees reported that rising unemployment is also creating economic factors that result in more people being on the street. Even if people laid off do not become homeless, some may move to low rent quarters, making the affordable housing market tighter.

Of those using services in Seattle in 2002, 60 percent were single adults in shelter or transitional housing. Less than 1 percent used a safe haven. Forty-one percent of the homeless people using services were female and 38 percent were white (compared to 80 percent of the general population), 37 percent were African American (compared to 5 percent of the general population), 10 percent were Hispanic (compared to 3 percent of the general population), 5 percent were Native American (compared to 1 percent of the general population), and 4 percent were Asian/Pacific Islander (compared to 10 percent of the general population). The most frequently cited disabilities among homeless people using services were mental illness and chemical dependency.

The increase in Seattle's homeless population can be attributed to many challenges that overwhelmed the efforts of programs to tackle the issue of chronic street homelessness. Seattle has seen an economic downturn at the same time affordable housing has decreased. Indeed, individual program data from DESC, CPC, and AHA indicate these programs are successful in assisting chronically street homeless individuals into permanent supportive housing.

Boston Street Counts

Beginning in 1986 the ESC has conducted annual street counts in Boston with the assistance of over 250 volunteers who cover designated geographical areas in the city to enumerate homeless individuals sleeping on the streets and in the city's shelters and other homeless facilities. According to the December 2002 annual street count, the total number of homeless individuals residing on the streets of Boston and in adult emergency shelters has increased over the last decade:

> The number of Boston's homeless increased by 41% in the past decade. There were 6,210 homeless people in the City of Boston in 2002 compared to 4,411 in 1992. There were 1,367 homeless children in Boston in 2002 compared to 800 in 1992, an increase of 71%. There were 1,572 homeless women in 2002 compared to 989 in 1992, an increase of 59%. There were 3,271 homeless men in 2002 compared to 2,622 in 1992, an increase of 25%. Although the number of homeless men rose at a slower rate than that of women and children, they remained the largest percentage of the population, 53%. The majority of these men have chronic disabilities such as mental illness and/or substance addiction (Menino, 2002, p.2).

The increase in the number of homeless individuals can be traced directly to a number of conditions, including but not limited to:

- The dramatic rise in housing costs;
- The decrease of affordable housing for low-income persons;
- A reduction of substance abuse treatment beds; and
- A lack of commitment to aftercare planning and next step resources for individuals being released from jails and prisons, acute mental health facilities, hospitals, and social services.

In an effort to track the demographic information on homeless individuals, the city of Boston has contracted with the Center for Social Policy at the McCormack Institute, University of Massachusetts to implement Connection, Service and Partnership through Technology, which maintains the HMIS data system. Formerly known as the ANCHOR project, the HMIS data system is used by over 40 providers and enables Boston to collect and track unduplicated information on over 4,750 homeless individuals and 350 homeless families in Boston in order to provide unduplicated services and other resources needed to assist homeless individuals move towards self-sufficiency and permanent housing.

Last year, provider data revealed that at least 1,500 homeless people obtained permanent housing throughout the city of Boston, including 550 chronically homeless individuals. The Pine Street

Inn NBOR Project, which serves chronically street homeless people, reports that of 356 clients who exited the program in the past two years, 38 percent (134) obtained permanent housing and another 22 percent (77) were referred into a transitional housing program. The majority of clients in 2001-2002 were successfully placed into housing and more than 60 percent of them (103 of 171) entered housing after *more than four years of homelessness* (another 19 percent had been homeless between one and four years). The program achieved similar results more recently in 2002-03: 58 percent (108 of 185) of those housed had been homeless *from 4-6 years,* and 26 percent (48 of 185) had been homeless for 1-4 years. Most of the individuals successfully placed are repeat users of health care, mental health care, substance abuse, and shelter services and the locus of care and services simply shifted from the streets to fixed-site programs that served as a staging area for their successful placement into transitional and permanent housing.

Chronically Homeless Individuals Moved to Permanent Housing

Philadelphia Movement of Chronically Homeless Individuals into Permanent Housing

Permanent supportive housing is one avenue that may help chronically homeless people with disabilities move off the streets and into stable housing. We asked the major PSH providers if they had data that could document whether residents of their PSH units had been chronically homeless and whether they had achieved housing stability in PSH programs. Two providers, Project H.O.M.E. and Resources for Human Development (RHD), were able to provide relevant data.

Project H.O.M.E. provided data about residents in the four safe haven programs (with 80 beds) that are coordinated through OCC, and about residents in its five PSH projects (with 121 units) for single adults. Since inception, the safe havens have served 539 clients. All safe haven residents are either mentally ill, substance abusers, or both, as well as being likely to have other problems. Data on length of homelessness before entering a safe haven are available for 160 people, of whom 47 percent had been homeless for longer than 1 year, with 32 percent being homeless for 2 years or more. Among the 399 people for whom previous living situation is known, 30 percent came from the streets and other non-housing locations, 17 percent came directly from mental health or substance abuse treatment facilities, and 36 percent came from emergency shelters or a different safe haven. Among the 537 people whose length of stay at a safe haven is known, 52 percent stayed for 6 months or less, and 30 percent stayed for more than 1 year, with an average length of stay of 1.3 years. Information about current living situation is available for 516 people, of whom 23 percent still live at the safe haven, 36 percent moved to better housing situations (such as PSH, own housing, with family), 2.5 percent died; 22 percent left for situations that were similar or less desirable, and current whereabouts could not be ascertained for 18 percent.

Project H.O.M.E.'s PSH programs have served 187 people since July 1, 1999. Among the 122 people for whom length of previous homelessness is known, 67 percent had been homeless for one year or more, with 44 percent of these experiencing homeless spells of at least 2 years. Length of stay in PSH is available for all 187, among whom:

- 136 (73 percent) stayed for at least 2 years;

- 93 (50 percent) stayed for at least 1 year:
- 51 (27 percent) stayed less than 1 year; and
- The average length of stay was 3.2 years.

Of the 90 people who left Project H.O.M.E.'s PSH, current whereabouts are known for 86 percent. Of these, only 13 percent are living in situations that would be considered homeless, including on the streets, in emergency shelters, safe havens, or transitional housing programs. The rest are in a variety of stable housing situations.

RHD has served 121 consumers since 1995 in its Supported Adult Living Team (SALT) program and another 25 (since 1989) in its Boulevard Apartments. RHD provides supportive services to people with serious mental illness living in scattered-site residential units (SALT) or multi-unit building rent-subsidized apartments. Of these 146 consumers, 45 came directly from homelessness. Most of the remainder, all in the SALT program, had significant periods of homelessness although their immediately prior residence was various transitional housing situations. Of these 146 individuals, 72 percent stayed for one year or more, including

- 61 (42 percent) who stayed for at least 2 years;
- 23 (16 percent) who stayed for at least 18 months but less than 2 years; and
- 21 (14 percent) who stayed for at least 12 but less than 18 months.

San Diego Movement of Chronically Homeless Individuals into Housing

San Diego's AB 2034 program for chronically homeless individuals with mental illness enrolled 404 persons between November 1, 1999 and January 31, 2003 in permanent supportive housing. It offered people immediate housing in a variety of settings, using hotels in the early period before safe haven and PSH slots became available. At the end of this period, 253 were still enrolled and 154 had been disenrolled for various reasons (59 percent of the 154 "disenrollees" dropped out of the program and another 17 percent moved out of the REACH program area).

Presumably most clients should be staying in permanent housing for a long period. If too large a percentage disenrolls, the program is having problems. Agencies can use simple length of stay in permanent housing to make some assessment of how a system is working. If the typical length of stay is six to eight months in a program designed to provide years of residence, the support services may be insufficient or the program may be taking in clients who do not need that high a level of care and are moving on to independent living. However, this does not appear to be a problem for the PSH programs we visited. Far more often providers noted that turnover among clients was much lower than expected, even after years of residence. Some communities are now beginning to think about lower-intensity options for tenants who have been stabilized for several years.

Birmingham Movement of Chronically Homeless Individuals into Permanent Housing

The Cooperative Downtown Ministries (CDM) has placed 189 persons into its transitional housing program since 2000. When placed about 80 percent were chronic street homeless individuals, 85 percent were substance abusers, 33 percent had a serious mental illness, and about 23 percent were dual diagnoses. The transitional housing program's **c**apacity was 30 individuals, but has recently been expanded to 87. Of the 189 persons who have been in the program, 17 percent are still there, 49 percent left for permanent housing, 19 percent have unknown whereabouts (most are thought to be in housing with family or friends), 10 percent went to another program or jail and 5 percent left the program for other reasons.

The CDM opened its own PSH program only a few months ago, but has been placing people from its transitional housing program into other PSH programs. Many others have been connected directly to other permanent housing programs by CDM shelter's case manager without going through CDM's transitional housing program. Of the 75 who went from its transitional housing program to a permanent supportive housing program, 47 percent have remained at least 24 months, 21 percent at least 18 months, 13 percent at least 12 months and 19 percent less than 12 months.

Reductions in Costs of Providing Emergency Health, Mental Health, and Shelter Services

In Columbus existing shelter data indicate a 7 percent decrease in the total number of clients sheltered in 2001 as compared to 1998 (note these are all homeless clients, not just those who are chronically homeless). Of the 2,959 clients sheltered in 2001, 298 had successful outcomes, meaning they exited the shelter system to either permanent or transitional housing. The average length of stay during this period of time remained relatively stable for men, while it increased by over 20 percent for women, increasing from 37 days in 1998 to 47 days in 2001. During this period of time the recidivism rate increased by 14 percentage points for men and 3 percentage points for women.

Despite the limitations of the HMIS, the Community Shelter Board has been collecting extensive data on its homeless service system for many years, data that have guided both program and policy development in Columbus. These data have been used to evaluate the costs of running various Rebuilding Lives programs The two-pronged strategy at the heart of the plan (emergency housing for those in crisis and supportive housing for those with long-term needs) was largely a response to the fact that chronically homeless people (a group that accounts for only 15 percent of all those in need of homeless assistance) were absorbing the bulk of the community's homeless assistance resources. The Task Force recognized that the needs of this high-cost group could be met much more effectively, and at a lower cost, by providing them with permanent housing with supportive services. Table 5.1 is drawn from the Task Force's initial report:

Table 5.1
Per-Bed Costs for Operations and Services of Franklin County Service Systems Used by Homeless Men with Long-Term Needs

Service System	Annual Cost per Bed	Daily Cost per Bed
Service-Enriched Housing	$13,000-14,000	$36-38
Minimum Security Misdemeanor Jail	$ 21,188	$58
Sub-acute Medical Detox	$ 69,800	$191
State Psychiatric Hospital	$172,900	$482
Hospital Inpatient	$396,025	$1,085

Source: "Report of the Scioto Peninsula Relocation Task Force," Final Report October 1998, drawing on data from the Ohio Department of Rehabilitation and Corrections; Columbus Health Department; Ohio Department of Mental Health; Maryhaven; and the Community Shelter Board.

With these figures in mind, the Community Shelter Board, service providers and funders, launched the initiative in July 1999.

In Philadelphia as elsewhere, 10 to15 percent of shelter users are absorbing half or more of shelter resources, at significant public expense. The idea that these people could be moved to housing and helped to maintain it through supportive services is appealing, in that it would help people leave the streets and save emergency shelter resources for true emergencies. In Philadelphia at present the city pays for about 2,100 shelter beds a night, comprising about 80 percent of the city's emergency shelter capacity. This number is down about 10 percent from 2001, reflecting the deliberate effort to switch occupancy from emergency to permanent supportive housing for chronic shelter users. Philadelphia is just starting its first program based on a pure "Housing First" approach, bypassing even the safe haven stage of moving from street to housing. Research evidence on housing first models has convinced officials that this is an important model to try.

In San Diego the Serial Inebriate Program (SIP) did a cost analysis showing the very high levels of public resources being absorbed by serial inebriates, compared to the costs of treatment. They calculated a cost of $977 for maintaining one serial inebriate in housing plus outpatient substance abuse treatment for one month, compared to $1,470 for the cost of one police contact with an ambulance visit to the emergency room followed by a day in jail. The SIP participants were all people with very long histories of addiction and street homelessness, and all were treatment resisters. Nevertheless, over 3 years the program has an average annual completion rate of over 40 percent compared to average completion rates for voluntary substance abuse treatment programs for homeless people of between 20 and 33 percent, with most falling at the lower end (Orwin et al., 1994).

Also in San Diego the Homeless Outreach Team (HOT) Program asked the UCSD Medical Center to track care received by 15 mentally ill chronically homeless individuals well-known to the HOT workers at Scripps Mercy Hospital, UCSD Medical Center, and the San Diego

emergency medical services system during an 18 month period from July 1, 1997 through December 31, 1998. The 18-month cost just for these 15 individuals was just under $1.5 million, which did not include physician fees or care that might have been incurred at other regional hospitals. UCSD physician charges totaled $87,017 for both in- and outpatient care for these same individuals during the study time period. HOT's expenditures of $69,820 a person a year to get chronic street homeless people with multiple disabilities into stable housing situations are close to the medical expenditures noted above, which would be $67,000 a person a year. If the costs of other public services such as law enforcement were added to the equation, HOT expenditures might be substantially offset by savings to other agencies, at least for the HOT participants who were high consumers of these services.

Among the communities we visited for this study, few had conducted cost avoidance studies of any complexity. Those we just documented form San Diego are fairly simple, yet have been effective in raising public consciousness that "doing nothing" is not free and that there may be better ways to invest public money, with more humane consequences as well as more livable downtowns. In recent years, several studies examining public crisis costs avoided as a result of offering permanent supportive housing or other service alternatives have been published and have excited national attention. The most prominent of these, by Culhane, Metraux, and Hadley (2002), was a key stimulant to development of national policy urging an end to chronic homelessness. Other similar analyses have been conducted for PSH programs in Connecticut (Anderson et al., 2000) and San Francisco (Martinez and Burt, 2003; Proscio, 2000). The most recent entry in the field is a three-year follow-up study of homeless veterans in a joint program of HUD and the VA that randomized assignment to housing plus case management versus just case management versus "usual services" (Rosenheck et al., 2003). The results of most of these studies show that a considerable proportion of the costs of PSH and supportive services may be compensated for by savings stemming from reduced use of public crisis services such as emergency rooms and public hospitals.

Reductions in Days Homeless, Hospitalized, or Incarcerated

In San Diego among the 253 formerly homeless clients currently enrolled, REACH had the following impacts, annualized to represent the 12 months before compared to the 12 months after enrollment, current enrollees have:

- 73 percent fewer homeless days;
- 55 percent decrease in incarceration days, and 71 percent decrease in incarceration episodes;
- 35 percent decrease in hospital days, and 62 percent decrease in hospitalization episodes; and
- 506 days of enrollment, on average, or about 1.4 years, in a program that in January 2003 had only been at full enrollment for about 2 years; 55 percent had been enrolled at least one year.

The Los Angeles AB 2034 program can show statistics with similar impacts, as can the program statewide. In Fiscal Year 2002-2003 the state expenditures for the program were $55 million, but the state estimates that at least $27 million was saved by the reductions in utilization of other

services (Davis, Johnson and Mayberg, 2003). Programs providing these statistics are one of the reasons the program has been funded for the current fiscal year at the same level, despite the extreme state budgetary pressures (Davis, Johnson and Mayberg, 2003).

In the Veterans Affairs Greater Los Angeles Health System (VAGLAHS), increasing housing options for homeless veterans, along with other changes in the system, helped to reduce the length of stay in medical, surgical, and psychiatric beds between 1994 and 1998 (McGuire, et al., 2001). The length of stay was reduced in medical beds by 28 percent, in surgery beds by 7 percent, and in psychiatric beds by 35 percent. Not only are programs assisting the VAGLAHS in decreasing the length of stay in their treatment and medical facilities, but the programs have also assisted the facility so they are not discharging patients to the streets, from which they will quickly cycle back. Both community program and VAGLAHS representatives report that the collaborative allows them to serve veterans better, and in a more cost-effective manner.

Conclusions

The primary ways that our study communities documented the progress of their approaches were through counts that showed reductions in the number of street homeless individuals, increases in the numbers of chronic homeless individuals being moved into permanent supportive housing, reductions in the costs of providing emergency services to homeless individuals, and decreases in the number of days that clients spent homeless, hospitalized or incarcerated. However, documenting progress is not an easy or straightforward process. None of the data described above is readily available in most communities. Furthermore, a community may have programs that are functioning well, but still have outcome measures, such as street counts, that are showing undesirable trends because of increases in the homeless population being driven by external events like slumps in the economy and/or reduction in state facilities for the mentally ill.

CHAPTER 6: HOW COMMUNITIES PAY FOR THEIR NEW APPROACHES

Introduction

Funding is, of course, the fuel that propels programs and services for ending chronic street homelessness. Housing is the single resource that does the most to end homelessness for chronically homeless and other homeless people alike. Housing is generally expensive to create and, because rent subsidies are likely to be a long-term need, expensive to help people occupy. Add to the costs of the housing itself the costs of the supportive services that help chronically disabled people maintain housing, and it is evident that most commonly used approaches to ending chronic street homelessness require a good bit of funding. The cost of permanent supportive housing has prompted researchers and advocates to show that leaving chronically disabled people homeless is far from free, by identifying the costs of public crisis services used by chronically homeless people who do *not* have permanent supportive housing (Andersen et al., 2000; Culhane, Metraux, and Hadley, 2002; Martinez and Burt, 2003). As these costs have proven to be virtually as high as the costs of the programs themselves for severely disabled former street people, more communities are recognizing the value to public health and well-being of reducing street homelessness through providing housing and supportive services.

This chapter describes funding streams that communities use to support services and housing to end chronic street homelessness. The communities we visited have different resources available and therefore take different approaches to funding for this population. Some communities such as Philadelphia, San Diego, and Boston have access to a great deal of local and state funding, compared to what is typically found nationwide, which makes a difference in how they can tackle street homelessness. Communities such as Birmingham, however, have to be more creative in finding resources because they have far fewer state or local supports.

We first explore local, state, and Federal sources of funding that at least some of our seven communities have called into use to serve the chronically street homeless population. Additionally, we describe the ways in which communities use and blend resources to help both providers and clients. Provider overload is eased by "funnel agencies" that assemble monies from various sources and allow providers to write one application to access different funding streams. Client access to services is enhanced by providers with multiple funding sources that allow them to serve clients regardless of insurance status, and bill the care to the appropriate payors.

Local Funding

The communities in this study used local funding such as general revenue, special taxing mechanisms and private sector resources to help finance the cost of programs to reduce chronic homelessness.

General Revenue Resources

All the communities we visited invest some local general revenues in homeless assistance. Most target some of these resources specifically to efforts directed at reducing chronic homelessness. We highlight two communities here—Boston and San Diego.

Boston has substantial local public resources committed to serving the homeless population. It focuses on solving its affordable housing crisis and expanding affordable housing for low-income and homeless individuals and families. The mayor and the Strategic Homeless Planning Group (SHPG) have developed a three-year strategic plan, Leading the Way, to build 7,500 new affordable housing units (3,200 of these will be in new affordable developments or in reclaimed public housing now vacant) and to preserve 10,000 units of existing affordable housing. The city is contributing over $30 million plus city-owned land to achieve the plan's goals. To date, 34 percent of the city's affordable housing units are targeted to low-income households (those earning less than 50 percent of Area Median Income). While this income level is far higher than formerly street homeless individuals are likely to attain, easing the affordable housing crunch on all low-income households reduces the odds that these households will ultimately contribute to the homeless population through housing crises.

The City of **San Diego** funds outreach services—the Homeless Outreach Team (HOT) and the Serial Inebriate Program (SIP)—through its police department, as described in Chapter 3. These programs have a high success rate and recover their costs by reducing expenditures on arrests, transportation, bookings, detox, and emergency services.

City, county, and state money support San Diego's REACH program, which we describe in Chapter 3. The San Diego Housing Commission helps fund most of the housing portion of the program while the state-funded AB 2034 program supports mental health and other services through a flexible funding pool that will cover "whatever it takes." The county and city contract with non-governmental agencies to provide case management and supportive services.

Special Taxing Mechanisms

Several of our communities had the advantage of funding for housing development and operations through special taxing mechanisms created by state or local law. In addition to housing trust funds that are becoming more common throughout the country, we found some interesting mechanisms whose proceeds were being used to create permanent affordable housing for formerly street homeless people—tax increment financing in San Diego, a housing tax levy in Seattle, redevelopment bonds in Philadelphia, and general revenue bonds for mental health and substance abuse services in Columbus.

Tax increment financing. San Diego's downtown redevelopment agency, Centre City Development Corporation (CCDC), helps to create new developments and economic activity, generating new tax revenues for the jurisdiction. California law stipulates that the redevelopment authority receive back a share of these additional taxes (called tax increments), and says that the authorities must invest at least 20 percent of the money they get back to increase affordable housing (tax increment financing, or TIF). CCDC invests these funds in affordable housing

projects, and has chosen to require some of them to set aside about one-fourth of their units for permanent supportive housing for the special needs street homeless population.

Property tax levies. Two of our communities, Seattle and Columbus, make significant use of voter-approved property tax levies to support housing and services, some of which benefit people who are or have been chronically homeless.

Seattle has a long history of voter-approved tax measures to finance low-income housing and housing for homeless people. Voters approved housing levies in 1981, 1986, 1995, and 2002. The 2002 housing levy totals $86 million over seven years with the cost to the average homeowner of $49 per year.[18] The program includes five major initiatives plus administrative costs: rental preservation and production (provides housing to people with disabilities, elderly, homeless, and working families and resources for rehabilitation, new construction, or redevelopment of units); home ownership for low-income working families; neighborhood housing opportunity program with a mixed income, mixed use emphasis; rental assistance to prevent homelessness; and operating and maintenance (for rental units for extremely low-income individuals and people with disabilities).

In Columbus, the Alcohol, Drug and Mental Health Board of Franklin County (ADAMH) coordinates all community-based alcohol, drug addiction, and mental health services for the city and county, including those addressing the needs of street homeless people and formerly homeless people now in permanent supportive housing. Almost half of the ADAMH system's resources are drawn from a single property tax levy (approved by voters); the remainder comes from state, Federal, and private sources. ADAMH does not provide any direct services, but contracts with a network of 45 public and private health care agencies to treat people in need.

Redevelopment bonds. Philadelphia's Redevelopment Authority recently obtained City Council approval for about $300 million in redevelopment bonds. Proceeds are being used to fund property acquisition and demolition as part of the mayor's Neighborhood Transformation Initiative. Some part of the housing being developed will be used for permanent supportive housing for formerly homeless disabled people. A much larger proportion will be used to preserve existing affordable housing and create more.

Use of Private Sector Resources

Given the paucity of public funding for homeless programs and services in Birmingham, providers have developed a number of approaches that build on the resources and interests of the private sector. Two nonprofit agencies that develop transitional and permanent housing (with and without supports) have had success approaching owners of dilapidated and wholly or partially vacant properties to see if they will donate the property. If they will, the agencies use capital financing from the Federal Home Loan Bank and private lenders, plus Low Income Housing Tax Credits, HOME funds, and donations from religious congregations and private individuals to renovate and make repairs. Property owners get tax write-offs on properties that were losing money and causing problems, the agencies get free buildings they fix up and use, neighborhoods

[18] Seattle Office of Housing website – www.cityofseattle.net/housing

get renovated and supervised buildings in place of eyesores and problem spots (not only not a NIMBY response, but a warm welcome), and participants in homeless job training programs gain construction skills as well as a sense of ownership as they prepare the housing for occupancy—perhaps by themselves.

State Funding

California and Massachusetts have extensive state funding programs for homeless-related programs and services and affordable housing. Ohio, Pennsylvania, and Washington have less extensive state funding but still have some state-level resources used by providers in the communities we visited.

California

AB 2034. California has a unique source of funding for homeless people, probationers, and parolees experiencing serious mental illness (Mayberg, 2002). Funding is authorized through Assembly Bills (AB) 34 (for the pilot year) and 2034 (for the first year of full funding) and is referred to as the AB 2034 program. The Department of Mental Health (DMH), Adult Systems of Care administers this program to provide community mental health services and outreach to mentally ill adults and transition-age adults who are homeless or at risk of homelessness, with the intention of preventing or ending their homelessness. In addition to homelessness, this population often experiences costly incarcerations and hospitalizations because their needs are not addressed until they are in crisis.

AB 2034 programs participate in a mandatory statewide evaluation that documents their impact. Statewide, the program has reduced hospitalization experiences; client data show a 66 percent decrease in hospitalization days statewide from the 12 months before to the 12 months after AB 2034 enrollment. Findings also show that about 60 percent of the clients are dealing with substance abuse issues in addition to mental illness and that once enrolled about 84 percent of clients continue in the program. Participation in AB 2034 services has reduced incarceration experiences, including the number of unduplicated clients who become incarcerated, the number of incarcerations overall, and the number of days incarcerated (82 percent fewer incarceration days statewide in the 12 months following enrollment compared to the preceding 12 months).

As of the 2002 report, California has spent $55 million overall on the AB 2034 program, or $13,000 annually per client statewide, meeting about 10 percent of the need according to county informants. This expenditure has been offset by $23 million in cost savings as a result of reduced inpatient hospital stays and reduced incarcerations. Two cities we visited have AB 2034 programs—Los Angeles and San Diego.

Other California funding streams. California has several other important state programs that communities use to fund programs to end chronic street homelessness and to create affordable housing. These include (Corporation for Supportive Housing, 2001):

- Supportive Housing Initiative Act (SHIA). SHIA, a program of the Department of Mental Health, encourages development of permanent, affordable housing with supportive

services that enables low-income Californians with disabilities to stabilize their lives. It covers services and operating costs (through rent subsidies) in supportive housing. Funding was about $20 million a year, but renewal funds have not been available the past two years and many grants have expired.. It may become an important source of funding again when the state budget is not facing crisis deficits.

- Multifamily Housing Program (MHP). MHP, a program of the Department of Housing and Community Development, provided streamlined, omnibus permanent financing program for affordable multifamily housing development for special needs and disabled households, including homeless persons or persons at risk of becoming homeless. It provides low-interest loans to developers of affordable housing for new construction, rehabilitation, acquisition and rehabilitation, or conversion of nonresidential structures. Rent write-downs may be added in future years. Passage of Proposition 46 in California in November 2002 created a special Supportive Housing Program under MHP, which is for homeless or at-risk households with a disabled adult member. The funds total $190 million available over 3 years. Proposition 46 also expanded the amount of funding for the General Program to $770 million over 4 years.

- Special Needs Affordable Housing Lending Program. This program, under the California Housing Finance Agency, Multifamily Programs section, is designed to serve special needs populations by reducing interest rates (to 3 or 1 percent, depending on tenant targeting) on multifamily loan products to develop projects that serve low-income disabled tenants in need of special services to create stable, long-term supportive housing environments.

- Emergency Housing Assistance Program (EHAP). A program of the Department of Housing and Community Development since 1993, EHAP funds emergency shelter, transitional housing, and services for homeless individuals and families, including safe haven/low demand programs. Funds are distributed to all counties based on a formula that combines poverty and unemployment statistics. Funding fluctuates, usually between $10 and $20 million a year.

- Low-Income Housing Tax Credits (LIHTC). California augments Federal LIHTC with its own program to encourage private investment in affordable rental housing. The state program supplements Federal tax credits in projects that are eligible for them. In 2002 state funds were actually greater than Federal funds--about $70 million added to the Federal $59 million.

Other State Funding Streams

Other sites we visited also have significant sources of state support. Boston has substantial state funding for homeless services. Massachusetts' Departments of Public Health and Mental Health combined invested about $31 million of mainstream funding to services for the chronically street homeless population. Philadelphia receives support from Pennsylvania's Homeless Assistance Program, mostly for families and thus not particularly useful for the street homeless population that is the focus of this report. The Washington State Housing Trust Fund and the Washington State Housing Finance Commission (tax credits for constructing transitional housing), provide

funding support for emergency shelter and transitional housing acquisition, rehabilitation, and construction in Seattle.

Federal Funding Other Than McKinney

Programs funded through the McKinney-Vento Act are the most common Federal funding sources for the agencies serving the chronic street homeless population. McKinney programs administered by HUD support emergency services and transitional and permanent supportive housing. Programs funding emergency services include the Emergency Shelter Grants program (which HUD distributes by formula to eligible jurisdictions) and the Emergency Food and Shelter Program (which a special board of the Federal Emergency Management Agency distributes by formula to eligible jurisdictions). Several funding streams support transitional and permanent supportive housing, including the Supportive Housing Program (transitional and permanent), Shelter Plus Care (permanent), and Section 8 Moderate Rehabilitation SRO. Other large McKinney programs include Health Care for the Homeless (administered by the Health Services Research Administration within DHHS), Projects for Assistance in Transition from Homelessness (administered by the Center for Mental Health Services within DHHS), education for homeless children (administered by the Department of Education), and several programs for homeless veterans (administered by the Department of Veterans Affairs. From time to time, McKinney has also included other programs and special research and demonstration projects.

While most homeless assistance providers and planners are aware of the homeless-specific funding streams included in McKinney, the communities we visited also used many other Federal sources of funding that might not be so obvious to other communities. Table 6.1 shows all the Federal funding streams appropriate to the task of reducing or ending chronic street homelessness that are used for that purpose by the communities we visited.

A number of communities use various block grants—including Community Development, Mental Health, Substance Abuse, and Preventive Health—to support housing and services for chronically street homeless individuals. Using Seattle as an example, King County uses CDBG funding to acquire and rehabilitate rental units for homeless persons. Seattle uses CDBG funding to operate emergency shelter, transitional housings, and day/hygiene centers. The city also uses MHBG funds to administer involuntary treatment to clients who have included an unknown number of homeless individuals. In 2003 MHBG funds will also be used to fund HOST (an outreach program for street homeless individuals) and the Crisis Triage Unit in Harborview Medical Center Emergency Room. King County uses SABG funds to support county services to homeless individuals, including the Emergency Services Patrol that provides chronic public inebriates with transportation to the Sobering Center or the Crisis Triage Unit. Also, both Seattle and Philadelphia were part of the ACCESS demonstration program for homeless services through the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (DHHS).

The Veterans Affairs Greater Los Angeles Healthcare System's collaborative network of services uses a number of Federal funding streams to finance its work. Many of the community-based organizations that are part of the network receive funding through the VA's Grant & Per Diem program. Each partner agency applies directly to the VA for the grant.

Table 6.1:
Federal Sources Invested in Ending Street Homelessness

Type of Investment	Site Visit Cities					
	Birmingham	Boston	Columbus	Philadel-phia	San Diego	Seattle
McKinney-FEMA		X	X	X		X
McKinney-ESG	X	X	X	X	X	X
McKinney-SHP	X	X	X	X	X	X
McKinney-S+C	X	X	X	X	X	X
McKinney-SRO Mod Rehab		X	X	X		
HOPWA	X	X	X	X	X	X
HOPE VI-relocation and supportive services						
HOME	X	X	X	X	X	X
Section 811						
Section 202						
Public housing units			X	X	X	
Section 8 (other than S+C)	X	X	X	X	X	X
Moving-to-Work (PHAs)				X		
CDBG	X	X	X	X	X	X
LIHTC	X	X	X	X	X	
Federal Home Loan Bank	X	X		X		
TANF-Services or MOE			X	X		X
SSBG				X		
MHBG		X	X	X		X
PATH		X	X	X		X
SABG		X	X	X		X
Preventive Health BG						
Health Care/Homeless	X	X	X	X	X	X
Medicaid		X	X	X	X	X
Medicare						
Workforce Investment Act (WIA-DOL)				X		
Homeless Veterans Reintegration Project (DOL)		X		X		
Department of Veterans Affairs	X	X	X	X	X	

Note: Funding information is not included for Los Angeles because no central system was studied.

The network also takes advantage of funding from the HUD-VA partnership known has HUD-VASH (VA Supported Housing). These funding sources do not appear in Table 6.1 because we did not do a funding table for Los Angeles as a whole. However, other communities should know about funding opportunities for homeless veterans available through the Department of Veterans Affairs.

One Birmingham provider gets loans through the Federal Home Loan Bank to renovate structures to create transitional and permanent supportive housing, and affordable housing without supportive services. Boston providers have also used this source of capital funds.

Five rows in the table have no entries: HOPE VI, Section 202, Section 811, Preventive Health BG, and Medicare. Although none of the communities reported using them, these are programs that can be used, and we are leaving them in to draw attention to their potential contributions.

Self Support

Some programs use client contributions to fund aspects of their services or housing. Programs with particular focuses on job readiness, training, and employment, usually for recovering substance abusers, require client contributions of some sort once the person is employed. For example, all of the agencies in Birmingham offering shelter and housing use client wages for rent once the client has a job, and the programs work very hard to get people ready for work and help them find jobs. Providers say they have little trouble placing people in employment, and have a large network of job opportunities because they cultivate employers. Rents for emergency shelter are relatively low, but for transitional housing they come close to market rate, in part because there are few alternative sources of housing support, and in part because tenants are ultimately expected to become independent and conditions in transitional programs are set to create incentives for them to do so. In Los Angeles, tenants in the Westside Residence Hall (a partner in the Veterans Affairs Greater Los Angeles Healthcare System collaborative network) also pay rent if employed.

Funds Blending and Access

One of the biggest problems for homeless assistance providers is assembling the funds to be able to offer all the various services that chronically street homeless people with disabilities are likely to need. Few funders cover them all, so the challenge for providers is to keep track of which sources will fund what, when one needs to apply for them, who is eligible for services from particular funding streams, and who has time to do the applications. People at every level of government and service provider talk about “funding silos” and “categorical funding” that inhibits getting clients what they need. It is no wonder that providers value funding programs such as California’s AB 2034, which can fund “whatever it takes” to end homelessness and prevent its recurrence. For homeless consumers, blended funding is also a boon. We highlight several approaches to providing wrap-around services through creative funding “funnels” at the consumer level.

Blending Funding from the Provider Perspective

In the absence of universal programs such as AB 2034, some communities have developed mechanisms that reduce the burden on providers by streamlining the funding acquisition process. We call these “funnel mechanisms” because, in theory at least, all the funding sources go in at the top, get blended, and come out at the bottom in single grants to providers to cover their program requirements. We found several examples of funnel mechanisms in the communities we visited, ranging from single requests for proposals (RFPs that offer blended funding from several agencies, arranged through memoranda of understanding among the funders) to routine funneling activity.

One-Time RFP. Agencies in San Diego are working to increase access to funding resources for homeless service providers by blending different funding sources. In 2002, the Centre City Development Corporation, the City of San Diego, Corporation for Supportive Housing, County of San Diego, and the San Diego Housing Commission (the city's public housing authority) developed a memorandum of understanding among themselves outlining resource and other commitments, and issued a first-ever joint request for proposals. This RFP "To Develop and Operate Transitional and Permanent Supportive Housing Facilities in the City of San Diego for Homeless Adults with Serious Mental Illness or Dual Diagnosis" invited qualified housing developers, nonprofit organizations, property owners, and development teams to submit proposals to create more supportive housing, representing a key strategic initiative for achieving the goals of creating 100 new transitional and 100 new permanent supportive housing units in the next several years. As a result, providers only have to submit one grant response to access all the above sources of money, making it easier and less costly to write proposals. Respondents felt that this blended approach was the best way to get proposals for programs that meet their requirements for ending chronic street homelessness, and anticipate repeating the process as funding permits. In the end the joint RFP was able to fund additional transitional units through Vietnam Veterans of San Diego, but did not result in the development of any additional permanent supportive housing units. However, the RFP did provide a model for future collaborative housing projects.

Stable Funnel Mechanisms. Both Columbus and Philadelphia have stable funnel mechanisms to make providers' lives easier.

Columbus

Rebuilding Lives is Columbus' integrated approach for moving chronically street homeless people to housing. As described in Chapter 4, resources for Rebuilding Lives are managed by a specially created "Funder Collaborative" that helps funders meet mutual goals as well as smoothing resource acquisition for providers. Members of the Funder Collaborative include the Community Shelter Board (which oversees the implementation of Rebuilding Lives, chairs the Funder Collaborative, and serves as the main fiscal agent for the initiative), the Alcohol, Drug, and Mental Health Board of Franklin County (ADAMH), City of Columbus Administration, Columbus City Council, Columbus Foundation, Columbus Health Department, Columbus Mayor's Office, Columbus Medical Association Foundation, Columbus Metropolitan Housing Authority, Corporation for Supportive Housing, Franklin County Department of Job & Family Services, Franklin County MR/DD, Franklin County Administration, Franklin County Office on Aging, Mid-Ohio Regional Planning Commission, Ohio Capital Corporation for Housing, United Way of Central Ohio, and the Veterans' Service Commission. Since Rebuilding Lives was launched, the Funder Collaborative has met monthly and now meets every other month to address funding and system issues—serving as the main mechanism for coordinating and monitoring the system.

Providers apply to CSB for a whole project, indicating the types of services and housing for which they need funding. CSB funds a project as a whole, funneling the money it receives from the sources described above in response to provider proposals and specifying reporting requirements. Projects may also receive direct funding through HUD's Supportive Housing Program, a small share of state dollars, and other funds. For the current year, the Rebuilding Lives budget is $5 million, most of which is for permanent supportive housing. Major funders

are the Franklin County Board of Commissioners, the City of Columbus, and the United Way of Central Ohio.

CSB does not fund capital grants but it does help agencies secure such grants. Now that it has a better sense of the actual costs of permanent supportive housing, it is better able to predict the financial needs of a project (and operational and service costs have to be renewable). The costs are about $14,000 per unit per year for operations (mostly rent) and services.

HUD dollars are the primary Federal dollars used to support Rebuilding Lives. There are no real restrictions on them other than to use them for supportive housing; "they are flexible and we can use them well" says CSB's director. There are some challenges associated with Federal guidelines passed within the last several years, such as tenants not having any prior felony convictions; CSB is still working on resolving these kinds of barriers to housing. Although each PHA uses the same Federal guidelines, they are just guidelines and each PHA can choose whether to embrace, weaken, strength, or enforce those guidelines.

Philadelphia

In Philadelphia, staff members at city offices combine local money with Federal and state money to address the needs of chronically street homeless individuals. Homeless assistance programs fall primarily under the responsibility of the city's Offices of Housing and Community Development and Adult Services (OHCD and AS). OHCD receives ESG, CDBG, HOPWA, and other Federal resources, and conducts the annual Consolidated Plan process. It funds some transitional housing directly, and transfers Federal resources to AS for funding emergency shelter and additional transitional housing. City, state (Homeless Assistance Program), and Federal funds flow through AS and its component parts, the Office of Emergency Shelter and Services, the newly created Housing Support Center, Riverview Home (a city-owned personal care residence for elderly and/or vulnerable Philadelphians) and the Office of HIV Planning (a body responsible for coordinated planning for Federal funding from the Centers for Disease Control and Ryan White Title I). AS is also the City's convener for the annual Continuum of Care application. Some other agencies—Office of Mental Health, the Coordinating Office of Drug and Alcohol Abuse Programs, and the Department of Human Services (the child welfare office)—maintain small numbers of units that are closer to "housing plus services" than to treatment, and which accept homeless people as residents.

Philadelphia also combined the resources of social services with housing monies to create a stock of permanent supportive housing before homeless-specific Federal funding was available. In the early 1990s, the director of OHCD committed his agency to supplying housing in cases where the social services side of city government could and did supply the supportive services. At that time, Philadelphia had underspent its CDBG allotment for a number of years, so that money was made available to support transitional and permanent housing development.

Agencies As Funding Funnels to Ease Client Access to Services

As difficult as it is for agencies to assemble adequate funding to cover all their offerings, homeless people themselves often have an equally or more difficult time putting together the care they need. Conflicting eligibility criteria, lengthy application procedures, dispersed service

locations, and simple ignorance about options and opportunities often mean that chronically homeless people do not get the services and supports that could help them leave homelessness.

"Case management," (which may mean a variety of things in different contexts) is often expected to help clients overcome these obstacles to getting appropriate services, and often it does just that. Case managers in most communities use their skills to broker the disparate services and programs that may be involved in aiding an individual homeless person. In our site visits we encountered some examples of "next steps" beyond simple case management that had decided advantages for clients—programs that within themselves combine enough varieties of funding, to cover enough varieties of supports, that they can "do whatever it takes" to help the client. They also had the accounting and fiscal sophistication to bill the appropriate funding sources without the client having to worry about eligibility. We found two forms of "funnel mechanisms" at the client level—mini-continuums and non-residential wraparound programs.

Mini-continuums. Mini-continuums bear mention here for their particular approach to funneling support to clients. The umbrella agency for a mini-continuum takes pains to acquire funding from many sources so that regardless of client characteristics every client is able to receive all the services offered. Clients are usually unaware of the funding sources for the services they receive. They may know that the agency is trying to help them obtain SSI, or Medicaid, or transitional cash benefits, but they also know that they will receive services whether or not they end up qualifying for these programs. Agency staff members offer clients whatever services they need, and then determine how to report service numbers and bill their funders. For example, the Lamp Community in Los Angeles receives a certain amount of AB 2034 money to serve clients coming from jail. However, the program continues to serve these clients once they have reached the "capacity" allowed under AB 2034 funds. All clients in the Lamp Community are offered available services as needed. Other examples of agencies that blend funding streams to serve clients comprehensively are Pine Street Inn and Friends of Shattuck Shelter in Boston, and several mini-continuums in Seattle.

A final example is Birmingham Health Care (BHC), which we highlight because it is quite unusual to find a full mini-continuum growing out of a program that began as a Health Care for the Homeless site. BHC's continuum begins with prevention, as its health clinics serve low-income communities generally, as well as homeless people. All people using BHC clinics are screened for housing needs, and referrals are made as needed. BHC has emergency shelter capacity in the form of hotel/motel vouchers, and also operates transitional and permanent supportive housing programs. Its fully certified health provider status means it has the ability to offer, and integrate, health, mental health, substance abuse, HIV/AIDS, and housing programs and services. BHC maintains one integrated client file across all programs and services, reinforcing to its employees the message that they are to consider, and work with, the whole person regardless of the "presenting problem."

"Whatever it takes" case management. Two of San Diego's most important programs focused on chronic street homeless people use an interesting approach to delivering supportive services to keep people in housing—they contract with behavioral health companies, one for-profit and one nonprofit. REACH contracts with Telecare Corporation for mental health case management, while Mental Health Systems, Inc. provides assessment, case management, and substance abuse and mental health services for SIP participants. REACH Program participants may also access other providers for a variety of services through their case manager. These companies are able to

deliver appropriate care with workers who often are dual-certified for mental health and substance abuse treatment and have experience with people coming from corrections settings. They are also sophisticated enough to handle Medicaid claims (Medi-Cal in California), and are able to finance a significant portion of the services they provide through Medi-Cal billing, after helping clients qualify for SSI and Medi-Cal. The more Medi-Cal pays for the services it will cover, the more program service dollars can be devoted to other service needs. These companies also have county contracts for health, mental health, and substance abuse care, and thus are able to serve clients as needed and bill whichever source will pay, without troubling the clients about multiple program eligibility rules, applications, and so on. In addition to these advantages of contracted behavioral health services, the REACH program has succeeded in increasing to 85 percent (from about 15 percent) the people receiving cash and other public benefits (usually health insurance, food stamps, SSI, and other cash assistance). As with expanded Medicaid billing, increased client receipt of public benefits increases the overall resources available to help them remain stably housed.

For this approach to work, clients must have housing from another source, as they do in San Diego. The case management agencies must also have multiple sources of funding, including some that will let them serve indigents without other insurance. In the San Diego case both agencies have service contracts with the county Mental Health Services agency to provide mental health and substance abuse services. While these case management agencies do connect clients to specialty services outside their areas of expertise when needed (e.g., to job readiness and training opportunities), they are able to supply the core health, mental health, and substance abuse services within their own framework and in partnership with the clients' housing providers.

Potentially Underused Funding Opportunities

The Ohio program office of the Corporation for Supportive Housing assembled a list of funding sources that she felt were underused in Columbus (Community Shelter Board, 2003). Columbus *does* use some of these, as do others of the communities we visited. As the list is likely to be interesting to many readers, we reproduce it here as Table 6.2; we have added a few potential sources, which appear in *italics*. The list includes state and local as well as Federal sources. To the extent that a state and community does not have particular types of funding, the list may also serve as a source of ideas for stimulating the creation of new state and local funding sources.

Finding the resources to pay for new programs and services is always a challenge. The experience of these seven communities indicates very strongly that reducing chronic street homelessness requires significant investment of mainstream public agencies, bringing both their commitment and energy, and *local* dollars. The goal cannot be met if the homeless assistance network providers are the only players, and Federal funding streams the only resources.

Communities are probably most familiar with the traditional Federal sources of funding for homeless-related activities, but as this chapter shows, more Federal sources exist than some may think. Perhaps even more important for many readers are the different funding sources that some state or local jurisdictions have developed to address chronic homelessness. These include a housing tax levy (Seattle), tax increment financing generated by a redevelopment agency and reinvested in permanent supportive housing (San Diego), community redevelopment bonds

Table 6.2:

Potentially Underused Funding Sources For Ending Chronic Street Homelessness

Capital Sources

- Department of Veterans Affairs – Capital grants for Veterans projects.
- Federal Home Loan Bank – Affordable housing development grants.
- HUD Section 811 – Use is for disabled, very low income; has experienced significant funding cutbacks in recent years.
- HUD Section 202 – Use is for seniors, very low income.
- *Community Development Block Grant—states have flexibility to use for capital needs.*
- State Housing Trust Fund – Gap funding for affordable housing projects.
- City/County Housing Trust Fund – Bridge loans for affordable housing projects.
- State Bond Funds – Long-term financing.
- *State or Local Housing Finance Agency—long-term, low-interest financing.*
- State General Funds – Ohio Department of Mental Health grants for mentally disabled housing development.

Sources for Supportive Housing Operating Costs

- State General Funds – Ohio Department of Mental Health and Ohio Department of Alcohol and Drug Addiction Services grants for operating.
- State Housing Trust Fund – Operating grants for affordable housing (<35% area median income).
- HUD HOPWA (Housing Opportunities for People with AIDS) – Operating grants for AIDS/HIV.
- HUD Section 202 – Provides rental subsidies through 5-year contracts.
- HUD Section 811 – Provides rental subsidies through 5-year contracts; program has had major cutbacks.
- Capitalized Reserves – Legal agreements needed; source of funds are Low Income Housing Tax Credit investment proceeds, Community Development Block Grant, HUD Section 811, Housing Trust Funds or other local General Revenue which are not statutorily or legally prohibited.
- Special state-funded supportive housing demonstrations – Have been successful in other states like Michigan, Minnesota, Illinois, and Connecticut.

Sources for Services

- HUD HOPWA (Housing Opportunities for People with AIDS) – Provides services for people with AIDS/HIV.
- Federal SAMHSA (Substance Abuse & Mental Health Services Administration) – programmatic grants.
- Federal PATH (Projects for Assistance in Transition from Homelessness) – Provides services for people with mental illness.
- "System of Care" models have been successful in Indianapolis, Minnesota and California.
- Medicaid and Medicaid Waiver programs, *including Medical Rehabilitation Option* – A local Medicaid Work Group continues to evaluate how best to use this as a source.
- SSI/SSDI – Payments, when appropriate, can be paid directly to the housing or service provider; can offset the cost of services.
- *Federal Block Grants—Social Services, Mental Health, Substance Abuse, Preventive Health, Community Services – States have flexibility to determine services delivered, eligibility, and distribution method.*
- Federal, state & county criminal justice systems – Have been successful in Illinois and New York.
- Special state funded supportive housing demonstrations – Have been successful in other states.
- State Housing Trust Funds – Could be a resource if OHTF has stable and growing source of revenue.

(Philadelphia), special state funding streams (California's Integrated Services for Homeless People with Mental Illness, and its Supportive Housing Initiative Act), and investments by Business Improvement Districts and other associations of downtown businesses and corporations (Birmingham, Columbus, Philadelphia, San Diego). Philadelphia's Community Behavioral Health also provides a unique source of public funding for homeless services. Part of its structure to insurers, including Medicaid, that help pay for services is a "profit" margin. As a city agency, it is committed to investing a part of this "profit" margin into homeless assistance services such as outreach that are not reimbursable on a fee-for-services basis, and in housing. Other states and localities may be more willing to replicate these funding sources once policy makers have evidence that making certain types of investment in ending chronic street homelessness pays off in savings in other areas.

CHAPTER 7: POLICY, PRACTICE, AND RESEARCH IMPLICATIONS

This is a time when communities are exploring new approaches to end chronic street homelessness. Realistically, the approaches are still at the stage of reducing such homelessness, and the evaluations of their success are still rudimentary. We selected seven communities that were reputed to have made progress in reducing their chronic street homeless population and would be able to document that progress. After conducting site visits, we found that only three of the seven had developed a true community-wide paradigm, but that each of the seven communities had made noteworthy innovations at the strategic level. Our research suggests that certain elements are essential for a community to make significant progress toward the goal of ending homelessness.

Above all our study indicates that reducing, and eventually ending, chronic homelessness is an achievable goal that will require permanent supportive housing programs. Moreover success will require a clear recognition of this goal, community-wide collaboration, strong leadership within an effective organizational structure, and significant resources from mainstream public agencies. Other elements that will increase the likelihood of success are significant resources from the private sector, commitment and support from elected officials, outcome evaluation mechanisms for program support and improvement, openness to new service approaches, and strategies to minimize negative neighborhood reactions to projects. In this chapter we explore the implications of these findings.

Implications for Policy

Our study has found that the most successful communities were employing community-wide, integrated approaches to reduce chronic homelessness. However, such approaches were not widespread. We searched for communities meeting these criteria and only found three. The scarcity of exemplary sites suggests that the effectiveness of community-wide, integrated approaches needs to be publicized. Communities also need assistance in recognizing and implementing the elements necessary for success, and funding support from Federal, state, and local agencies that is directed toward these new strategies.

During site visits many respondents offered suggestions for how Federal policy and Federal agencies could help them as they pursue their goal of ending chronic homelessness. Their suggestions reflect their own experiences of what has helped them, and also what they feel could continue to ease the way toward reaching their goal. These include suggestions for Federal, state, and local agencies. A particular problem for communities was that diverse, uncoordinated funding streams required them to submit numerous proposals to many different agencies in order to provide total wraparound housing and supportive services for the chronically homeless. The policy implications of these findings are:

- Federal agencies should continue to prioritize community-wide planning and integrated approaches for reducing chronic homelessness in general, and street homelessness for people with severe mental illness, chronic substance abuse, HIV/AIDS, or any combination in particular.

- Federal agencies should make technical assistance widely available to teams from communities that have reached the stage of starting to plan an approach to reducing street homelessness.

- Federal agencies should facilitate opportunities for practitioners and planners to observe new approaches in action, speak with consumers, see results, and consider how these practices could be applied in their own community.

- Federal legislative action should increase the flexibility of Federal agencies to blend their funding to support innovative community-wide practices that integrate services across local agencies to reduce chronic homelessness. State and local agencies should adjust rules and regulations to facilitate access to mainstream benefits, programs, and services for chronically street homeless people.

- State and local agencies should establish procedures and resources to assure that people leaving psychiatric care, substance abuse treatment, correctional facilities, or foster care do not become homeless.

- State and local agencies should facilitate capacity to serve chronically homeless clients by improving liaison and integrated service arrangements among mental health, substance abuse, medical care, and housing authorities.

Implications for Practice

The site appendices of this report include "practices of potential interest to other communities" with contact information for people who are involved in these activities. Readers should browse these practices to see whether any of them might be appropriate for their own community. There are, however, some general implications for practice. To successfully reduce chronic homelessness within a community:

- Homeless providers need to develop dual competence and dual certification—mental illness and substance abuse issues must be handled together.

- Mainstream mental health and substance abuse agencies need to have an integrated approach to mental illness and substance abuse for chronically street homeless people.

- Mainstream health, mental health, substance abuse, and welfare agencies should make their clients' housing stability a high priority and create positions of housing developers and coordinators.

- Housing providers need to understand the benefits of supportive services to their *whole* tenant base and not just to those who were once homeless.

- Strong, skilled leaders committed to an integrated community-wide approach need to come forward and have the backing and resources of local mainstream agencies and elected officials.

Implications for Research

Although the study communities were documenting the "success" of their approaches, research on the outcomes and the cost effectiveness of their various strategies often had flaws in design or incomplete data. We discovered many gaps in knowledge that hindered our ability to establish with greater confidence which approaches and strategies were most fruitful and hold the most promise for other communities. The following research suggestions are those that we think will provide the most useful information to show effective approaches to ending chronic street homelessness.

- Longitudinal tracking studies should follow people once they leave supported housing to document housing stability. A primary outcome to observe in this research would be housing stability within and after leaving the homeless assistance network, and what factors contribute to it. These studies would be most relevant to conduct for formerly street homeless people with severe mental illness and co-occurring disorders.

- Research should compare the effectiveness and cost-effectiveness of different pathways into permanent housing for different subpopulations. Ideally this research would use random assignment intervention studies; if that is impossible, it *must* employ meaningful comparison groups.

- Research on pathways should include (1) directly from the street into permanent supportive housing, (2) directly from the street into transitional housing as a step before permanent supportive housing, (3) directly from the street into safe haven as a step before permanent supportive housing, and (4) transitional housing with expectation of movement into affordable housing in the community (no supportive services).

- Research should test the following approaches within the pathways just described (1) sober versus harm reduction models, (2) voluntary versus coerced treatment (the latter through drug court or its equivalent), (3) different physical structures and service delivery mechanisms (for example, scattered site, only-formerly-homeless single site, and mixed-use single site), and (4) if transitional housing is part of the pathway being tested, what is the optimal duration of transitional housing to increase the odds of maintaining recovery.

- Research should support a reasonable sample of permanent supportive housing providers to collect and maintain better data on their tenants, and assemble these data at the national level. The providers would need to collect data (1) at intake about tenant histories, (2) during residence, and (3) after people leave permanent supportive housing, to document continued progress or return to homelessness. 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 the follow-up interviewing, if one wanted to assure acceptable completion levels.

APPENDIX A: BIRMINGHAM

Birmingham—Brief Description

Birmingham, with a 2000 population of 242,820, is the largest of 30 municipalities in Jefferson County, Alabama and comprises a little more than one-third of the county's total population.[1] In the 2000 Census Birmingham's poverty rate was 24.7 percent and Jefferson County's was 14.6, both higher than the nation's 11.3. Jefferson County's 2002 unemployment rate was 4.4 percent compared to the nation's 5.8.[2] Given the city's poverty rate, its unemployment rate is likely higher than the county's, and higher than that of the nation.

Among the communities included in this study, Birmingham is unique in having almost no state or local public dollars invested in its homeless assistance network, including its efforts to end chronic street homelessness. Public agencies involved in homeless-related services in Birmingham are those that rely primarily on Federal funding, including the Birmingham Department of Community Development, the Department of Veterans Affairs, the Jefferson County Housing Authority, and the Jefferson-Blount-St. Clair (JBS) Mental Health/Mental Retardation Authority. Further, income and other eligibility criteria for Medicaid are so stringent that very few people qualify, so in Birmingham Medicaid is not the important resource for funding supportive services that it is in many other communities.

Against this backdrop, Birmingham providers and advocates have developed some interesting responses to homelessness. The entity orchestrating most of the homeless network planning and development is Metropolitan Birmingham Services for the Homeless (MBSH), a membership organization with no formal authority or control over its members. Agencies have developed some innovative ways to blend the interests of property owners and poor people to create affordable housing with very little government funding, and have involved the business community in other ways to address street homelessness.

The network of programs and services developed to encourage people to move from the streets into housing includes outreach, emergency shelter, and transitional and permanent supportive housing. A safe haven is expected to open in December 2003. Employment and community service are important emphases in programs working with people whose homelessness is complicated by chronic substance abuse. On our visit to Birmingham on May 7 and 8, 2003, we interviewed 17 people and attended the monthly MBSH meeting with many others. The people interviewed represented county and regional agencies; nonprofit outreach, drop-in, shelter, and housing providers; and agencies serving homeless people through casework, mental health and substance abuse treatment, health care, and employment services. People who had experienced

---

[1] http://www.census.gov/prod/2002pubs/00ccdb/cc00_tabC1.pdf.

[2] 2000 poverty statistics for Birmingham, http://censtats.census.gov/cgi-bin/pct/pctProfile.pl; 2000 poverty statistics for Jefferson County, www.census.gov/prod/2002pubs/00ccdb/cc00_tabB5.pdf; for United States, quickfacts.census.gov/states/00000.html; February 2003 unemployment statistics for Birmingham MSA, http://data.bls.gov/cgi-bin/surveymost; for United States, www.bls.gov/cps/home.htm#overview.

chronic street homelessness were included in a separate focus group. A full listing of persons interviewed, other than focus group participants, may be found at the end of this appendix.

Practices of Potential Interest to Other Jurisdictions

In Birmingham we found several practices for reducing chronic street homelessness that may have applications for other communities:

- **Expanding Heath Care into a Total Continuum of Care.** Birmingham Health Care (BHC) has grown from providing health, substance abuse, and mental health services for homeless people into a multi-faceted agency doing outreach, case management, transitional housing, and permanent supportive housing for homeless people as well as myriad services for housed poor people. As a health service agency that went on to provide housing for its clients, BHC had the advantage of already having a very strong service component in place to go with its housing. Being one agency helps BHC provide prompt and unbroken services to homeless individuals and integrate their case management and service records. (Contact person: Jonathan Dunning, Chief Executive Officer, JWDunning@cs.com, 205.439.7201.)

- **Requiring Employment and Community Service in Substance Abuse Treatment Programs.** In addition to 9 hours of treatment sessions, the Firehouse requires that participants work and perform 15 to 20 hours per week of community service. In focus groups, successful participants said that employment was a start toward economic self-sufficiency and that community service improved their self-concept. All the major programs in Birmingham focused on street addicts have significant employment components, including BHC, Aletheia, and First Light, in addition to Cooperative Downtown Ministries (CDM). (Contact person: Steve Freeman, Executive Director, cdm-shelter@prodigy.net, 205.252.9571.)

- **Using Building Donations and Other Private Resources.** Birmingham housing providers have been successfully soliciting donations of dilapidated buildings from the private sector. Sponsors help fund rehabilitating building units and program participants learning construction trades help do the work. The neighborhoods are improved and the donor receives a tax write off. The Birmingham Continuum of Care is developing its HMIS using private donations so that it does not drain funding away from other programs being proposed in Birmingham's applications to HUD. (Contact person: Chris Retan, Executive Director, Aletheia House, Chris_Retan@yahoo.com, 205.324.6502.)

- **Using a Powerful Volunteer Association to Spearhead a Continuum of Care.** In an environment of little local government funding, Metropolitan Birmingham Services for the Homeless (MBSH) has emerged as a powerful volunteer coordinating body even though it has no formal authority or controls over its members. MBSH helps government agencies, nonprofits, and the private sector work together to create affordable housing and provide other services to address street homelessness. (Contact person: Michelle Farley, Acting Director, -Metropolitan Birmingham Services for the Homeless, Metropolitan Birmingham Services for the Homeless, mmfarley2003@yahoo.com, 205.254.8833.)

Primary Contact Person

Michelle Farley
Interim Director of Metropolitan Birmingham Services for the Homeless
Metropolitan Birmingham Services for the Homeless
2230 4th Avenue North
Birmingham, AL 35203
Phone: 205.254.8833
Fax: 205.323.8362
mmfarley2003@yahoo.com

History and Context—How the Current System Evolved

Birmingham's array of programs and services for chronically street homeless adults emerged piecemeal over the years, despite some early efforts to focus on street homelessness. About five years ago a Mayor's Task Force was assembled to address street homelessness in response to a city council member's proposal of an ordinance to outlaw "urban camping." The ordinance suggestion was roundly denounced, but all of the organizations working with street homeless people assembled as a task force to figure out how to help people leave the streets. It evolved four goals: (1) getting more professional staff in shelters; (2) developing more beds so the wait was not so long for substance abuse treatment; (3) starting a women's program (First Light); and (4) allowing the Birmingham Housing Authority to use some of its many vacant units for transitional housing. HUD vetoed the last of these proposals, and lack of funding meant that most of the remainder did not happen, at least at that time.

One result of the Task Force was that programs got to know each others' services better, which facilitated access to services for the residents of individual programs. Another result was that the Mayor's Task Force gave some impetus and leverage to some providers' plans to expand their programs into transitional and permanent housing. For instance, CDM was able to fulfill one of its own goals to develop a transitional housing program when a property owner donated a building. CDM raised private money for renovations from the Birmingham Jaycees and the Community Foundation; other support came from CDM itself and from churches that sponsored apartment renovations at $2,000 to 3,000 an apartment. Men from CDM's Firehouse Shelter were trained and hired to do the renovation work.

The Mayor's Task Force eventually blended into MBSH. Over the years, as different municipalities felt the need to have a plan related to homelessness, MBSH became the organization they all eventually sought out. Now Birmingham gives MBSH money to do its planning with respect to homeless issues, and the city is in the fourth year of a five-year plan developed through MBSH. The county's 30 mayors, 30 city councils, and the county commissioners have accepted that MBSH will be more successful at conceiving, developing, selling, and following through with a plan than they will themselves. They have, instead, become members of MBSH and work on homeless issues through the MBSH mechanism.

While MBSH handles the overall planning and interagency communication in Birmingham, individual providers have been busy expanding their offerings relevant to chronic street homeless people. First Light and CDM's Firehouse have already been mentioned. Other providers that

have expanded to provide both supportive housing (transitional and permanent) and "regular" affordable housing are Aletheia House and Birmingham Health Care.

Aletheia House, a large substance abuse treatment provider, has developed hundreds of units of transitional housing to help its clients extend their sobriety in a stable housing environment. For the same reason and also because it recognized the need for affordable housing, Aletheia House has become the largest developer of affordable rental housing (without services) in the Birmingham area. Its own (now self-supporting) clients can move into this housing, as can clients who will always need supportive services. Housing costs for the latter are subsidized by Shelter Plus Care and Section 8.

Birmingham Health Care is another unique type of program. It is not often that an entire continuum of care springs out of a health care setting, but Birmingham has two examples in Aletheia House and BHC. BHC began as a Health Care for the Homeless site, and now offers physical health care, mental health and substance abuse treatment, transitional and permanent supportive housing, employment services, and integrated case management to chronically street homeless people along with other homeless and simply poor people through eight different clinics and health centers.

The next section describes Birmingham's approach to ending chronic street homelessness in its downtown area, including documentation of progress to date. Thereafter we give more detail about selected system components, examine funding mechanisms, describe how the current system evolved and where it is going, and describe issues that have arisen with respect to community relations.

Approach to Chronic Street Homelessness

This section briefly describes the network of programs and services focused on reducing or ending chronic street homelessness among single adults. It also examines characteristics of people the system serves, how services are coordinated, and approaches or models in current and anticipated use. Continuum of care components addressing chronic street homelessness are described in more detail in the section entitled "Selected System Components," along with activities and investments related to increasing the stock of affordable housing.

As already noted, MBSH is the key organization for homeless-related issues in Birmingham. It is an incorporated nonprofit with 501(c)(3) status, but until September 2002 made do with one or more part-time employees. In September 2002 it hired its first full-time employee, someone with a fundraising background. Its membership is large and growing—an average of 40 agencies and organizations are usually represented at its monthly meetings, and the membership list is about twice as large. Participation in MBSH is completely voluntary and open to any organization or person interested in joining. Membership is eclectic and includes nonprofit and faith-based homeless assistance providers; business associations; housing developers, banks, and individual businesses; organizations representing people with various disabilities; representatives of city, county, regional, and Federal government agencies; elected officials; neighborhood associations; and formerly homeless individuals.

Birmingham did not have a specific focus on chronic homelessness or street homelessness until very recently. As recently as its 2002 CoC application, presentations of its approach describe the community as trying to end all homelessness without distinguishing between chronic and crisis homelessness. Specific foci include gathering data to understand the scope of the problem and addressing the need for more affordable housing. The desire to respond to the Federal Chronic Homelessness Initiative Notice of Funds Availability (NOFA) in spring 2003 stimulated MBSH to focus on the chronically homeless population. All of the providers focusing on chronic street homelessness are members of MBSH, which will now have a specific chronic homelessness subgroup that intends to meet monthly for the hour after the regular MBSH meetings.

The MBSH approach is to identify a problem and craft solutions through information sharing and discussion. In cases where funding is potentially available, MBSH tells all of its members of the opportunity and asks all interested parties to step forward. The results are usually that providers take stock of their capabilities and the direction they want their own agency to follow, look at who else might want to be involved, and sort themselves into reasonable combinations of applicants. This was the result recently in response to the Federal NOFA for the Chronic Homelessness Initiative, with a score of agencies expressing initial interest and three agencies plus MBSH being involved in the final proposal.

Program and Service Network

Birmingham has a number of agencies that offer emergency shelter to single homeless people. However, not all of these are involved in addressing chronic street homelessness. Table A.1 shows the agencies with the strongest concentration of the street homeless population, including all that offer permanent supportive housing and/or transitional housing with follow-up services for people whose major issues are addiction-related. Rows represent different providers; columns represent the types of programs and services offered. An "X" in a cell indicates that the provider offers that program or service. An "F" indicates that a public agency funds a program or service, and an "E" indicates that the provider offers expert advice, technical assistance, or training.[3] Three providers, BHC, CDM, and First Light, provide the broadest spectrum of programs and services for chronically street homeless single people. BHC does outreach, has vouchers for emergency/crisis housing in lieu of running an emergency shelter, has transitional and permanent supportive housing, and is a fully qualified primary health care, mental health care, and substance abuse treatment provider. CDM programs, which serve homeless men, range from outreach through PSH and will shortly include Birmingham's first safe haven for chronically homeless people with severe mental illness. First Light's programs, which serve homeless single women, include emergency shelter, transitional and permanent supportive housing, and mental health and substance abuse treatment.

An important aspect of all the programs in Birmingham serving chronically street homeless people is their emphasis on employment. All have job training, job readiness, and job search components to their programs, and getting a job is an expected and *necessary* part of many

[3] Table A.1 does not represent the entire network of homeless assistance programs and services in Birmingham. These and other providers may also offer programs and services for single people with brief homeless experiences, as well as homeless families with children and homeless youth.

programs' strategies for their residents. As soon as people have a job, they are expected to begin paying for the days they stay in the program, and also to open a savings account. Given the relatively low funding levels of the shelter and housing programs in Birmingham, this strategy is necessary to allow residents to remain in the programs as long as they need to, and to keep the programs functioning financially. Along with the work emphasis, a number of Birmingham programs also have a community service requirement—residents have to do 15 to 20 hours of community service a week. The rationale behind this requirement, and the effects that residents say it has on them, are described in more detail in the section on "Selected System Components."

Involvement of Mainstream Agencies

A few mainstream agencies play important roles in Birmingham's approach to chronic street homelessness, chief among which are JBS Mental Health/Mental Retardation (MH/MR) Authority, the Jefferson County Housing Authority, the Birmingham Department of Community Development, and the VA Medical Center. JBS has operated a homeless program for about 15 years, staffed with its own employees and serving people with serious mental illness but without a permanent address or income. Services include mental health care and medications at a free clinic, conducting assessments at locations convenient for the people being assessed, and making referrals for housing, vocational rehabilitation, and transportation. JBS also covers supportive services for formerly homeless people with serious mental illness who live in PSH, including Shelter Plus Care.

The Jefferson County Housing Authority and the Birmingham Department of Community Development both use a variety of Federal funding sources to support emergency shelters, transitional and permanent supportive housing, and to create affordable housing. The VA Medical Clinic serves veterans who are or have been homeless, offers services in some housing supported through Shelter Plus Care, and was a partner (with JBS and Birmingham Health Care) in Birmingham's application under the Federal Chronic Homelessness Initiative.

Use of Private Sector Resources

Given the paucity of public funding for homeless programs and services in Birmingham, providers have developed a number of approaches that build on the resources and interests of the private sector.

- **Donated buildings**. Two agencies that develop transitional and permanent housing (with and without supports) have had success approaching owners of dilapidated and wholly or partially vacant properties to see if they will donate the property. If yes, the agencies use capital financing from the Federal Home Loan Bank and private lenders, plus Low Income Housing Tax Credits, HOME funds, and donations from religious congregations and private individuals to renovate and make repairs. The following benefits accrue:

    - Property owners get tax write-offs on properties that were losing money and causing problems;
    - The agencies get free buildings they fix up and use;

  - Neighborhoods get renovated and supervised buildings in place of eyesores and problem spots (not only not a NIMBY response, but a warm welcome); and
  - Participants in agency job training programs gain construction skills as well as a sense of ownership as they prepare the housing for occupancy—perhaps by themselves.

- **Employment focus for program participants**. All of the agencies offering shelter or housing have job readiness, training, and placement services. They appear to be quite successful at moving people into employment, even while still in shelter or transitional housing. Once employed, residents' wages help fund the program through payment of rent.

- **Private funding of HMIS**. MBSH expects to be able to fund its HMIS through private donations, leaving all of the funding obtained through its CoC application for programs and services.

Who Is Served?

Chronically homeless street people with severe mental illness are served through JBS and various housing programs. If they have a co-occurring substance abuse disorder, however, JBS cannot address that issue, and can only refer clients to private substance abuse treatment programs. As we were told several times, the State of Alabama "considers substance abuse a choice," which means there is no public support, either financial or staff resources, for substance abuse treatment. Nevertheless, several programs specialize in helping chronic substance abusers with long histories of homelessness. They do this through highly structured treatment programs that have major components of community service and employment. Once residents are employed, their wages help to offset the cost of housing and continued program participation.

Table A.1: City of Birmingham: Agencies Involved in Reducing/Ending Chronic Street Homelessness

	Homeless-Related Programs and Services																					
	Prevention	Outreach\Drop-in	Shelter	Safe Havens	Trasitional Housing	Permanent Supportive Housing	Other Housing (non-disabled)	Alcohol and Other Drugs	Mental Health	Health	Employment	Corrections	Public Assistance	Child Welfare	Advocacy	Food	Case Management	Cross-agency Coordination of Service Access and Delivery	Planning	Staff Training	Data\Documentation	PR, Public Acceptance
Nonprofit Programs/ Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People (listed alphabetically)																						
AIDS Alabama					X	X		X			X			X		X	X	X	E		X
Aletheia House		X			X	X	X	X			X			X		X	X	X	E		X
Birmingham Health Care		X	*		X	X		X	X	X	X			X	X	X	X	X	E	X	X
Church of the Reconciler		X														X	X				
Cooperative Downtown Ministries		X	X	**	X	X		X	X		X			X		X	X	X	E		X
First Light			X		X	X		X	X		X			X		X	X	X			X
Metropolitan Birmingham Services to the Homeless (MBSH)														X			X	X	E	X	X
Pathways		X									X			X	X	X	X	X			X
Business Associations																						
City Action Partnership (CAP, Birmingham's BID)		X,F												X			X	X			X
Government Programs/ Services/ Agencies Serving Currently Fromerly Chronic Street Homeless People																						
City Agencies																						
Department of Community Development			F		F	F	F										F	X		F	
Police Department																		X		X	
County Agencies																						
Jefferson Co. Housing Authority						F											X			X	
JBS MH/MR Authority		X							X							X	X			F	
Community Development Department			F		F	F	F										F				
VA Medical Center (federal)					X	X		X	X	X	X					X	X	X		X	

X = Provider E = Expert TA Provider F = Funder

* In emergency situations, BHC uses vouchers to pay for hotel/motel stays, though it does not run an emergency shelter.

** CDM is developing Birmingham's first safe haven, which is scheduled to open in December 2003.

Coordination Mechanisms

Planning and program development. MBSH is the key organization in Birmingham for homeless-related planning and program development. The organization was started in 1984 by a handful of homeless service providers, and became a tax-exempt nonprofit organization in 1988. As already noted, MBSH membership covers every possible type of organization, agency, business, and person interested in homeless people and solutions to homelessness in the greater Birmingham area, including representatives from neighboring city and county governments. Even when individual jurisdictions recognize the need to develop a plan and begin the process, people eventually say "why not go to MBSH with this, they'll know what to do." So they eventually come to MBSH and become members. This process of expanding membership has, over the years, made MBSH meetings the venue to learn about services, air concerns, discuss how to respond to everything from Federal NOFAs to local legislative issues, bring disparate interests together, and bridge communication gaps.

MBSH also takes on tasks that affect many of its members. Developing the CoC plan and application is one of these, as was Birmingham's response to the recent Chronic Homelessness Initiative NOFA. MBSH is spearheading a drive to raise all the funding needed for an HMIS (estimated at about $500,000) from private sources, after membership decided that all the HUD funding through the CoC application was needed for programs and services. In addition, the missions that provide much of the emergency shelter in Birmingham are interested in participating in the HMIS, but would not do so if Federal monies were involved, as they do not accept any public money. The fact that MBSH appears likely to succeed in raising these HMIS funds attests to the linkages it has with the local business community and the level of agreement reached among members of both the need for an HMIS and the way they prefer to support one.

Working with chronic street homeless people. While Birmingham has no formal coordination mechanism that helps case managers link chronically homeless people with services, linkages occur fairly smoothly because "we all know each other," in the words of many people interviewed. MBSH facilitates shared knowledge of the nature and availability of services through presentations at its monthly meetings. Different configurations of agencies work together to serve particular groups among chronically homeless people through co-location, joint teaming arrangements, and referral. For instance, First Light runs emergency shelter and transitional and permanent supportive housing for single women. JBS operates a clinic on the First Light premises where women can receive mental health and substance abuse services. A day program called PATH after its Federal funding source developed to complement First Light, and PATH merged with a domestic violence shelter program to become Pathways. First Light's women go to Pathways for lunch; Pathways guests come to First Light for counseling and therapy. JBS and First Light facilitate referrals to Shelter Plus Care and if the woman's mental illness is severe enough, JBS continues to provide supportive services. Another example of program linkages illustrates the ways that street homeless people may get into services—JBS and City Action Partnership (CAP, which is Birmingham's Business Improvement District), do street outreach, coordinate with each other, link street homeless people to CDM's Firehouse Shelter and to First Light, and work with those programs' case managers. In addition, the Street Outreach Program (STOP) funded by HUD provides two CDM social workers to team with the CAP Patrol. Finally, the VA Medical Center, Jefferson County Housing Authority, and

Birmingham Health Care worked together to develop the Chronic Homelessness Initiative application.

Pathways to Housing, Approaches and Models

- *Emergency shelter to transitional housing to housing*. This is the pathway followed by most chronically homeless people whose primary issue is substance abuse. It is a "clean and sober" route involving 12-step meetings and other aspects of substance abuse treatment, community service, job readiness and subsequent employment, and eventual movement from transitional housing into regular market rate housing. Most of the people following this route are men.

- *Outreach/drop-in and/or emergency shelter plus mental health services to PSH*. This appears to be the route most commonly taken by chronically homeless people for whom severe mental illness is the primary issue, most of whom are women. A medical or psychiatric contact is the first step, with emergency shelter a "holding" option until a PSH slot opens up either through Shelter Plus Care, other HUD-funded PSH projects, or within the mental health system itself.

Selected System Components

MBSH offers a common meeting ground for agencies focused on reducing the downtown chronic street homeless population. As Table A.1 indicates, most of the agencies serving chronic street homeless people offer only a few aspects of a CoC, while a few offer a broad spectrum. Together these agencies include most of the usual CoC components.

Several agencies within the system make outstanding contributions, because of the breadth or nature of their services. BHC provides free public meals; most types of housing (emergency shelter (ES) through hotel vouchers); especially strong and well integrated health, mental health and substance abuse services; employment training and on-the-job experience; advocacy for legislative programs; case management; cross-agency coordination of service delivery and planning; evaluation and planning data; and public relations and education. BHC is also an important research site for a National Institute on Drug Abuse study of substance abuse treatment.

CDM also has a broad array of services, and makes a special contribution through its emergency shelter program which links to community outreach programs and provides temporary housing for clients of BHC and other agencies. CDM uses BHC for health care, and a BHC medical van visits CDM weekly. Law enforcement agencies also use CDM as a resource for street homeless individuals encountered on patrol or being discharged from jail. Participants can go beyond ES by accepting case management services and entering CDM's substance abuse and employment programs. In addition, CDM has developed two transitional housing programs and permanent supportive housing, and is on track to open the city's first safe haven by the end of 2003.

First Light is especially important for providing single homeless women with emergency shelter, transitional and permanent supportive housing, and mental health and substance abuse treatment.

The JBS MH/MR Authority is a key provider of mental health assessments and care to homeless people; it takes referrals from agencies providing other services and works on site at other agencies.

Prevention

No MBSH members have homeless prevention as a primary focus. However, some agencies provide preventive services in the course of their other activities, such as financial assistance for rent, mortgage, and utility payments; temporary lodging, and homelessness prevention classes.

Because BHC serves housed as well as homeless households, it is able to assist clients who might become homeless if health, mental health, and/or substance abuse crises were not handled in a holistic manner. Bread and Roses and PATH operate employment readiness programs to ensure that women do not lose housing because of insufficient incomes. An Aletheia House outreach worker goes to jails and prisons to help addicted offenders avoid homelessness and transition to appropriate community programs.

State actions have counteracted prevention efforts with respect to people with severe mental illness. Between 1985 and the present, bed capacity at the state mental hospital has dropped from 5000 to 350, with a large drop in the last two years. Not only do local agencies have great difficulty in placing potentially street homeless clients in the state facility, but Birmingham's street outreach programs report seeing increasing numbers of mentally ill individuals released from the state hospital with no plans and no place to go.

Outreach/Drop-in

In the late 1990s the Birmingham City Council was considering an ordinance that would have banned "urban camping," clearly aimed at street homeless people in the downtown area. The proposal galvanized support for an alternative—active outreach programs to bring people off the streets without criminalizing them. Advocates of the ordinance complained that street homeless people were creating problems such as panhandling, litter, poor sanitation, and safety concerns. Advocates for the homeless population wanted to develop a more constructive and less punitive approach. The Mayor created a Task Force on Homelessness to address the issue.

As an outgrowth of the Task Force, CAP funded an assistance-oriented uniformed patrol. CAP officers provide services downtown that range from directing shoppers to stores to helping case managers locate homeless individuals when they need to deliver medications or other services. CAP prepares pamphlets listing resources by needs with addresses and maps for food, shelter, clothing, and employment services. With funding from HUD, the CAP Patrol added STOP, a street outreach program that teams social workers from the CDM Firehouse Shelter with CAP Officers. In addition, the Police Department began employing Community Service Officers, who are trained social workers, to do crisis intervention and referrals to shelters and hospitals. The Firehouse Shelter increased its own outreach teams' activities to bring clients into its supportive housing program or, if the fit was not right, provide them with temporary housing until they could be placed in another residential treatment program. The Firehouse Shelter also set aside eight beds (four each for males and females) for police referrals. Contributing to this overall

effort to provide better outreach to street homeless individuals, the University of Alabama Birmingham agreed to be the designated Mental Health Emergency Room to meet crisis treatment needs.

Other agencies are also involved in outreach. BHC conducts daily street outreach and also makes contacts through its mobile medical units. Hope House does runaway youth outreach from a food and clothing van, and Aletheia House has an outreach worker who visits shelters, soup kitchens, and the streets to find addicted homeless veterans.

Low Demand Transitional Residences

Birmingham did not have safe havens or low demand residences at the time of our visit. The shelters require residents to be clean and sober and participate in treatment programs, although some programs give residents who relapse multiple chances to return and try again. CDM is about to open a "safe haven" for dually diagnosed homeless individuals, but this facility is likely to require participation in treatment programs and discourage continued substance abuse.

Emergency Shelters

The CDM emergency shelter program (50 beds) is noteworthy because it links into CDM's transitional housing, which has substance abuse treatment and employment programs. The Salvation Army is the largest provider of emergency shelter beds for individuals (139 beds) followed by Jimmie Hale Mission (100 beds), but neither of these programs provides transitional housing for individuals, and linkages across programs are not made consistently.

Transitional Programs

The major transitional programs in Birmingham have, in addition to treatment sessions, strong employment and community service components. CDM operates the largest transitional housing program (80 beds); the program requires sobriety, but allows participants to return after a relapse. Participants have little idle time, as CDM tightly schedules their week with employment or employment training (20-40 hours), community service (15-20 hours), and treatment class attendance (9 hours). Four members of our participant focus group who had failed other programs stated that the greater structure in the CDM program played an important part in their recovery. Two other focus group participants thought that the CDM program was too dictatorial, and preferred a more self-structured approach that they found in another program.

BHC, Aletheia House and AIDS Alabama provide transitional housing (40, 18, and 13 beds, respectively) that links to their permanent supportive housing programs. Fellowship House is the second largest provider of transitional housing (70 beds), providing inpatient residential treatment for persons with severe mental illness who are homeless and have a co-occurring disorder. But Fellowship House does not have strong ties to the CoC and attends meetings infrequently.

Permanent Supportive Housing

The Jefferson County Housing Authority through its Shelter Plus Care Program is the largest funder of permanent supportive housing with 200 individual slots. Various providers actually operate the housing, including BHC (50 beds), Aletheia House (28 beds) and AIDS Alabama (39 beds). All the providers accept referrals from other social service agencies.

Supportive Services

The major providers of emergency shelter and transitional housing also provide case management to assess individual needs, develop a case plan, link participants to other supportive services and assist them in qualifying for public benefits such as Social Security Disability Income (SSDI), food stamps, and Medicaid. Agencies doing this work include Aletheia House, AIDS Alabama, YWCA, Bread and Roses, Community Kitchens, Birmingham Health Care, JBS, Interfaith Hospitality House, PATH, CDM, Salvation Army, and First Light Women's Shelter.

JBS provides psychiatric assessments by appointment on Thursdays during its homeless clinic. Aletheia House provides substance abuse assessment Monday through Friday by Master's level therapists. AIDS Alabama provides assessment upon intake at its central facility, followed by referrals as needed. Interfaith Hospitality House provides intake and assessment upon entry into its facility. The YWCA's Compliance Manager meets with persons interested in housing and other services and conducts an assessment of needs. At BHC, all clients see a case manager who conducts a needs assessment covering housing, substance abuse, mental health, and social support needs. Jefferson County Housing Authority determines eligibility for Shelter Plus Care housing based on homelessness, income level, and documented disability of substance abuse, serious mental illness, and or HIV/AIDS. Pathways provide skills assessments to homeless women to identify skill levels for job readiness programs.

Job training and referral is a key component of services in Birmingham. Aletheia House and BHC work together on a Homeless Veterans Reintegration Project. Funded by the U. S. Department of Labor, it provides job training and support services to more than 75 homeless veterans each year. HUD funds two other job training programs, one at BHC and one at Community Kitchens. BHC runs an 18-week on-the-job training program for homeless persons who graduate from substance abuse treatment. Community Kitchens operates a food preparation-training program for homeless individuals. Bread and Roses and PATH operate job training for homeless women. Providers interviewed during our visit to Birmingham said that people in their programs have no trouble getting jobs, including those going through substance abuse treatment and those completing formal job training programs.

Birmingham's CoC has several providers of mental health services. JBS provides assessment and mental health care to Birmingham's homeless population. Cooper Green Hospital or University of Alabama at Birmingham (UAB) Center for Psychiatric Medicine provide facilities for hospitalizing seriously mentally ill individuals. Eastside, Western, and UAB Community Mental Health Center (CMHCs) provide ongoing treatment of mental health disorders.

The three main substance abuse treatment providers for the chronic street homeless population, CDM, Altheia House and BHC, have developed job training, work experience, and post treatment housing components so that individuals completing treatment do not have to return to emergency shelters. Once participants are working a portion of their earnings are applied to the cost of housing.

Affordable Housing

Birmingham has few government programs to promote affordable downtown housing. In fact, Aletheia House, originally just a substance abuse treatment program, has grown to be the largest developer of affordable housing in the Birmingham area. The Housing Authority of Jefferson County did not build its first public housing until the 1960s, completed its last units in the 1980s, and currently owns only 369 public housing units. It also operates a Section 8 voucher program and services twelve Farmer's Home Units.

The housing affordability data for Birmingham partly explain this low level of activity. Compared to most metropolitan areas, it is relatively easy to buy a house in or near downtown Birmingham. In the 2000 Census, neighborhoods near downtown had median house prices below $50,000. However, apartment renting is a different story. Downtown apartment occupancy rates are over 95 percent, rents for a one-bedroom/one bath apartment start at $650 (Urban Land Institute, 2002), and about 35 percent of renters are unable to afford fair-market rent (Campbell, 2001). There appear to be better opportunities to buy than to rent, and three formerly homeless people in our focus group had bought or were in the process of buying a home.

As its economy grew during the 1990s, Jefferson County’s population shifted to the suburbs, leaving downtown Birmingham with fewer people and fewer housing units. Between 1990 and 2000, Birmingham lost 6 percent of its households and 10 percent of its population. Annual house tear-downs outnumbered new house constructions 500 to 200. The availability of attractive new homes in suburban cities and the shift of population out of downtown is holding down the costs of the dwindling supply of old downtown houses. Although their prices are rising, they are far below national medians.

Documenting Reductions in Chronic Street Homelessness

Street Counts

Birmingham has conducted street counts of its homeless population in 1995, 2001, and 2003. Included in the data are breakdowns of street homeless individuals, some of whom may have been in families. The latest survey also asked detailed questions about the characteristics of the general homeless population. Table A.2 below includes data provided by Mark LaGory of the University of Alabama at Birmingham combined with data from the latest survey’s executive report. The remaining data are from the executive report.

Table A.2:
Street Counts of Birmingham Homeless Population

Year of Survey	Homeless Persons	Street Homeless Persons
1995	1,404	330
2001	1,667	244
2003	1,616	220

In 2003 the number of street homeless persons (220) was 19 percent lower than in 1995. The 2003 non-street homeless population counted 1,616, while below the numbers in 2001, are 12 percent higher than 1995. The survey also gathered information on characteristics of homeless individuals, such as age, sex, race, ethnicity, family status, education, income, veterans, status, disabilities, health care, and homeless services being received. These characteristics data have not yet been released broken down separately for the street homeless population.

Movement of Street Homeless into Housing

The Cooperative Downtown Ministries has placed 189 persons into its transitional housing program since 2000, of whom about 80 percent were chronic street homeless individuals. Among those characterized by chronic homelessness, about 85 percent are substance abusers, 33 percent have a serious mental illness, and about 23 percent are dually diagnosed.

The transitional housing program's capacity was 30 individuals, but has recently been expanded to 87. Of the 189 persons who have been in the program, 17 percent are still in the program, 49 percent left for permanent housing, 19 percent have unknown whereabouts (most are thought to be in housing with family or friends), 10 percent went to another program or jail, and 5 percent left the program for other reasons.

The CDM opened its own PSH program only a few months ago, but has been placing people from its transitional housing program into other PSH programs. Many others have been directly connected to other permanent housing programs by CDM's case manager without going through CDM's transitional housing program. Of the 75 who went from its transitional housing program to a permanent supportive housing program, 47 percent have remained at least 24 months, 21 percent at least 18 months, 13 percent at least 12 months and 19 percent less than 12 months.

Public Funding

Birmingham does not have any special local or state funding of programs to reduce chronic street homelessness, which may be why it has developed private funding more than the other sites visited. Table A.3 indicates the local agencies providing funds or staff, and the sources of their funding.

Community Relations

Birmingham's experiences illustrate that carefully bringing together law enforcement, the business community, mainstream agencies, providers, and advocates, including formerly homeless individuals, to address the problems of chronic street homelessness can lead from conflict to cooperation. These diverse groups have the common interests of keeping homeless people out of costly inappropriate settings such as jails and emergency rooms, and moving them into supportive housing where they can stabilize and receive appropriate services.

One consequence of a Mayor's Task Force on Homelessness is that Birmingham's business community has become involved in programs for homeless individuals. CAP officers team with workers from other agencies to provide outreach and support services. The private sector has also supported the CoC by donating housing to help expand residential programs for Aletheia and CDM, and private, local funds are expected to pay for Birmingham's HMIS.

NIMBY has not been a serious problem in Birmingham because the providers are improving neighborhoods by renovating dilapidated buildings or putting up new buildings that meet community standards. The programs also have good public relations because participants devote substantial time each week to community service.

Churches have a history of being strongly involved in civic affairs in Birmingham, and actively support programs for homeless people. CDM, for example, involves churches as sponsors for rehabilitating housing units. The focus group of program participants indicated that religious beliefs are also a strong force for many of the community's homeless individuals, who attest to the importance of religion in their recovery from substance abuse and other problems.

Maintaining and Enhancing the System

MBSH will be the mechanism for identifying gaps and developing multi-agency responses. But individual agencies will continue to find ways to expand their services and work jointly with other providers to serve their clients. The more elaborate and multi-faceted the response needed, the more likely MBSH will be the sounding board for shaping the ultimate configuration of programs and services.

Table A.3: Local Agency Investments In Ending Street Homelessness

Agency	Type of Investment		
	Fund Services	Staff Provide Services	Fund Housing
Birmingham City Agencies			
Department of Community Development: CDBG, HOPWA, ESG, and HOME, general revenue	X		X
Police Department: general revenue		X	
Franklin County Agencies			
Jefferson Co. Housing Authority: SHELTER PLUS CARE, Section 8, general revenue	X	X	X
JBS MH/MR Authority: general revenue	X	X	X
Community Development Department: CDBG		X	X
VA Medical Center (Federal)		X	
Federal Agencies			
Federal Home Loan Bank			X
Health Care for the Homeless	X		

Birmingham Site Visit Participants

Participants	Organization
Rachel Cabanis	First Light
Angie Craft	Jefferson Blount St. Clair
Charlotte-Ann Duckett	The Old Firehouse Shelter
Jonathan Dunning	Birmingham Health Care
Brenda Durham	Jefferson County Housing Authority
Renè Elliott	Department of Veterans Affairs
Steve Freeman	The Old Firehouse Shelter
Beverly Gosnell	HUD Regional Office
Brandy Herschbach	Birmingham Health Care, Inc.
Chris Retan	Aletheia House
Jo Morris Sherer	Church of the Reconciler
John Stamps	The Salvation Army
Renae Thigpen	Metropolitan Birmingham Services for the Homeless
Sharon Waltz	Birmingham Health Care
Kim Williams	The Old Firehouse Shelter

Birmingham Acronyms

BHC	Birmingham Health Care
CAP	City Action Partnership
CDM	Cooperative Downtown Ministries
CMS	Case Management System
ES	Emergency Shelter
JBS MH/MR	Jefferson-Blount-St. Clair Mental Health/Mental Retardation
HOME	Federal block grant to create affordable housing
MBSH	Metropolitan Birmingham Services for the Homeless
NOFA	Notice of Funds Availability
STOP	Street Outreach Program
UAB	University of Alabama at Birmingham

APPENDIX B: BOSTON

Boston—Brief Description

Boston is the largest city in Massachusetts and the 20th largest city in the nation with a population of 589,141 in 2000, a 2.6 percent increase from the 1990 census.[4] With its concentration of higher education, health care, financial services, professional and business services, and tourism-hospitality, Boston has succeeded in transitioning from a manufacturing to a knowledge-based economy. By 2000, Boston 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 at a near record low of 2.9 percent. As in other parts of the country, however, the next two years saw many changes. A national recession and depressed stock market, coupled with the terrorist attacks of September 11th, led to job losses and drastic reductions in state revenues and budgets (revenues declined by 26 percent in the spring quarter of 2002 alone). These in turn are threatening many social services and public health programs, especially those serving low-income and other vulnerable populations (The Boston Foundation, 2002).

Against this backdrop, Boston city residents find themselves in the fourth most expensive housing market in the country (behind the borough of Manhattan in New York, San Francisco, and Chicago) and a crisis in affordable housing that is worsening every year. In 1994, a statewide referendum ended rent control in Boston and two surrounding communities (Brookline and Cambridge). This led to the loss of rent increase and eviction protections for 60,000 units of affordable housing, and in the following two years another 8,000 to 20,000 units were de-controlled in a phased process that further squeezed housing markets and unleashed escalating rents. By mid-2000, the rent for an average two-bedroom apartment in Boston was $1,448, a 59 percent increase from 1995 (City of Boston, 2002). In 1999, under the leadership of the Mayor Thomas M. Menino and the Housing Strategy Advisory Group (HSAG), Boston was able to save more than 1,000 affordable housing units from being converted to market rate housing and the city was able to develop more than 2,000 additional housing units.

Recognizing the hardship caused by the lack of affordable housing, in 2000 the mayor launched an affordable housing plan, *Leading the Way*, as a blueprint for affordable housing production and preservation. Its overall goal, as outlined in a report on Boston's housing strategy, was to produce 7,500 new affordable housing units and preserve 10,000 existing affordable housing units by the end of 2003; this goal was reached by mid-year (City of Boston, 2002). Of the new housing units, 2,100 units are earmarked for low-income residents (under 50 percent of area median income (AMI)) and 1,000 of these have been set aside for homeless people.

Boston has struggled with increases in its homeless population through periods of both economic growth and decline. Between 1992 and 2002, the total number of people homeless in

[4] 1990-2000 population statistics for Boston, quickfacts.census.gov/states/00000.html.

Boston grew by 41 percent, reflecting rents that were increasingly out of reach for the lowest income families and individuals in the city, and resulting in the expansion of service capacity, especially for transitional housing. Based on the city's annual street and shelter count, there were 2,606 single men and women homeless on the streets and in adult emergency shelters on December 9, 2002. This was a slight decrease from the 2,700 people enumerated the year before (Emergency Shelter Commission, 2003). This decrease may reflect the loss of more than 300 emergency overflow shelter beds in the city, and the added difficulty in counting or tracking those left unsheltered by this loss.

Boston has an extensive and committed community of service providers and advocates working with homeless people. Through a collaborative network of programs and services, the city moves several thousand individuals out of homelessness each year through services such as street outreach and drop-in centers, emergency shelter, substance abuse and mental health treatment, medical services, educational programs, career development and employment services, transportation, and transitional and permanent housing programs. Service components specifically focused on ending chronic street homelessness are described in more detail in the section entitled "Selected System Components," along with activities and investments related to preventing homelessness and increasing the availability of affordable housing.

On our visit to Boston on April 8-9, 2003, we toured several emergency shelters and housing programs in addition to interviewing over 70 individuals representing government and city agencies, nonprofit services agencies, street outreach teams, drop-in centers, shelter and housing providers; agencies serving homeless people through casework, mental health and substance abuse treatment, and health care; community development organizations, data managers and analysts, and other advocacy organizations. We also held a focus group discussion with individuals who had experienced chronic street homelessness and we rode along in two nighttime homeless street outreach vans. A full listing of persons interviewed, other than focus group participants, has been included at the end of this appendix.

This chapter describes Boston's approach to ending chronic street homelessness. In addition, it describes in more detail the history and context of how its current system evolved, selected system components, funding mechanisms, community relations, documentation of Boston's success to date, and issues, gaps, and barriers that were identified by respondents during the site visit. The information contained in this chapter is derived from site visits, telephone interviews, written reports, agency websites, and Boston's 2002 Continuum of Care Homeless Assistance (CoC) application prepared by the city in collaboration with the Homeless Planning Committee (HPC).

Practices of Potential Interest to Other Jurisdictions

Boston offers several practices for reducing chronic street homelessness that may be of interest to other jurisdictions:

- **Commitment of Local and State Dollars.** Boston provides an excellent example of how state and city governments can take the lead in initiating and expanding programs to end chronic street homelessness. The state is the primary source of funding for

emergency homeless assistance and oversees one-third of all transitional housing units in the city. Under the direction of Mayor Menino, the city staff participates in and provides technical support for groups planning services for the homeless. The mayor has also expanded the CoC by committing city revenues and leading efforts to find outside funding. (Contact person: Eliza Greenberg, Director, Emergency Shelter Commission, Eliza.Greenberg@cityofboston.gov, 617.635.4507.)

- **Boston's Health Care for the Homeless Program (BHCHP).** Boston has a single-decentralized system that is self-determined by homeless individuals and relies on the efforts of the street outreach teams to assist homeless individuals in getting off the streets. Through the coordinated efforts of the street outreach team and BHCHP, Boston offers a compassionate treatment modality that provides outreach, assessment, and health care services to homeless individuals in shelters and on the street seven days a week. In addition, BHCHP provides outreach vans and street outreach teams that assist homeless individuals by providing food, emergency care, medical assistance, referrals, and transportation to shelters, service providers, and hospitals. In 2001, 40 percent of BHCHP clients were chronically homeless. (Contact person: Dr. Jim O'Connell, Director, joconnell@bhchp.org, 617.414.7779.)

- **Area A-1.** Boston relies on its partnership with the Area A-1 Task Force to handle community issues regarding the homeless population in the downtown area. The Area A-1 Task Force is able to bring to the table a strong collaborative which consists of providers, community members, health care professionals, support services, police department, formerly homeless and homeless individuals. Through the Area A-1 Task Force, a dialogue of understanding between police department, service providers, the business community, and various health departments has been established and led to better coordination of services for individual street homeless people in the city's downtown community. (Contact person: Sergeant Tom Lema, Community Service Supervisor, 617.343.4238.)

- **HomeStart.** HomeStart is a Boston-based nonprofit housing agency that provides housing search, stabilization, and outreach services to homeless individuals. The agency works in partnership with shelter caseworkers to assist homeless individuals residing in shelters with locating housing. HomeStart also serves as a clearinghouse for the 10 percent of the Department of Neighborhood Development (DND) housing units that are set aside for homeless people. As such, it monitors leasing activity and provides information and outreach to potential applicants and referral sources for the set-aside units. HomeStart is able to provide some stabilization services to formerly homeless households for up to one year after placement. (Contact person: Linda Wood-Boyle, Director, woodboyle@homestart.org, 617.542.0338.)

- **Management Information System.** Boston has contracted with the Center for Social Policy at the McCormack Institute, University of Massachusetts to implement Connection, Service, and Partnership through Technology (CSP Tech), which maintains the HMIS data system. The system is used by over 40 providers and enables Boston to collect and track unduplicated information on over 4,750 homeless

individuals and 350 homeless families in Boston. (Contact person: Nancy Sullivan, Director, nancyk.sullivan@umb.edu, 617.287.3393.)

Primary Contact Person

Eliza Greenberg, Director
Emergency Shelter Commission
One City Hall Plaza, Room 713
Boston, MA 02201
Telephone: 617.635.4507
E-mail: Eliza.Greenberg@cityofboston.gov

History and Context—How the Current System Evolved

For nearly 20 years, Boston has made considerable efforts to combat homelessness through the coordinated efforts of government agencies, advocates, service providers, business leaders, nonprofit and public agencies, and consumers. Beginning in the early 1980s, Boston's homeless population increased dramatically as the city's economy began to deteriorate, its affordable housing decreased, and its mentally ill residents were being deinstitutionalized. To address the increasing demand for shelter, in 1983 Boston City Hospital opened its doors to provide 100 temporary emergency overnight shelters beds for homeless individuals. Three months later, the city realized that the 100-bed facility was not sufficient to shelter the growing number of homeless individuals and began to develop and expand emergency shelters throughout the city of Boston.

Massachusetts' governors and Boston mayors have led the development of programs to address homelessness. In 1983 the state became the primary source of funding for emergency homeless assistance, and that same year the city's mayor appointed three advocates to serve as the Emergency Shelter Commission (ESC). ESC was developed to assist homeless individuals with shelter needs and services through a referral process to community agencies. ESC also organizes the annual street count activities and provides information to the public on issues and data related to the homeless population. In 1994, the mayor created the HPC to assist the city with the development of supportive housing and services as well as the development of housing policies. HPC is composed of 21 members (nominated by the community) who coordinate and plan activities and services for homeless individuals.

In 1997, DND was established to oversee state and Federal funds for providing rental assistance for homeless individuals. Since the late 1990s, Boston has also developed a variety of preventive programs that aid individuals at risk of homelessness and move large numbers of individuals out of homelessness and into housing. The collaborative efforts of ESC, DND, and HPC have secured over $40 million in new resources for homeless services and housing; these funds have supported the creation of a coordinated system of care that offers many different options for homeless individuals as well as individuals at risk of homelessness.

Approach to Chronic Street Homelessness

Boston estimates that approximately 40 percent of people in its shelter system at any given time meet the following definition of chronic homelessness: an individual with a disability (such as mental illness, substance abuse, HIV/AIDS, physical impairment, and dual diagnosis) that substantially impedes independent living who has been living on the streets (or other places not meant for human habitation) *or emergency shelter* for over two years.[5] They also report that of the 178 homeless people receiving outreach and/or healthcare services through Boston's Health Care for the Homeless Program (BHCHP) in 2001, 71 percent had been homeless for more than *three* years. Using point-in-time data from the city's December 2002 homeless census, Boston estimates that they have about 1,042 chronically homeless people in their community. Of these, 212 were enumerated on the street and the remaining 830 in shelters (it should be noted, however, that the 2002 census was conducted on a bitterly cold night and, therefore, the number of street dwellers was much lower than usual). Confirming the findings of many other studies, Boston has found that chronically homeless people in their community are predominantly male, single, and between the ages of 25 and 74.

Boston's main approach to ending chronic street homelessness to is to maintain and strengthen its current homeless service system (at a time when both Federal and state funding streams have been reduced), strengthen its outreach and assessment efforts, and increase the number of transitional and permanent supportive housing units (including various types of low-demand housing). The community has decided to prioritize projects that serve chronically homeless people, and the city of Boston has established a goal of creating 100 units of permanent supportive housing per year to address their housing needs. Efforts to improve coordination and collaboration among service providers to better meet the needs of underserved populations (including chronically homeless people) and prevent homelessness through improved discharge planning and cross-agency coordination are ongoing.

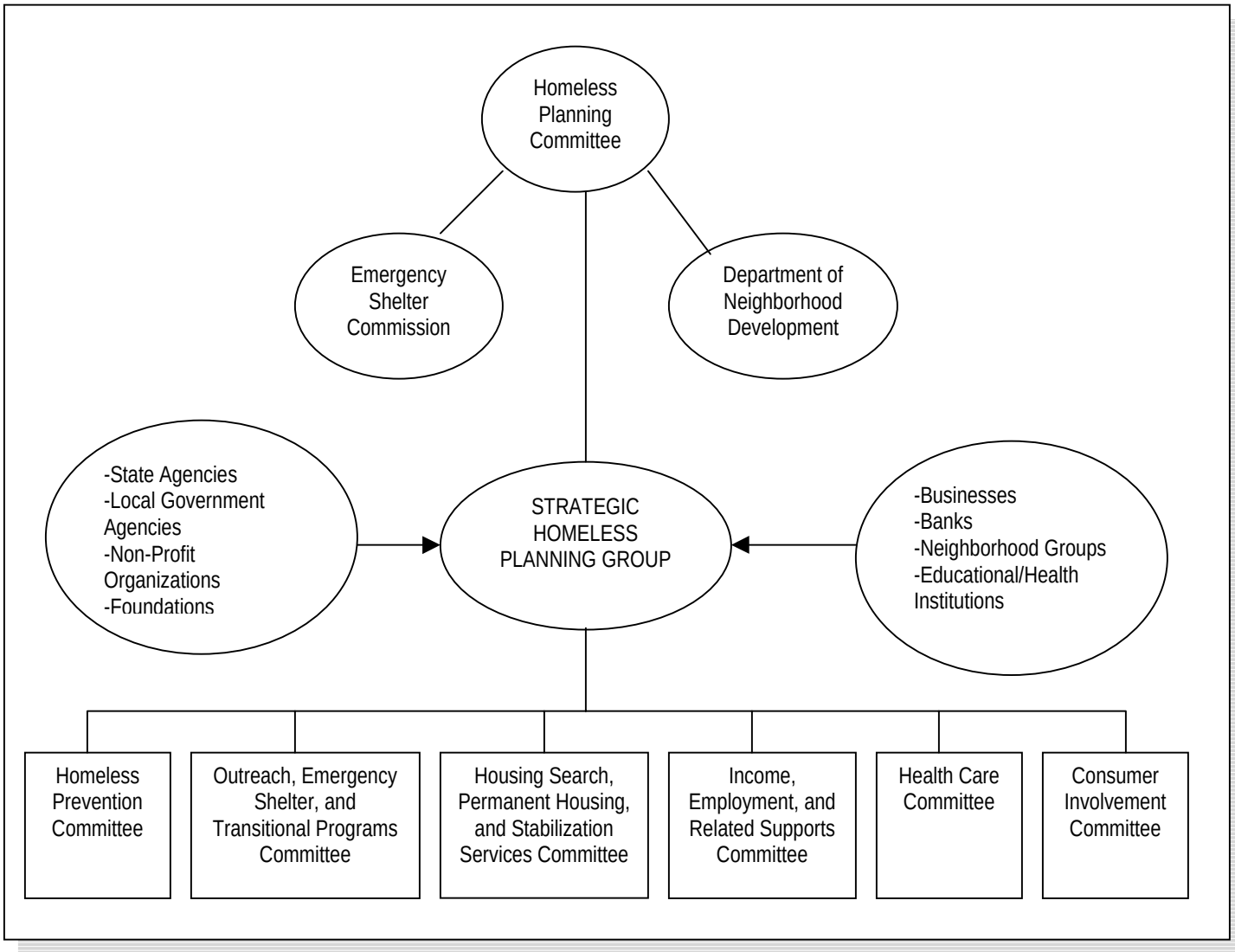
Boston's approach for ending chronic homelessness has built on the experience and expertise of outreach and emergency shelter providers whose service to this population covers both the explosion of homelessness of the 1980s and the evolution of a continuum of services of the 1990s. Assessments conducted by the city's Emergency Shelter Commission in 1995-96 identified gaps in the outreach, service, and housing needs of unsheltered homeless people. The citywide provider and community response has resulted in a significant increase in service infrastructure, targeted resources, and long-term transitional and permanent housing outcomes for this vulnerable population.

Coordination of these efforts is largely the result of strategic planning efforts of the City of Boston's Homeless Planning Committee, a diverse body of 19 members who represent city housing and homelessness planners, service providers, advocacy coalitions, and consumers who are leaders in Boston's efforts to fight homelessness. In 1998, the HPC convened the Strategic Homeless Planning Group (SHPG) to develop a five-year strategic plan to address rising

[5] Note this definition of chronic homelessness is broader than the one used for this study, which does not include people with long-term stays in emergency shelter. These estimates are based on data collected from Boston's service providers and CSPTech (Boston's homeless management information system). *See Boston's Continuum of Care Homeless Assistance (CoC) Application*, Boston, MA, 2002, p. 6-E.

homelessness in the city. The mission of SHPG was to ensure that Boston's overall homeless planning and policy decisions included meaningful input from a wide range of key entities, and to identify innovative strategies to address homelessness in Boston (Strategic Homeless Planning Group, 2000). The organization chart below shows the many agencies and other bodies involved in planning and developing the city's homeless service system. The HPC oversaw and coordinated the activities of the SHPG, while the ESC and the DND provided technical assistance and policy direction for SHPG on behalf of the HPC. The SHPG was comprised of six committees composed of key stakeholders that focused on specific planning topics, namely homeless prevention; outreach, emergency shelter, and transitional programs; permanent housing (including search and stabilization services and permanent supportive housing); income, employment, and related supports; integrated health care; and consumer involvement.

Chart B.1
Strategic Homeless Planning Group



SHPG has developed a five-year strategic plan to guide the community in ending homelessness based on information obtained from the six committees of SHPG. The major recommendations (goals) of the plan are to:

- Expand the supply of and access to permanent affordable housing;
- Expand employment opportunities and economic services to assist homeless people in becoming self-sufficient;
- Prevent homelessness through improved discharge planning and ongoing coordination among state and local criminal justice and social service agencies;
- Maintain and strengthen the existing infrastructure and current capacity of Boston's homeless system;
- Improve coordination and collaboration among homeless providers to meet the needs of under-served populations; and
- Advocate with Federal, state, and local agencies to increase public awareness and access to mainstream resources (Strategic Homeless Planning Group, 2000).

Boston uses the assistance of Connection, Service, and Partnership through Technology (CSPTech) to examine the demographics and characteristics of individuals the system serves, as well as how homeless services are coordinated. CSPTech also maintains the Homeless Management Information System (HMIS), which tracks over 4,750 homeless individuals in the city of Boston. The HMIS is used and updated by over 40 agencies throughout the city as well as city planners who allocate mainstream resources. CSPTech is housed at the Center for Social Policy in the McCormack Institute, University of Massachusetts Boston.

The many agencies involved in reducing/ending chronic street homelessness in Boston are shown in Table B.1.[6] The rows of the table represent Boston agencies that offer one or more types of services for street homeless individuals, while the columns represent the types of programs and services they offer. An "X" in a cell indicates that the agency offers the particular service listed at the top of the column. An "F" indicates that a public agency funds a program or service, and an "E" indicates that the agency offers expert advice, technical assistance, or training.

Mainstream Agency Involvement

Boston provides an excellent example of how state and city government can take the lead in initiating and expanding programs to end chronic street homelessness. As early as 1983, Governor Michael Dukakis expanded overnight emergency shelters and day programs for

[6] Table B.1 represents specific agencies involved in Boston's CoC efforts to provide services to chronic street homeless individuals; it does not include agencies that provide services for homeless families with children and homeless youth.

homeless individuals. Under his leadership, significant planning to end homelessness emerged and the state became the primary source of funding for emergency homeless assistance. Today, the Massachusetts Department of Mental Health (DMH) is also a major provider of transitional housing in Boston. Under the direction of Mayor Menino, city officials participate in and provide technical support for the Homeless Planning Committee and the more broadly focused Strategic Homeless Planning Group. Mayor Menino has also expanded the CoC by committing significant amounts of city revenues annually and leading efforts to find outside funding.

Other state level mainstream agency involvements in Boston programs to end homelessness include the following: Executive Office of Health and Human Services provides special allocation Section 8 vouchers for homeless individuals with disabilities. The Department of Transitional Assistance (DTA) provides outreach, on-site health services, emergency and transitional shelter, day programs, supportive services and case management. DMH provides supportive services for chronically homeless mentally ill people moving to permanent housing, transitional shelters, on-site mental health services in emergency shelters, day rehabilitation and employment programs, outreach assessment, and crisis intervention. The Department of Public Health (DPH) assists in street outreach, detox, emergency shelter, case management, support services, recovery homes and residential treatment centers, and dental care—as well as special rental assistance, supportive services and residences for homeless persons with HIV/AIDS. Department of Veterans Services provides shelter and transitional housing for homeless veterans. Executive Office of Elder Affair provides emergency housing and case management for homeless elderly. In addition, Department of Education provides on-site literacy and adult basic education; Division of Medical Assistance does Medicaid enrollment outreach in shelters; the Department of Housing and Fair Practice provides intensive case management and primary care by nurse practitioners; and the Massachusetts Housing Partnership operates permanent housing projects. Mainstream state programs provide substantial funding support in Boston. The largest programs are DMH and DTA at over $20 million each and DPH at over $14 million. Other substantial state programs are Multifamily Housing Program ($4.6 million), Department of Housing and Community Development ($3.5 million), and Department of Veterans Services ($2.7 million).

Boston city departments or programs that provide funding or staffing to end homelessness include: the Emergency Shelter Commission, which coordinates policy, provides funding for gap services, targets resources toward emerging needs, and advocates for constituent services; the DND, Boston Housing Authority (BHA), and Boston Redevelopment Authority (BRA), the partner agencies for *Leading the Way*, develop permanent housing; Neighborhood Development Funds provide move-in and short-term rental funds and develop permanent housing; the Public Health Commission's Homeless Services provide emergency shelter, stabilization services for substance abusers, employment and training through transitional housing programs, and develop permanent housing; Lead Safe develops permanent housing; BRA develops permanent housing; and general city funds support emergency shelters and related services. General city funds, which totaled $5.6 million in programs for homeless individuals, are the largest city resource. Leading the Way provided $0.9 million and the Public Health Commission $0.2 million.

Table B.1: City of Boston: Agencies Involved in Reducing/Ending Chronic Street Homelessness

	Homeless-Related Programs and Services																						
	Prevention	Outreach/Drop-in	Shelter	Safe Havens	Transitional Housing	Permanent Supportive Housing	Other Housing (non-disabled)	Alcohol and Other Drugs	Mental Health	Health	Employment/Job Training	Corrections	Public Assistance	Child Welfare	Advocacy	Food	Case Management	Referrals	Cross-agency Coordination of Service Access & Delivery	Planning	Staff Training	Data/Documentation	PR, Public Acceptance
Nonprofit Programs/ Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People (listed alphabetically)																							
Pine Street Inn	X	X	X			X	X	X	X	X	X			X	X	X	X	X	X	X	X	X	
Friends off the Shattuck Shelter	X	X	X		X	X	X	X	X	X	X			X	X	X	X	X	X			X	
St. Francis House		X	X		X			X	X	X	X				X	X	X	X				X	
Boston Health Care for the Homeless	X	X							X	X					X	X	X	X	X				
Home Start	X	X	X														X	X				X	
DMH Homeless Outreach Team		X			X			X	X									X					
Tri-City Mental Health		X		X				X	X								X	X					
Boston Public Health Commission Homeless Services	X		X		X			X	X	X	X				X	X	X	X	X	X	X	X	
New England Shelter for Homeless Veterans			X		X	X			X	X	X				X		X	X					
Victory Programs					X	X																	
New England Medical Center									X	X													
Community Work Services															X								
Massachusetts Coalition for the Homeless															X								
Massachusetts Housing and Shelter Alliance		X													X								
Ecclesia Ministries/Neighborhood Action		X													X								
Homeless Emergency Action Task Force															X								
Government Programs/ Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People																							
Emergency Shelter Commission (ESC)	X														E	F		E	E	E		E	E
Department of Neighborhood Development (DND)	F		F	F	F	F	F			F	F	F			E,F				E	E			E
Area A-1 Task Force												E			E					E			
Department of Transitional Assistance (DTA)		F	F	F	X,F	F																	
Department of Mental Health		X,F	X,F	X,F	X,F	F		E	E														
Department of Public Health (DPH)																							
Boston's Emergency Medical Services (EMS)		X								X								X				
Massachusetts Department of Housing and Community Development (MDHCD)																							
Boston's Public Health Commission			F		F	F	F							X	X	X			X				
Boston Housing Authority	X				F	F	F												X				
Metropolitan Boston Housing Partnership (MBHP)			F		F	F	F												X				
UMass Boston Center for Social Policy																			X,E			X,E	X

X = Provider E = Expert TA Provider F = Funder

In Boston, private resources being tapped for programs to end homelessness range from foundations to city-imposed developer fees. Cash donations from individuals to programs were also substantial, totaling $12.5 million. The private mainstream resources include: tax credit equity funding from private investors; city fees paid by developers to fund permanent housing; private bank loans for permanent housing; Developer's Equity for permanent housing; United Way emergency shelter, transitional housing, and support services; cash, and in-kind donations from businesses, religious, and civic organizations totaling over $3.6 million; and over 50 foundations contributing over $9 million. The United Way is the largest single private mainstream resource providing over $3 million. Other large private funders are the Boston Foundation Starr Fund ($1.3 million), Developer's Equity ($1.1 million), Putnam Sr. Executive Fund ($1.1 million), and Fireman Foundation ($1.5 million).

Exhibit B.1 and Table B.1 clearly illustrate that Boston has succeeded in getting most of its agencies "at the table." Planning and decision-making around homeless services appear to be broad, democratic, and very inclusive.

Selected System Components

Boston has a comprehensive well-coordinated continuum of care that serves all homeless people including those who are chronically homeless. This system includes prevention efforts, outreach and drop-in, some save havens and other low-demand residences, emergency shelters, transitional and permanent supportive housing, supportive services, and affordable housing. Each of these components is described in turn.

Prevention

Boston has a variety of homelessness prevention programs. In general these programs help people at risk of homelessness obtain the necessary resources to prevent them from becoming homeless. These resources include housing counseling to support housing stability, rent/mortgage/utility assistance, preservation of existing affordable housing to prevent current occupants from being displaced, housing stabilization for previously homeless individuals, and diversion plans targeting special populations at risk of homelessness.

Of particular benefit to chronically street homeless individuals are programs offering substance abuse recovery beds available to people leaving the criminal justice system and precluding their entry into the emergency shelter system. Five different agencies throughout the city offer 35 such beds in all. The Massachusetts Department of Mental Health is a major contributor to primary and secondary prevention of homelessness through its transitional housing programs discussed below in the transitional programs section of this chapter. Other prevention activities are available to Boston veterans. With over $260,000 in state funding, the Veterans Benefit Clearinghouse runs an outreach center that provides veterans with food, housing, and other services that help keep them stably housed.

In addition to these, Boston is also working through the collaborative efforts of HomeStart and the Metropolitan Boston Housing Partnership. The city provides annual rental stipends, money management, and supportive services to at least 100 formerly homeless individuals. HomeStart

is another agency that provides general prevention assistance and counseling services to formerly homeless individuals through Federal, state, and city funds and with the support of several private foundations.

Boston's CoC is also working to develop additional programs that will expand current preventive efforts. The City of Boston's 2002 CoC Homeless Assistance Application included several preventive strategies. The Clean Slate Project addresses issues of homelessness among ex-offenders and methods needed to change discharge policies to prevent homelessness; the Tenancy Preservation Project is a linkage of supportive services and housing for individuals who are chronically homeless; and the Boston Diversion Project is a diversion plan for non-violent mentally ill offenders to move into treatment facilities rather than incarceration.

Outreach and Drop-In

Boston's outreach efforts build on the city's longstanding commitment to provide shelter, services, economic, and housing opportunity to every person in need. A gaps assessment conducted by the Emergency Shelter Commission led to the addition of the Pine Street Inn's Project NeighBOR in the city's first McKinney CoC application to HUD. At the same time, the DPH began funding the Friends of the Shattuck Shelter street outreach programs. Beginning in 1997, the BHCHP also began to field a nurse practitioner working on the streets, and Tri-City Mental Health intensified mental health outreach to unsheltered persons on the streets of Boston. Collectively, these programs enhanced existing overnight mobile outreach efforts and the Department of Mental Health's Homeless Outreach Team (HOT) that had served the chronic street population since 1986. Outreach efforts in Boston were re-examined and strengthened after the street deaths of more than 13 homeless individuals in 1998. Under the leadership of Mayor Menino additional resources from the city's budget were allocated to provide funding for a second night outreach van, and through the city's Emergency Shelter Commission, provided funding for additional street outreach to chronically homeless people in the evenings. The three lead agencies conducting street outreach in Boston, Friends of the Shattuck Shelter, Pine Street Inn, and Tri-City Mental Health, see a majority of chronically homeless individuals. They provide extensive outreach activities intended to assist homeless individuals in getting off the streets, while linking them to supportive services, fixed-site case management and, ultimately, housing. These agencies provide day and night street outreach activities to specific geographical areas in Boston, offering a range of intensive case management services for homeless individuals. Outreach services include food, clothing, blankets, medical care, psychiatric services, and referrals for treatment and housing services. Outreach teams also provide transportation or vouchers for city transport to homeless individuals going to shelters, detox, or drop-in centers.

Street outreach teams work collaboratively with other agencies such as DMH's HOT Team, BHCHP, and Boston Emergency Services Team (BEST). Together these agencies provide on-the-street health care services to homeless individuals. HOT employs clinical workers to assist the street outreach teams in identifying and assessing the health care needs of homeless individuals. Once an individual moves into the shelter or other types of housing, HOT continues to provide a system of care to meet individuals' needs.

BHCHP is another health care organization that works in collaboration with the street outreach teams to provide emergency care, limited medical assistance, referral, and transportation to city hospitals. BHCHP maintains the medical records of homeless individuals through hand-held computers that link to extensive medical records throughout the hospital and shelter-based clinics and street teams of the BHCHP health care network. BHCHP will continue to provide unlimited services to the individuals until they move into permanent housing with supportive care. They have also started thinking about providing primary health care (such as monitoring blood pressure) to people who are homeless on the street. The director of Boston's BHCHP noted that health issues are "a great front door" into housing from both the client and housing provider's perspective, that the community needs options for different types of housing, and that everyone has to share in creating the avenues into housing. As an example, he noted than an individual street homeless person may break a leg, come into a BHCHP facility for treatment, get sober and begin to think clearly, and then conclude "I don't want to go back out there," meaning to the streets. Unfortunately, it can take a year or longer before getting someone into housing.

BEST also works with the street outreach team in a capacity that provides crisis intervention to chronically homeless mentally ill individuals who are suicidal, violent, or in need of urgent care. Outreach teams also work with the Boston Police Department (BPD), the Boston EMS, local businesses, and community residents to identify homeless individuals in need of services. They monitor an outreach phone line that receives calls during the evening hours pertaining to the whereabouts of homeless individuals in need of shelter or care.

Another group that has been instrumental in Boston's effort to address chronic street homelessness in the downtown area is the Area A-1 Police District Homeless Task Force. Developed in 1994 under the leadership of Boston Police Captain Ronald Conway, the Downtown Crossing Association, the Pine Street Inn, and the City of Boston's Emergency Shelter Commission, the Area A-1 Task Force is comprised of over 30 representatives from various community agencies and programs that collectively identify and engage street homeless people and work repeatedly to get them off the streets and connected to needed services. Members of the Area A-1 Task Force include the Boston ESC, the Boston Parks and Recreation Department, the Boston District A-1 Police Department, the Pine Street Inn, Shattuck and BHCHP street outreach teams, the DMH, City Council, local businesses, representatives from area hospitals, Emerson College and other educational institutions, nonprofit and public agencies, and formerly homeless and homeless individuals.

The Area A-1 Task Force meets on a monthly basis to address homeless issues and problem solve efforts to reduce homelessness. Through the Area A-1 Task Force, members quantify and prioritize the gaps to be filled in the collaborative effort. In addition, attendees of the Area A-1 Task Force meetings are able to vent, share information, make connections among the provider community, and develop dialogues of understanding on issues of homelessness.

The Downtown Crossing Association is a nonprofit agency that, in addition to being one of the Area A-1 Task Force leading members, works on economic and cultural development in the downtown retail district. The Association involves retail, civic, and higher educational institutions to bring innovative ideas and partnership with providers and downtown businesses to enhance outreach efforts, interventions, and assistance for homeless individuals in the downtown area. The Association facilitates communication between downtown businesses, the police, and

service providers when they have an issue or concern regarding homeless individuals residing in downtown neighborhoods. The Association also provides office space and support for Project NeighBOR.

Emergency Shelters

For more than three years emergency shelters in Boston have had to operate at full capacity plus periodic overflow situations. The 2002 annual homeless census found 2,394 individuals residing in the city's 14 emergency shelters for single adults (Emergency Shelter Commission, 2002). This is a slight decrease from the 2001 annual street count, which documented 2,423 individuals residing in the shelters.

Boston's emergency shelters are designed to offer a temporary place for homeless individuals to reside until they can receive supportive services to move into permanent housing. Currently Boston has 1,729 emergency shelter beds available for single homeless adults (with an additional 300 temporary emergency shelter beds available during the winter months). Two of the city's emergency shelters (with 93 beds in total) are actually innovative programs run by BHCHP that provide medical respite care. These programs offer short-term residential care for homeless adults who do not require hospitalization, but are too ill to sustain the stresses of staying in an emergency shelter or living on the streets. In some of the other adult shelters throughout the city, more than 80 emergency beds have been converted into post-detox pre-recovery beds because of the shortage in post-detox recovery beds in the city. This conversion has been done in an effort to prevent people from going (back) out to the streets.

Homeless individuals can come into emergency shelter through self-referrals, walk-ins, outreach workers, BPD, or EMS. As part of Boston's collaborative effort, any homeless individual turned away from an emergency shelter because of sleeping capacity will be transported to another shelter that has an available bed.

Low-Demand Residences

Although Boston has a well-developed continuum of care, the city does not currently have many units of "low-demand" housing for chronically homeless people. There is one save haven in the city, run by Tri-City Mental Health, with six beds devoted to mentally ill homeless women. Tri-City Mental Health provides referral services, food, clothing, home furnishings, or other items needed to make the individual feel safe in his or her residence. Other "low-demand" housing options include some post-detox housing and Shelter Plus Care units. According to Boston's 2002 CoC Homeless Assistance application, the few low-demand programs they do have may need to be closed down because of funding shortfalls.

Transitional Programs

The city of Boston has close to 1,408 transitional housing slots, provided by 38 agencies, that are designed to provide rehabilitative and social services for up to 24 months to assist homeless individuals to move into permanent affordable housing. Through Boston's transitional programs,

homeless individuals are able to receive outreach, case management, health care, recovery and relapse prevention, job training, parenting classes, and social services benefits to assist them as they transition back into the community and into permanent housing. Many of the city's transitional housing programs are focused on special populations such as substance abusers (1,005 beds in 2000), mentally ill people (325 beds), veterans (148 beds), those with dual-diagnoses (165), and HIV/AIDS patients (136).

A major provider of transitional housing in Boston is the state DMH. It oversees about one-third of all transitional housing beds in the city's shelter system. DMH has targeted 50 percent of its transitional housing units for individuals who have experienced recent evictions, were inpatients, or were recently released from prison. Boston's winter 2002 count of homeless people documented 325 people in state Department of Mental Health programs.

Boston's process for transitional housing is to assist homeless individuals and individuals at risk of homelessness to obtain supportive services while maintaining residential stability within the community. Homeless individuals receive the linkages they need to move out of short-term residential settings and into independent living environments.

Permanent Supportive Housing

The City of Boston has developed 2,090 permanent supportive housing units of which 355 are Shelter Plus Care units that serve formerly homeless persons, and as part of Boston's CoC effort, the city has a three-year blueprint to develop more permanent housing for the homeless including 128 additional PSH units (91 for single homeless people) with $2.5 million in city funds. In Boston's 2002 CoC application to HUD, the only new projects seeking funding were those creating permanent supportive housing units. In addition, the city's homeless set-aside policy requires that at least 10 percent of all city assisted rental housing units be reserved for homeless individuals and homeless families. The city has also requested that the Boston Housing Authority (BHA) develop a policy that would grant Priority 1 status to homeless individuals for Section 8 Vouchers, and that BHA continue to set aside 100 Section 8 subsidies for homeless individuals.

The total number of Permanent Supportive Housing (PSH) units administered by the city includes 355 Shelter Plus Care units; 80 Housing Opportunities for Persons with AIDS (HOPWA) units; 800 Section 8 and public housing units; and 634 Moderate Rehabilitation Units. Individuals from the city shelters and transitional housing programs can access PSH services through HomeStart and ABCD. Both agencies provide housing placement services such as referrals for PSH, housing search, and assistance with housing application based on individual needs.

In addition to the individual agencies that provide PSH services, the Massachusetts funds Mass Access, an interactive web-based computerized registry that monitors and tracks vacant housing units across the state that are accessible to homeless individuals and families.

Supportive Services

Boston has a wide array of supportive services to help homeless people move through its continuum of care. These services include case management services for more than 6,705 homeless individuals; life skills services for up to 5,013 homeless individuals; alcohol and drug abuse services for up to 1,625 homeless individuals; mental health services for 1,203 homeless individuals; HIV/AIDS related services for 2,010 homeless or previously homeless individuals; educational activities such as vocational rehabilitation, Graduate Equivalency Diploma and English as a Second Language courses for up to 250 homeless individuals; employment assistance services and training for up to 1,731 homeless individuals; and housing search and placement services for up to 4,051 homeless individuals. Transportation services are offered to assist homeless individuals in need of shelter, treatment, or services; and free health care services are offered for homeless individuals through BHCHP and MassHealth (the state Medicaid program).

Boston like many cities across the country continues to struggle with targeted budget cuts, which have caused a dramatic decrease in the number of available detox and recovery beds for homeless individuals. The winter 2002 annual street count reported that 292 homeless individuals were residing in detox facilities, up from 277 in 2001. With fewer detox and recovery beds as a result of the budget cuts, the already growing number of homeless people living on the streets and in shelters may increase further.

The city of Boston has been able to provide the above services through funding from the city, state, and Federal resources as well as McKinney Act funding and grants from private foundations. Through the efforts of the CoC and various funding mechanisms, Boston has been able to offer a variety of services and support to meet the individualized needs of the homeless population. Information about these services is disseminated through the city's referral guide, community posters, word of mouth, or by calling an interactive voice system that provides up-to-date information.

As in many communities, there are many obstacles to providing dually and triply diagnosed homeless people (those with mental health, alcohol or drug use, and even physical health problems) with housing and other supportive services. Many of these obstacles stem from the multiplicity of the problems and the fact that the service systems for mental illness, substance abuse, and physical health often operate autonomously.

Affordable Housing

The city of Boston, being the fourth most expensive housing market in the nation, is acutely aware of the challenge of maintaining and developing affordable housing. The mayor and SHPG have developed a three-year strategic plan, Leading the Way, to expand affordable housing for low-income and homeless individuals and families. The city is contributing over $30 million and city-owned land to achieve the plan's goals of building 7,500 new affordable housing units and preserving 10,000 units of existing affordable housing. During FY 2002 the city of Boston allocated an additional $3 million from the city's budget to go towards affordable housing once

the existing funds were exhausted. To date, 34 percent of the city's affordable housing units are targeted to low-income households earning less than 50 percent of AMI.[7] In addition, the city's homeless set-aside policy requires that at least 10 percent of all city-assisted rental housing units be reserved for homeless individuals and homeless families with an income no greater than 30 percent of AMI. Through DND, the homeless housing set-aside policy also requires that any unoccupied set-aside units remain vacant until occupied by a homeless household. The city has also requested that BHA develop a policy that would grant Priority 1 status to homeless individuals for Section 8 Vouchers, and that BHA continue to set aside 100 Section 8 subsidies for homeless individuals (not a large number relative to need).

Documenting Reductions to Chronic Street Homelessness

Beginning in 1986 the ESC has conducted annual street counts in Boston with the assistance of over 250 volunteers who cover designated geographical areas in the city to enumerate homeless individuals sleeping on the streets and in the city's shelters and other homeless facilities. According to the December 2002 annual street count, the total number of homeless individuals residing on the streets of Boston and in adult emergency shelters has increased over the last decade:

The number of Boston's homeless has increased by 41% in the past decade. There are 6,210 homeless people in the City of Boston in 2002 compared to 4,411 in 1992. There are 1,367 homeless children in Boston in 2002 compared to 800 in 1992, an increase of 71%. There were 1,572 homeless women in 2002 compared to 989 in 1992, an increase of 59%. There are 3,271homeless men in 2002 compared to 2,622 in 1992, an increase of 25%. Although the number of homeless men is rising at a slower rate than that of women and children, they continue to be the largest percentage of the population, 53%. The majority of these men have chronic disabilities such as mental illness and/or substance addiction (Menino, 2002, p.2).

The increase in the number of homeless individuals can be traced directly to a number of conditions, including but not limited to:

- The dramatic rise in housing costs;
- The decrease of affordable housing for low-income persons;
- A reduction of substance abuse treatment beds; and
- A lack of commitment to aftercare planning and next step resources for individuals being released from jails and prisons, acute mental health facilities, hospitals, and social services.

[7] Note that SSI benefits in Boston (which in 2002, would be $659.39 per month, a figure that includes a state-funded supplement of $114.39) amount to only 15.2 percent of AMI. Housing priced at 50 percent of AMI is still out of reach for most SSI beneficiaries. See Ann O'Hara and Emily Cooper, *Priced Out in 2002*, Technical Assistance Collaborative, Boston, MA, May 2003, p. 23.

In an effort to track the demographic information on homeless individuals, the city of Boston has contracted with the Center for Social Policy at the McCormack Institute, University of Massachusetts to implement Connection, Service and Partnership through Technology which maintains the HMIS data system. Formerly known as the ANCHoR project, the HMIS data system is used by over 40 providers and enables Boston to collect and track unduplicated information on over 4,750 homeless individuals and 350 homeless families in Boston in order to provide unduplicated services and other resources needed to assist homeless individuals move towards self-sufficiency and permanent housing.

Last year, provider data revealed that at least 1,500 homeless people obtained permanent housing throughout the city of Boston, including 550 chronically homeless individuals. The Pine Street Inn's Project NeighBOR, which serves chronically street homeless people, reports that of 356 clients who exited the program in the past two years, 38 percent (134) obtained permanent housing and another 22 percent (77) was referred into a transitional housing program. The majority of clients in 2001-2002 were successfully placed into housing and more than 60 percent of them (103 of 171) entered housing after *more than four years of homelessness* (another 19 percent had been homeless between one and four years). The program achieved similar results more recently in 2002-03: 58 percent (108 of 185) of those housed had been homeless *from 4-6 years*, and 26 percent (48 of 185) had been homeless for 1-4 years. Most of the individuals successfully placed are repeat users of health care, mental health care, substance abuse, and shelter services and the locus of care and services simply shifted from the streets to fixed-site programs that served as a staging area for their successful placement into transitional and permanent housing.

Public Funding

The Boston CoC makes very significant use of Federal, state, and local mainstream agencies. Some of the funding provides emergency shelter and services rather than directly moving homeless individuals into transitional and permanent housing. However, the mainstream funding of emergency needs can be used to free up resources for agencies with a focus on ending homelessness for individuals. Some of the programs assist families as well as individuals, but in the discussion below we omit programs that serve only families.

The sums received from the Federal programs are very substantial. As Table B.2 shows, these funds support services, staffing, and housing (both capital investments and operations). Federal mainstream agency involvement in programs for chronic street homeless people in Boston including the following: HUD Community Development Block Grants ($0.5 million) support permanent housing development, move-in and short-term rental funds; HUD, Home Investment Partnerships Program ($3.5 million) funds permanent housing development; HUD Section 8 vouchers ($25 million not limited to homeless assistance) cover client rent; HUD Housing Opportunities for People with Aids ($1.0 million) funds housing search, case management and transitional programs; DHHS Mental Health Block Grants provide outreach, assessment, crisis intervention and support services; DHHS Substance Abuse Block Grants ($5.2 million) support transitional recovery homes, treatment clinics, detox and related services; a DHHS Welfare-to-Work Block Grant provides on-the-job training of homeless individuals; DHHS Projects for Assistance in Transition from Homelessness fund outreach and supportive services for homeless

people with mental illness; DHHS also funds various HIV services ($1.6 million) and a combination of outreach and health care at local sites providing services for homeless individuals ($1.9 million); a Department of Labor Homeless Veterans Reintegration Project ($0.6 million) provides employment and training services, as well as, vouchers for homeless veterans to attend computer training programs; Emergency Food and Shelter Program provides shelter and meals; and the Federal Home Loan Bank ($0.5 million) provides capital funds for permanent housing development.[8]

Table B.2: Boston Investments in Ending Street Homelessness

Agency	Type of Investment		
	Fund Services	**Staff Provide Services**	**Fund Housing**
Department of Neighborhood Development (SHP, ESG, SPC, HOPWA, SRO Mod Rehab, HOME, CDBG)	X		X
Boston Housing Authority (Section 8—both tenant and project based, admin. funds)		X	X
Department of Mental Health (MHBG, PATH)	X	X	X
Department of Public Health (SABG)	X		X
Department of Medical Assistance (Medicaid, Medicare)	X		
Department of Transitional Assistance	X		X
Boston Public Health Commission	X	X	X
Department of Veterans Services	X		X
Emergency Shelter Commission	X	X	X
Department of Housing and Community Development			X
Nonprofit Providers (use myriad funding streams including private $)	X	X	X
Boston Police Department		X	
Inspectional Services Department		X	
Executive Office of Health and Human Services	X		
Boston Emergency Medical Services		X	

[8] Figures cited from Boston's 2002 Continuum-of-Care Application.

Community Relations and Advocacy

There is a well-established and active homeless advocacy community in Boston and throughout the state of Massachusetts. Homeless service providers also enjoy the strong support of local political leaders, including the Mayor of Boston who has guaranteed every homeless person an emergency shelter bed. However, despite high levels of advocacy and political support, the community continues to struggle with very severe NIMBYism. This is probably due to the tight housing market generally, and perhaps other local political and cultural factors as well. Agency officials and program administrators were universal in their assessments of how difficult it was to site new programs including permanent supportive housing programs. These challenges have been acknowledged in the city's overall housing strategy. In their January 2002 mid-point progress report on *Leading the Way, Boston's Housing Strategy FY 2001-2003,* the city notes the need to develop a policy "that would assist in the siting of supportive housing in Boston's neighborhoods." They have developed a framework for this policy and are considering a variety of options including requiring "that project sponsors demonstrate and document a solid facility management track record, financial feasibility in both the development and long-term operational phases, and significant (but not necessarily unanimous) community support" (The City of Boston, 2000).

The Future—Maintaining and Enhancing the System

Boston has a fundamental goal of maintaining and strengthening its current homeless service system at a time when the funding available to support this system is shrinking. It also wants to strengthen its outreach and assessment efforts, increase permanent supportive housing (as part of a very broad community-wide housing strategy), and improve coordination and services for homeless people with dual diagnoses. Boston is committed to ending chronic homelessness, has prioritized programs serving these individuals, has a large, well-established and well-functioning continuum of care, and enjoys the support of its political leaders and many mainstream agencies. Unlike some other communities, however, it has not decided to tackle chronic street homelessness in radically new ways (such as by reconfiguring its shelter system, or adopting some of the newer low demand housing strategies).

Boston is just beginning to incorporate some of the newer approaches. For example, it has applied for funding to support a "Housing First" demonstration. During our site visit, we found high levels of skepticism to Housing First approaches among service providers. Many street outreach workers including healthcare providers working with BHCHP, however, appeared to be more supportive of the approach (and harm reduction more generally).

Boston's current strategies are quite general and rely on existing models of service. For example, the action steps to address chronic homelessness in the 2003 CoC application include activities such as "combine data from street outreach workers to compile a master list of the chronically homeless and reduce the list by 10 percent each year" and "implement and conduct an additional homeless count targeted exclusively to the chronically homeless to enhance Boston's ability to track these individuals." Yet with its well-developed continuum of care, innovative groups such as the Area A-1 Police District Homeless Task Force, and the commitment of mainstream agencies such as the state Departments of Public Health and Mental Health, which have invested over $31 million in mainstream resources for chronically homeless people, Boston may well succeed in reducing its chronically homeless street population with its current approach.

Boston Site Visit Participants

Participants	Organization
Leo Adorno	Pine Street Inn Outreach Programs
Beth Avery	Berkeley YWCA
Jennifer Balboni	Department of Public Health
Barry Bock	Boston Health Care for the Homeless
Marcy Bouley	Downtown Crossing Association
Sarah Ciambrone	Boston Health Care for the Homeless
Joe Crispin	Speak Up
Barry Davis	Friends of the Shattuck Shelter
Lyndia Downie	Pine Street Inn
Sue Estes-Shaw	Department of Mental Health Homeless Outreach Team
Carol Fabyan-Takki	Project SOAR/Safe Harbor
Donna Haig Friedman	McCormack Inst. Center for Social Policy
Meghan Goughan	Pine Street Inn
Eliza Greenberg	Emergency Shelter Commission
Jim Greene	Emergency Shelter Commission
Jennifer Greer	Emerson College
Elisha Harrig-Blaine	Ecclesia Ministries
Mary Heafy	CWS Project Independence
Mary Ellen Hombs	Massachusetts Housing and Shelter Alliance
Jim Hooley	Boston Emergency Medical Services
Gillian Jesty	Friends of the Shattuck Shelter
Theresa Johnson	Friends of the Shattuck Shelter, Transition to Independent Living I & I
Michelle Kahan	McCormack Inst. Center for Social Policy
Michael MacDonald	Tri-City Mental Health
Elena Mansour	City of Boston ~ Supportive Housing

Bill MCCARRISTON	CWS Project Independence
Margaret McDonough	Tufts-New England Medical Center
Sharon Morrison	Boston Health Care for the Homeless
John Nolan	Veterans' Transitional Program
Jim O' Connell	Boston Health Care for the Homeless
Sue Pacheco	Friends of the Shattuck Shelter, Transition to Independent Living I & II
Judy Parks	YWCA Boston
Bill Silvestri	McCormack Inst. Center for Social Policy
Fred Smith	MAP/Next Step
Nancy Sullivan	McCormack Inst. Center for Social Policy
Stacy Swain	Boston Health Care for the Homeless
Bob Taube	Boston Health Care for the Homeless
Julia Tripp	McCormack Inst. Center for Social Policy
Beverley Waring	Tri-City Mental Health
Rich Weintraub	Project SOAR/Safe Harbor
Linda Wood-Boyle	HomeStart

Boston Acronyms

AMI	Area Median Income
BEST	Boston Emergency Screening Team
BHA	Boston Housing Authority
BHCHP	Boston Health Care for the Homeless Program
BPD	Boston Police Department
BRA	Boston Redevelopment Authority
CDBG	Community Development Block Grants
CSPTech	Connection, Service and Partnership through Technology
DHHS	Department of Health and Human Services
DMH	Department of Mental Health
DPH	Department of Public Health
DND	Department of Neighborhood Development
DTA	Department of Transitional Assistance
DVS	Department of Veterans Services
ESC	Emergency Shelter Commission
EMS	Emergency Medical Services
HOME	Home Investment Partnerships Program
HOT	Homeless Outreach Team
HPC	Homeless Planning Committee
SHPG	Strategic Homeless Planning Group

APPENDIX C: COLUMBUS

Columbus—Brief Description

With its population of 711,470, Columbus is the largest city in Ohio, and the 15th largest city in the nation.[9] With its blend of government, education, and private sector employers, Columbus is well known for its diverse, well-balanced economy, one that is more resistant to business downturns than other areas dependent on a single business sector or industry. Central Ohio has added 196,000 new jobs to its economy since 1990, and the Columbus metropolitan statistical area enjoys the lowest unemployment rate of any metro area in Ohio, one below the state and national rates.

Despite these strengths, the economic downturn of the last few years and a lack of affordable housing have meant that homelessness remains an ongoing problem in Columbus. The city has a poverty rate of 13.4 percent, higher than the national average of 10.9 percent.[10] An estimated 175,000 people in Franklin County are in families with incomes too low to meet even basic living costs, and wages are not keeping pace with rising housing costs. Less than 20 percent of rental units are within the financial reach of low-income households. In 1997, a full-time worker had to earn $9.53 an hour in order to afford a two-bedroom apartment, but the same apartment required a wage of $15.10 in 2002. A Columbus resident earning minimum wage ($5.15 per hour) needs to work 63 hours per week just to afford the average rent for a studio apartment.[11] Further complicating matters, the number of units operated by the public housing authority has dropped 20 percent during the last seven years, between 30 and 40 percent of people with Section 8 vouchers/certificates cannot find a place to live within the 120-day time frame, and over 6,000 households are on waiting lists for public housing (Community Shelter Board, 2001).

To better understand how Columbus is ending chronic street homeless, we conducted a site visit there on April 3-4, 2003. As part of this visit we interviewed 20 people from agencies providing housing, health and mental health, substance abuse treatment, and case management services in addition to the staff from the local public housing authority and the Community Shelter Board (CSB). We toured several programs providing permanent supportive housing along with an engagement center, which takes in public inebriates, and its associated substance abuse treatment program. A complete list of people interviewed during the site visit is included at the end of this appendix. While in Columbus, we also conducted a focus group with eight formerly homeless men who have been stably housed for at least six months.

---

[9] 2000 General Demographic Characteristics for Columbus Ohio, http://factfinder.census.gov/bf/_lang=en_vt_name=DEC_2000_SF3_U_DP3_geo_id=16000US3918000.html, 2000 General Demographic Characteristics for Franklin County, Ohio, http://factfinder.census.gov/bf/_lang=en_vt_name=DEC_2000_SF3_U_DP3_geo_id=05000US39049.html.

[10] 2000 poverty statistics for Columbus, http://factfinder.census.gov/bf/_lang=en_vt_name=DEC_2000_SF3_U_DP3_geo_id=16000US3918000.html; for United States, http://factfinder.census.gov/bf/_lang=en_vt_name=DEC_2000_SF3_U_DP3_geo_id=01000US.html.

[11] National Low Income Housing Coalition, www.nlihc.org.

For this chapter we obtained information from telephone interviews conducted before and after the site visit, individual and group interviews conducted during the site visit, written material provided by agencies that partner with the Community Shelter Board, and information garnered from agency websites and the Columbus and Franklin County Continuum of Care application.

Practices of Potential Interest to Other Jurisdictions

- **The Community Shelter Board.** The Community Shelter Board (CSB) is really at the heart of the homeless service system in Columbus, and its independence, strength, and vision are what make initiatives such as Rebuilding Lives possible. (For more information, see the Community Shelter Board's website at www.csb.org.)

- **Rebuilding Lives and the Rebuilding Lives Funder Collaborative.** Rebuilding Lives is a comprehensive and ambitious initiative that represents a "paradigm shift" in the community's approach to homelessness. In addition to providing Columbus with a well-developed vision and goals, the initiative included a very concrete mechanism for funding and monitoring the plan. The Funder Collaborative is clearly a key element of the initiative's success to date. (For more information, see the Community Shelter Board's website at www.csb.org.)

- **Good Neighbor Agreements and Community Relations.** In addition to making very persuasive moral and cost arguments in support of Rebuilding Lives, the Community Shelter Board has developed very real tools (agreements) to ensure that local neighborhoods can control and have input into what's happening in their community. The Good Neighbor Agreements, the process used to secure these agreements, and the support services themselves have all been key to gaining the support of the community at large. (For more information, see the Community Shelter Board's website at www.csb.org.)

- **Data/documentation**. The Community Shelter Board's ability to produce reliable up-to-date data on their system (who is being helped, how, and at what cost) is very impressive. These data are not necessarily part of their HMIS system, which is still in development, but they allow the community to evaluate the HMIS data. Accurate and reliable data have been key to securing the support of "investors," elected public officials, and the community at large. (For more information, see the Community Shelter Board's website at www.csb.org.)

- **Sunshine Terrace.** Sunshine Terrace is a very interesting partnership between Columbus' public housing authority (CMHA) and a local social service agency (the YMCA of Central Ohio). The two agencies joined together and with the help of CSB, established a Rebuilding Lives permanent supportive housing program within an existing public housing high-rise. In doing so, they were able to provide the community with 65 units of permanent supportive housing, offer Rebuilding Lives supportive services to all of the other public housing tenants in the 180-unit building, dramatically increase the occupancy rate of the building (and the neighborhood's acceptance of the building and its tenants), and save the building from being closed down and lost to people in need of public housing. (Contact person: John Hahn, Deputy Director, CMHA at 614.421.6400.)

Primary Contact Person

The primary source for more information on the Columbus site is the Community Shelter Board's website at www.csb.org.

History and Context—How the Current System Evolved

The lead agency for the homeless service system in Columbus is the Community Shelter Board, an independent nongovernmental nonprofit agency founded in 1986 by a group of civic leaders, business associations, local government leaders, and representatives from a variety of foundations. CSB does not provide any direct services within community, nor is it an original source of money for homeless assistance services. Its main responsibilities are resource development and investment, service delivery coordination and planning, program accountability, and systems change and public policy reform.

The Rebuilding Lives initiative grew out of a request to CSB by the City of Columbus in August 1997 for a plan to address the needs of people experiencing housing crises who were being affected by the development of the Scioto Peninsula, a riverfront corridor in downtown Columbus where many street homeless people congregated. In response to that request, the Community Shelter Board, with the support of the Franklin County Board of Commissioners, the City of Columbus, and United Way of Central Ohio, established the Scioto Peninsula Relocation Task Force, which issued the Rebuilding Lives plan in October 1998. It is interesting to note that the letter introducing the Task Force's report is addressed "To the Franklin County Community." Columbus views ending homelessness the responsibility of the entire community, not some smaller group such as the Community Shelter Board, homeless service providers, or elected officials.

The two-pronged strategy at the heart of the plan (emergency housing for those in crisis and supportive housing for those with long-term needs) was largely a response to the fact that chronically homeless people (a group that accounts for only 15 percent of all those in need) were absorbing the bulk of the community's homeless assistance resources. The Task Force recognized that the needs of this high-cost group could be met much more effectively, and at a lower cost, by providing them with permanent housing with supportive services. At the core of the plan is a commitment to provide 800 units of stable supportive housing programs for homeless individuals with long-term needs. Table C.1 is drawn from the Task Force's initial report.

With these figures in mind, the Community Shelter Board, along with many providers and funders, launched the initiative in July 1999.

Table C.1
Per-Bed Costs for Operations and Services of Franklin County Service Systems Used by Homeless Men with Long-Term Needs

Service System	Annual Cost per Bed	Daily Cost per Bed
Service-Enriched Housing	$13,000-14,000	$36-38
Minimum Security Misdemeanor Jail	$ 21,188	$58
Sub-acute Medical Detox	$ 69,800	$191
State Psychiatric Hospital	$172,900	$482
Hospital Inpatient	$396,025	$1,085

Source: "Report of the Scioto Peninsula Relocation Task Force," Final Report October 1998, drawing on data from the Ohio Department of Rehabilitation and Corrections; Columbus Health Department; Ohio Department of Mental Health; Maryhaven; and the Community Shelter Board.

Because of its autonomy and independence, the Community Shelter Board can represent the homeless service system "as a whole" and can distance itself (somewhat) from the internal struggles common to local homeless coalitions. In response to several questions about how it was able to effect a given change or make something happen, the executive director simply responded "we're not a coalition" (meaning it had the ability and authority to make final decisions, including ones that may not have been popular in the provider community). Another advantage is the consistency CSB has brought to the community: the homeless service system has high staff turnover but not CSB. Finally, it focuses on solutions—calling meetings around a single or a short list of problems—and provide "consistent, gentle advocacy." As one state senator reportedly noted, he counts on the Community Shelter Board to "clearly state the community's needs, be fact-based, and even-handed."

It is also important to note that while an initiative such as Rebuilding Lives could be replicated in other communities, it has a great deal of community support and political backing. The executive director of the Community Shelter Board explained that both Columbus and Franklin County have highly committed elected officials and the community has a long-standing tradition of caring about people, not just homeless people. The message is "bipartisan and very moderate—you don't have to support us because you like homeless people, you can just not like homeless people on the street in front of your business." Also, the business and political leadership mentors itself and ensures that this tradition of caring for and helping others continues over time.

It is unclear how well an effort such as Rebuilding Lives—an initiative that is in many ways a "paradigm shift"—would have fared without CSB orchestrating the change. Service providers in the community generally agreed that CSB is a unifying factor, and while they acknowledged the challenges associated with having fewer resources at a time when there are increasing needs, they generally characterized CSB as being fair and inclusive.

Approach to Chronic Street Homelessness

The Community Shelter Board currently allocates $6.2 million annually to 17 partner agencies for programs serving homeless individuals and families in Columbus.[12] As part of its work it orchestrates the community's main strategy for ending chronic homelessness embodied in an initiative known as "Rebuilding Lives." A summary of the many agencies involved in the Rebuilding Lives initiative (and the services they provide) is shown in Table C.2. The rows depict each agency and the columns represent the types of services offered by the agency.

The Rebuilding Lives supportive housing initiative is targeted at people who meet all three of the following eligibility criteria:

- are disabled by any one or a combination of multiple special needs that substantially impede the success of obtaining or maintaining housing, such as a severe and prolonged mental disability, a chronic substance abuse problem, a long-term health disorder, or long-term unemployment;
- are homeless according to the McKinney Act definition; and
- have spent at least 120 days homeless or have had at least four separate episodes of homelessness.

The basic goals of the Rebuilding Lives initiative are "to improve the system of care for long-term homeless men and women in Columbus, to meet individual needs to end the cycle of homelessness, to work with our neighborhoods, and to provide long-term housing solutions." With its emphasis on permanent supportive housing rather than shelter care as a solution to chronic homelessness, the plan seeks to provide long-term homeless men and women with more stable and productive lives. There is widespread support for Rebuilding Lives including among traditional outreach and shelter providers. Providers also agreed that despite a general shortage of resources for serving homeless people, Rebuilding Lives was not draining resources away from the sheltering system.

As of April 2003, 355 units of Rebuilding Lives supportive housing were operational in the Columbus area, and another 172 units were in development and expected to open within the next two years (a total of 372 units are expected to be operational by the end of 2003). These units are part of 10 distinct programs being run by 5 lead agencies in the community. In general, the projects have experienced very low turnover in residents (much lower than was expected), departures tend to be for "good" reasons such as someone getting a place on their own, and the waiting lists for each project are very long.

[12] These agencies are Catholic Social Services, Columbus Health Department, Columbus Neighborhood Health Center, Community Housing Network, Faith Mission, Friends of the Homeless, Gladden Community House, Homeless Families Foundation, Jewish Family Services, Lutheran Social Services, Maryhaven, Salvation Army, Southeast, Inc., Take It to the Streets Foundation, Volunteers of America, YMCA of Central Ohio, and YWCA of Columbus.

Table C.2: City of Columbus: Agencies in Reducing/Ending Chronic Street Homelessness

	Homeless-Related Programs and Services																					
	Prevention	Outreach\Drop-In	Shelter	Safe Havens	Transitional Housing	Permanent Supportive Housing	Other Housing (non-disabled)	Alcohol and Other Drugs	Mental Health Services	Health	Employment	Corrections	Public Assistance	Child Welfare	Advocacy	Food	Case Management	Cross-Agency Coordination of Servic Access and Delivery	Planning	Staff Training	Data\Documentation	PR, Public Acceptance
Nonprofit Programs/ Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People (listed alphabetically)																						
(COHHIO) Coalition on Homelessness and Housing in Ohio														X								
Columbus Coalition for the Homeless														X			X					
Columbus Neighborhood Health Center		X				X				X						X						
Community Housing Network				X		X		X	X		X					X				X		
Community Shelter Board	F	F	F		F	F								X		T,F	X	X	X	X	X	
Corporation for Supportive Housing						E					E			X		T,F	X	X	X		X	
Faith Mission	X		X		X	X				X	X				X	X						
Friends of the Homeless			X		X	X		X			X					X						
Maryhaven			X	X		X		X	X	X						X				X		
Rebuilding Lives Funder Collaborative						F								X		F	X	X				
Southeast		X				X		X	X		X					X				X		
Take It To The Streets		X														X						
YMCA of Central Ohio			X			X					X					X				X		
YWCA of Columbus			X		X	X	X							X		X						
Government Program/ Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People																						
(ADAMH) Alcohol, Drug, and Mental Health Board of Franklin Co.						F		F	F							F	X	X	X		X	
Columbus Health Department										X						X						
Columbus Metropolitan Housing Authority						X	X															
Franklin County Department of Job and Family Services	X										F			X		X						
Ohio Department of Rehabilitation and Correction												X				X						

X = Provider E = Expert TA Provider F = Funder

In order to be eligible for a Rebuilding Lives unit, an individual must either have been homeless on the streets or in shelter for 120 days or more, or have had 4 or more homeless episodes. Many if not most of those in the program have had long histories of street homelessness. Rebuilding Lives tenants are mostly single men (80 percent), most have alcohol and/or drug problems, and a large share of these have co-occurring mental illness (a smaller share have mental illness alone).

Rebuilding Lives offers a variety of housing "models," largely because of the diversity of programs and agencies participating in the initiative. There is variation on both the housing and services sides of the effort. Rebuilding Lives housing includes scattered site and Single Room Occupancy (SRO) high-rise housing, public housing, and Section 8-based housing. Service approaches range from "clean and sober," to "stages of change," to low-demand "harm reduction" models.[13] Yet others use psychiatric models of care. In all Rebuilding Lives programs, services are optional and the housing is not time-limited.

Mainstream Involvement

The original 1998 Rebuilding Lives plan envisioned a major role for mainstream agencies, which were already heavily invested in combating homelessness. The Community Shelter Board recently reviewed the roles of key collaborators as described in the original plan to assess how well they were doing. The results of this review are reported below in Table C.3. The table is interesting for several reasons. First, it illustrates the wide variety of agencies that play a major role in Rebuilding Lives; second, it details exactly what the plan expects of each agency; and third, it shows that plans can fall short of reality. In some cases, what was expected of an agency simply "did not occur" or was "determined to be not feasible." Finally, it is worth noting that the roles are not limited to providing funding or other resources to the initiative: they include things like identifying appropriate housing stock, providing technical assistance, and taking on leadership roles.

In general, most of the key collaborators are "at the table" and are meeting or exceeding their original roles. Some Federal agencies, such as Veterans Affairs and the Social Security Administration, are "cooperative but not collaborative." In other words, it has taken a lot of work to get them to participate and they appear to be willing to do things but tend not to do them in a timely manner. It is not clear why this is the case, it may be the result of cultural differences between agencies/organizations but it is often simply a function of the interests and commitments of who heads the agency. As the Executive Director of the Community Shelter Board noted, it also takes resources (meaning time and money) to build relationships with other (mainstream) agencies, to understand their internal bureaucracies and how they think about people and problems.

[13] The "harm reduction" programs have the longest waiting lists. Also, the Community Shelter Board does not intend to fund any additional "clean and sober" models as part of Rebuilding Lives.

Table C.3: Roles of Key Collaborators[14]

1998 Rebuilding Lives Plan	2003 Rebuilding Lives Status Report
City of Columbus	
Capital grants consistent with plan and priorities	Invested HOME capital funds in supportive housing. Invested Community Development Block Grant (CDBG) capital in Faith Mission on 8th Avenue and Harmon Avenue shelters.
Commit General Revenue Funds for Funder Collaborative and Shelter Operations	Invested additional General Revenue Funds, HOME rental assistance and Emergency Human Services for supportive housing. Maintained flat commitment of funds for shelter operations.
Adopt Shelter Certification as part of the development review process	Did not occur.
Franklin County	
Commit General Revenue Funds for Funder Collaborative and Shelter Operations	Invested additional General Revenue Funds and Temporary Assistance for Needy Families (TANF) for supportive housing. Maintained commitment of funds for shelter operations, cost of living increases through 2002. Invested in building of the Engagement Center.
Through Mid-Ohio Regional Planning Commission (MORPC), capital grants consistent with priorities and plan	Created new Community and Economic Development Department. Invested HOME capital funds in supportive housing.
Revenue source for Housing Trust Fund (HTF)	HTF not created for supportive housing. HTF created with City of Columbus to address affordable housing.
Community Shelter Board	
Convene the Funder Collaborative	Facilitates the Collaborative, which has met monthly since inception.
Fund operations of emergency shelters consistent with Task Force plan and priorities	Invested additional private funds in emergency shelters.
Fund shelter diversion activities and contract for these services on behalf of the Funder Collaborative	Invested additional state and private funds in homeless prevention and street outreach.
Monitor Task Force plan implementation	Issues annual report to funders as well as periodic updates.
ADAMH (The Alcohol, Drug and Mental Health Board of Franklin County)	
Take lead on development of Crisis Stabilization Program	Led development of the Engagement Center.
Put resources into Funder Collaborative	Invested in the operations and services provided at the Engagement Center. Invested services funding in supportive housing.
Get funded agencies to the table and focused on the plan	Several ADAMH agencies are active partners in supportive housing.

[14] This is drawn from pp. 10-11 of Community Shelter Board, "Moving Forward, March 2003, Rebuilding Lives: Breaking the Cycle of Homelessness," Columbus, Ohio, 2003.

1998 Rebuilding Lives Plan	2003 Rebuilding Lives Status Report
Corporation for Supportive Housing	
Put resources into Funder Collaborative	Provided operating grant for supportive housing through Hilton Foundation.
Assist with development of capital finance packages for housing	Provided as needed due to the level of experience and knowledge of providers thus far.
Technical assistance and project development capacity-building	Provided direct financial assistance to sponsors and technical assistance to develop capacity.
Support to Funder Collaborative	Provided administrative support to Collaborative.
CMHA (Columbus Metropolitan Housing Authority)	
Identify housing stock that can be reused as part of the system (surplus units, assets, Sunshine, scattered site and small projects)	Implemented partnership at Sunshine Terrace.
Identify units in the HUD portfolio that could be reused as part of the system	Determined to be not feasible.
Implement program for Section 8/employment linkage	Invested substantial Section 8 (tenant and project based) for supportive housing.
Reallocate Shelter Plus Care to provider agencies that can maximize their use	Determined to be not feasible.
Veterans Services Commission	
Put resources into Funder Collaborative	Did not occur.
Get VA and other veterans organizations to the table and focused on the plan	VA participates in one project.
Franklin County Department of Human Services (now Job and Family Services)	
Provide TANF funds to CSB for families to enable CSB to free up resources to contribute to Funder Collaborative	Provided 3 years of support through 6/30/02.
Franklin County Office on Aging	
Put Senior Options resources into Funder Collaborative	Did not occur.
United Way	
Put resources into Funder Collaborative	Invested in capital, operations, and services for supportive housing.
Get funded agencies to the table and focused on the plan	Several United Way Columbus (UWCO) agencies are active partners in supportive housing.
Provide leadership to build business and community support for implementation of the Task Force plan.	Housing Vision Council and board of trustees provided leadership from business community and consider Rebuilding Lives to be a strategic initiative of UWCO.
Other Philanthropic Organizations	
Put resources into Funder Collaborative	Multiple foundations, businesses and individuals have invested in capital, operations, and services for supportive housing.
Capital grants consistent with plan and priorities	Capital grants provided for the new Faith Mission on 8th Avenue and multiple supportive housing projects.
Provide leadership to build business and community support for the Task Force plan	Columbus Foundation and Columbus Medical Association Foundation are active members of the Funder Collaborative. CSB Trustees and Advisory Council provided business and community leadership to the initiative.

Selected System Components

Effectively addressing homelessness, including chronic homelessness, requires many different types of services and system components. These range from street outreach efforts to any of a variety of housing programs, as well as supportive services and homelessness prevention. In general, outreach and drop-in programs (and intake and assessment services) are the gateway into housing for homeless individuals, but Columbus has a very open shelter system and many people living on the streets (or "on the land" as they say in Columbus) have in fact touched the shelter system at some point in time. Although it is possible to obtain permanent supportive housing through self-referral, formerly homeless individuals indicate that it is extremely difficult to get in without some type of caseworker advocating on their behalf.

Once connected with the system, clients with short-term emergency housing needs are provided emergency (and possibly transitional) shelter, and then move back into permanent housing in the community. Clients with longer-term needs are provided permanent supportive housing or permanent subsidized housing without supportive services. In many cases, they move directly into permanent supportive housing from the streets. Note that the Community Shelter Board is at the center of this system and connects directly with each component.

Most of the individuals interviewed as part of this study reported that there are no major gaps in Columbus' system, but that "more of everything is needed." Several people added that there can be very long waits (lasting many months) for mental health services after an initial contact is made through NetCare Access (ADAMH's 24-hour emergency response by phone, on-site, or through mobile services). Another observer pointed out that the primary access point to mental health services is not through ADAMH but through the shelter system. Yet others added that the many outreach programs in Columbus are only just beginning to coordinate with one another. Below, we briefly review the many components that comprise Columbus' homeless service system.

Prevention

Homelessness prevention is a major component of Columbus' ten-year plan to end chronic homelessness. Prevention efforts include both improved housing retention/stability and primary prevention through better discharge planning with the Ohio Department of Rehabilitation and Corrections (ODRC) and the mental health system.

Lutheran Social Services is the lead agency in the Homelessness Prevention Program. Services provided include assistance with rent, mortgage and utility payments, mediation, budget counseling, employment leads, assistance with housing searches, and linkages to other community resources. These programs are funded with resources from the Community Shelter Board, the Federal Emergency Management Administration, and the State of Ohio Adult Emergency Assistance Program.

In addition to ensuring that all homeless people are properly connected to the Franklin County Department of Jobs & Family Services (FCDJFS) and ADAMH systems, the Community Shelter Board has entered into a collaborative agreement with the ODRC to reduce discharge to shelters or the streets. The state has made reforms, known as the Ohio Plan, to improve how inmates are

discharged from ODRC facilities, and Franklin County is one of three counties in Ohio participating in a special initiative known as the Core Plan that targets discharge and other enhanced services to high-risk inmates. In general, the community reports that they have good discharge *policies* in place and CSB has established good working relationships with ODRC, but there is now a need to "bring practice in line with the policy."

Outreach and Drop-in

The Community Shelter Board currently contracts its outreach services with one agency. Specialized teams target their outreach activities toward homeless persons with specific needs such as serious mental illnesses. ADAMH also funds a van (the NetCare van) whose staff members take public inebriates to Maryhaven's Engagement Center for sobering services. Even though this service is voluntary, the alternative can be spending the night in jail. Another agency uses Projects for Assistance in Transition from Homelessness (PATH) fund to enhance its outreach team with a behavioral component consisting of a psychiatrist, a nurse, a chemical dependency counselor, and a case manager. This team of professionals travels to encampments and other gathering spots for homeless individuals by van, enabling it to provide immediate services and referrals.

The Columbus Homeless Coalition sponsors the Outreach Cluster, comprising six agencies that perform outreach activities together on a weekly basis. Their function is simply to locate homeless individuals, gain their trust through the engagement process, and connect them to services. However, they may not be able to follow up with their clients after making initial appointments; delays of as much as four months are not unusual.

Outreach services appear to be duplicative. Even though the groups from the Outreach Cluster are aware of the groups from the Community Shelter Board, they frequently conduct their activities in the same areas. One observer reported that on a single afternoon three separate agencies provided outreach services in the same homeless encampment. Current efforts are underway to reduce duplication of services and increase collaboration by convening monthly meetings among all outreach providers. It also appears that many outreach programs have their own orientation/outlook on homeless people, one that is not always consistent with bringing people in off the streets. Many outreach workers are most interested in helping people "survive on the streets," and may have their own mistrust of mainstream agencies. Having a coordinated outreach system (with a single point of contact, a shared data system, etc.) is a goal but not yet a reality in Columbus.

Emergency Shelters

A clear point of entry into Columbus' homeless service system is through one of its emergency shelters or through Maryhaven's Engagement Center. Emergency shelters provide no-cost, short-term housing, usually with a maximum stay of 90 days. Beyond providing a secure clean place to sleep, emergency shelters also give access to basic services such as showers, meals, healthcare, and material assistance. Many emergency shelters also provide case management services including assessments and linkages to mainstream service providers, mental health and substance

abuse treatment services, medical care, and employment services. The total shelter capacity for adults is 464 beds, of which 317 beds are contracted through the Community Shelter Board.

The Maryhaven Engagement Center provides overnight accommodations and services for male and female public inebriates. Clients can remain in the Engagement Center for three days without receiving substance abuse treatment or ten days if they participate in Maryhaven's outpatient detoxification program which is right next door. Individual inebriates, however, can be admitted to the engagement center as often as needed. The usual stay is for one night. Once an individual enters the Engagement Center, attempts are made to engage the individual in substance abuse treatment and other services working towards the goal of permanent housing. The Engagement Center is funded by the Community Shelter Board, the ADAMH Board, and a HUD save havens grant. It has an overall capacity of 54 beds.

Interestingly, in a group meeting with many of Columbus' "traditional" shelter providers, there was widespread support for the Rebuilding Lives initiative (and most of them said they would like to see more of it). While they did not feel that the initiative was pulling resources away from their programs, they did note how important it was to preserve the emergency shelter system for short-term needs. A variety of circumstances (the September 11th terrorist attacks, a sagging economy, etc.) have increased acute homelessness at a time when there are severe downward pressures on the job and housing markets. The housing stock continues to dwindle; landlords and employers are becoming more selective.

Transitional Programs

Columbus has 742 transitional housing beds of which 347 are reserved for individuals. The Community Shelter Board currently has no plans to develop additional transitional housing units; it is devoting its resources to developing more permanent supportive housing units. The three transitional housing programs run by CSB partners offer shelter services, alcohol and drug services, and health and employment services, and some of them have substance abusers as their primary focus population.

Permanent Supportive Housing

The Community Shelter Board contracts with nine programs that together provide 355 units of permanent supportive housing through Rebuilding Lives (see Table C.4) other permanent supportive housing operates independently of CSB. Project sponsors include non-profit housing developers, mental health agencies, and multiple partnerships. Housing ranges from scattered site apartments to small SROs to large high-rise apartments (projects ranging in size from 15 to 65 Rebuilding Lives units). One of the programs, a save haven, has 13 efficiency units combined with a drop-in center.

In addition to developing the housing, project sponsors are responsible for recruiting tenants and overseeing the program. Generally, sponsors recruit directly from the shelters and streets, and there does not appear to be any collaboration in recruiting for projects among different housing providers. The units have seen very low turnover (10-20 percent), so initial rent-up (when new

projects come on-line) is the main way in. There are long waiting lists: one 25-unit project, for example, has 100 people on its waiting list.

Once participants are recruited and given housing, they may remain permanently. All Rebuilding Lives programs are "low demand" in that the only requirement is a basic tenant-landlord agreement: pay rent, don't disturb the neighbors, and don't destroy the property. Other services are generally voluntary but engagement is high: 60 to 100 percent participate, mostly in case management, employment, treatment and recovery, and basic life skills. Programs also link tenants to mental and physical health services, including local community health centers that also help people apply for Supplemental Security Income (SSI), food stamps, etc. Not surprisingly, given the variation in how programs are structured and run, service levels can vary from one Rebuilding Lives program to another. The services—which tend to be more supportive and engaging rather than highly clinical or rigid in nature—help keep tenants housed, contribute to their health and employment prospects, and increase their sense of self-worth. Interestingly, the executive director of CSB also commented that the exact mix of services is not as important as the housing itself, and that the (presence of) services is "as much about getting landlords and neighbors to accept you [the program], as it is about benefiting tenants." She also added that generally Rebuilding Lives housing "feels like normal housing" rather than "program" housing.

The official policy of Rebuilding Lives is that all supportive services are voluntary, but there are some exceptions. For example, Federal statute requires that tenants benefiting from Shelter Plus Care grants meet with a case manager twice a year. Other Rebuilding Lives projects require service participation *for admission*. The YMCA SRO initially wanted to have mandatory service participation/engagement; instead it instituted a 60-day orientation period during which time services are mandatory. After 60 days, participants must pay rent so it effectively requires people to either receive services or pay rent. As the executive director of CSB explained, through Rebuilding Lives many housing providers have had to learn about engagement, and have had to relinquish some of the "hammers" (i.e., mandatory requirements such as sobriety, etc.) they were accustomed to using and learn other strategies for engaging people. Some traditional shelter providers commented that even the older sobriety-based programs in the community were now "gentler" as a result of the arrival of "harm reduction" in Columbus.

CSB's preferred model for permanent supportive housing units is one that combines Rebuilding Lives clients with the other clients because it normalizes the living environment. Some sites have a 50-50 mix of clients while other sites have a 2:1 ratio of non-Rebuilding Lives residents to Rebuilding Lives residents. The residents who are not part of Rebuilding Lives are able to provide support and encouragement for the Rebuilding Lives clients, who are then able to pattern their behavior after the mainstream residents. The residents who are not part of Rebuilding Lives are also able to access services offered to the Rebuilding Lives residents on a lesser scale so the program benefits all residents.

Rebuilding Lives has led to a number of unique collaborations among community agencies. One particularly interesting partnership is that between the YMCA of Central Ohio and the Columbus Metropolitan Housing Authority (CMHA). The two agencies jointly entered into an agreement to revitalize a public housing high-rise building project (Sunshine Terrace) that had been earmarked for demolition. CMHA invested $2 million in physical renovations and improvements and the YMCA provides support services (through Rebuilding Lives) and property management. Sixty-

five of the 180 units in the building are devoted to Rebuilding Lives clients, who meet all of the criteria for the initiative. This has been a successful collaboration because each partner is able to bring a different component to the table.

It should be noted that the Columbus Metropolitan Housing Authority's involvement in Rebuilding Lives extends far beyond Sunshine Terrace. About 300 of the 350 permanent supportive housing units that are part of the initiative have some type of public housing subsidy attached to them, including Section 8 (both project- and tenant-based). CMHA is also part of the Funder Collaborative and helps with streamlining procedures, interpreting rules as flexibly as possible, etc.

Studies have demonstrated a higher success rate at maintaining housing for clients who receive case management services, (U.S. Department of Housing and Urban Development, 1995) and both the YMCA and CMHA explain that this is this is anecdotally true at Sunshine Terrace. Case managers are able to intervene for tenants if they are unable to pay their rent or to intervene on the behalf of management if a tenant's behavior is inappropriate.

Table C.4: Rebuilding Lives: Supportive Housing Projects

Program	Lead Agency	Units	Brief Description
Units On-line			
Parsons Avenue Apartments	Community Housing Network	25	For the Rebuilding Lives target population with chronic alcoholism. This stages of change program is implemented in collaboration with Friends of the Homeless and Southeast.
Cassady Avenue Apartments	Community Housing Network	11	For the Rebuilding Lives target population with substance abuse issues. This clean and sober program is implemented in collaboration with Friends of the Homeless, Columbus Neighborhood Health Center, and the Columbus Health Department.
Safe Havens	Community Housing Network	13	For the Rebuilding Lives population with serious mental illness and substance abuse issues. This low-demand program is implemented in collaboration with Friends of the Homeless and Columbus Neighborhood Health Center.

Table C.5: Per Unit Costs (Operations and Services) for Rebuilding Lives Projects

Program	Lead Agency	Units	Brief Description
Scattered Site	Community Housing Network	60	For the Rebuilding Lives population with substance abuse issues. This clean and sober program is implemented in collaboration with Columbus Neighborhood Health Center and the Columbus Health Department.
Sunshine Terrace	YMCA of Central Ohio	65	A collaborative between the YMCA, the Columbus Metropolitan Housing Authority, and Columbus Neighborhood Health Center to provide housing to 65 men and women from the Rebuilding Lives target population and to help stabilize the 180 unit high-rise apartment building.
North High Street Apartments	Community Housing Network	36	For the Rebuilding Lives target population with severe mental illness or dual diagnosis. This stages of change program is implemented in collaboration with North Central Mental Health Center.
North 22nd Street	Community Housing Network	15	A total of 30 supportive housing units, 15 for the Rebuilding Lives target population for veterans and those with serious mental illness. This program is implemented in collaboration with Columbus Area Mental Health Center and the Department of Veterans Affairs.
Scattered Site	Volunteers of America	15	For the Rebuilding Lives target population with substance abuse issues.
Permanent Supportive Housing at 40 West Long Street	YMCA of Central Ohio	65	Within the YMCA's 40 West Long Street location, 65 units for Rebuilding Lives target population with mental illness and substance abuse issues.
Scattered Site	Southeast	50	For the Rebuilding Lives target population with dual diagnosis of mental illness and substance abuse. This low-demand program also uses an Assertive Community Treatment team.
Units to be On-line in 2003			
Commons at Grant	National Church Residences	50	New construction of 100 units, 50 for the Rebuilding Lives target population.

Source: Rebuilding Lives: Supportive Housing Projects, Community Shelter Board, accessed on-line at http://www.csb.org/Publications/projects.html on May 19, 2003.

Supportive Services

Supportive services are available to all residents at facilities housing Rebuilding Lives clients. The official policy of Rebuilding Lives is that all supportive services are voluntary. Participation is high nonetheless, with about 60-100 percent engagement. Typically, supportive services include case management, pre-employment and employment services, substance abuse treatment and recovery groups, and basic life skills training. Linkages are also provided to both mental and physical health services (in some cases health services are on site) and mainstream agencies providing SSI and welfare. The executive director of CSB observed "there is no good way of getting people access to SSI and Medicaid" (to the extent that they are eligible for these). This has not been a priority until quite recently.

Supportive services are also available to those who are not in permanent supportive housing. They can be obtained through the shelter system, through ADAMH, the FCDJFS, the 24-hour information and referral line, and referrals from churches, hospitals and clinics, law enforcement agencies, and schools.

It should be noted that there has been, and continues to be, some resistance in the provider community to the "housing first" model. CSB has tried to educate providers, and convince them that they do not need to rely on the old tools of coercion, such as threats of eviction, to manage people. When asked how they have overcome the resistance, CSB simply responded, "We're not a coalition. We write the rules." CSB has also made the moral argument that it's time for them (meaning chronically homeless people) to "move to the front of the line."

As part of our site visit to Columbus, we conducted an in-depth focus group discussion with residents of three Rebuilding Lives programs. All were men who had spent long periods of time homeless on the streets of Columbus. Support and appreciation for the program was universal. Some participants noted that while their needs were being met, they still had to make an effort to benefit from the supportive services, while another one said that one can become complacent because "all this stuff's been given to me." When asked about the importance of the supportive services and staff, another person noted that if you need (want) the help, then it's important that it's there and he's glad it's there, but "otherwise the day just goes on." They all agreed that these types of programs and supportive housing programs would greatly benefit their friends and others who were still living on the land. There was widespread uncertainty about how exactly one gets into a Rebuilding Lives program. Participants commented that they just "stumbled in on this," or a caseworker "happened to know about it" and helped them (four participants came into their program directly from the streets while others had been in shelter). Many participants noted that without the program they would be drinking and drugging on the streets and would probably be dead. One respondent commented that program should be called "Saving Lives" rather than Rebuilding Lives, because that is what it has done for him.

Affordable Housing

Affordable housing is a significant problem in Columbus as it is in many communities across the nation. Only 17.6 percent of all housing units in Columbus are identified as being within financial reach of low-income households and only 67 percent of the scattered site rentals have affordable leases. As mentioned earlier, a person earning minimum wage in Columbus would

need to work 63 hours per week to afford a studio apartment. The Community Shelter Board identifies a deficit of approximately 22,000 housing units available to extremely low-income individuals. Additionally, the Continuum of Care application identifies a gap of over 1,000 beds for homeless individuals.

Columbus has several groups committed to addressing the problems associated with affordable housing.[15] Among others, they include:

- The United Way Housing Vision Council is a group of 30 individuals representing donors, consumers, neighborhood groups, United Way Board of Trustees and agencies, and local experts working together with the common purpose of identifying and achieving the results necessary to address the community's most critical housing needs.

- The Columbus Compact is the lead agency in developing and focusing resources in central city neighborhoods while encouraging collaboration in neighborhood development and central city policy issues.

- The Columbus and Franklin County Affordable Housing Trust Corporation combines private and public funds to finance the development of affordable housing, including rental housing, within the city.

- The Building Responsibility, Equality, and Dignity (B.R.E.A.D.) Organization is an interfaith coalition that addresses core issues pertaining to housing in addition to crime, safety, jobs, and education.

- The Franklin County Housing Advisory Board makes recommendations to the County Commissioner for bonds aimed at expanding and preserving the supply of affordable rental housing in Columbus and Franklin County.

- The ADAMH Board collaborates with the Community Shelter Board to create permanent supportive housing for homeless individuals.

Documenting Reductions in Chronic Street Homelessness

Columbus has not conducted many street counts of its homeless population, but it has an "open shelter" system and most people homeless on the street "touch" the shelter system at some point (even if it is just through the winter overflow shelters). As a result, CSB has a good sense of the size of its street homeless population based on its shelter data. There are between 150 and 250 people homeless on the streets of Columbus on a given day, and no more than 1,000 individuals homeless on the streets throughout the year. They have yet to document reductions in their street population as a result of Rebuilding Lives, although the program is clearly succeeding in housing long-term chronically homeless individuals for long periods of time.

[15] Columbus and Franklin County Continuum of Care Narrative, 2002, pp. 3-4.

The Community Shelter Board does collect data on each individual served by its partner agencies. CSB has used an HMIS since 1990 and has been using Service Point since 2001. Currently CSB is able to use Service Point to measure impact at the individual program level only. Measures include average monthly occupancy, length of residence, reasons for departures, numbers returning to shelter, etc. The system can support analyses of long-term recidivism (looking at any time period of interest, for example, 3, 6, 9, or 12 months). Again, because of their "open shelter" model, the community's shelter data are likely to reveal if someone who has left permanent supportive housing has returned to the streets. There are also some limited street outreach data (from the primary outreach providers) that have been part of the HMIS since April 2002.

Some agencies interviewed expressed frustration and difficulties with using Service Point. The difficulties centered on consistency of data input between workers, mostly associated with high staff turnover and problems generating reports. At least one agency tracks data in duplicate to assure accurate reporting. The Community Shelter Board convenes monthly HMIS administrative meetings at which the agencies can bring problems and request technical assistance.

Existing shelter data indicate a 7 percent decrease in the total number of clients sheltered in 2001 as compared to 1998 (note these are all homeless clients, not just those who are chronically homeless). Of the 2,959 clients sheltered in 2001, 298 had successful outcomes, meaning they exited the shelter system to either permanent or transitional housing. The average length of stay during this period of time remained relatively stable for men, while it increased by over 20 percent for women, increasing from 37 days in 1998 to 47 days in 2001. During this period of time the recidivism rate increased by 14 percentage points for men and 3 percentage points for women.

Despite the limitations of the HMIS, the Community Shelter Board has been collecting extensive data on its homeless service system for many years, data that have guided both program and policy development in Columbus. Indeed, because it has these data and CSB "knows our system," it is better able to evaluate the quality of the Service Point system (other communities may not have such an advantage). These data have been used to evaluate the costs of running various Rebuilding Lives programs. Scattered site models are more administratively challenging to operate and are not as able to access Federal or state funding. Larger supportive housing developments that include a mix of formerly homeless and other low-income persons (low-income working people, students, retirees, etc.) appear to be the most cost effective, and are also more stable and more acceptable to the community.[16]

The cost benefits result from economies of scale, as well as the ability to leverage substantial Federal, state, and private investments in larger housing developments. Scattered site developments are funded exclusively by local dollars; they cannot take advantage of tax credits for developers, McKinney HUD funds, or project-based Section 8 supports. With larger projects, one can also achieve a better mix of clients with high and low needs. To be cost effective, one

[16] Note that when projects/buildings house both Rebuilding Lives and other tenants, the support services are generally available to *all* of the residents of the building (engagement and use of the services, however, may be higher among the Rebuilding Lives tenants).

needs to provide just the right level of services to keep clients stably housed. With small projects, clients arrive and need highly intensive services on an ongoing basis. Over time, however, their needs diminish and yet the high intensity services are still there. With larger projects, there is a better mix of high- and low-need clients and the support services that are available are used more efficiently. However, a project can also be too large, both absolutely and with respect to its community. The basic efficiency issue in Columbus, other than accessing funding sources for housing, is the efficiency with which supportive services staff can be used.

The Community Shelter Board is just beginning to encourage individual Rebuilding Lives projects to make their costs more consistent (and consistently low). Also, CSB no longer pays for some types of services, such as alcohol and drug treatment, physical health, and employment services (these are still available to residents but must be covered through mainstream sources). CSB is working on securing the funds to bring in an outside evaluator to examine the Rebuilding Lives initiative and document its impact on whole community, including changes in the shelter system (which was one of the goals of the initiative).

Public Funding

A major focus of the original plan is identifying and securing the resources needed for implementation. The plan outlines several options for new financial resources: establishing dedicated local revenue sources for broad-based affordable housing activities; encouraging innovative, entrepreneurial businesses tied to programs serving homeless individuals; and generating private, state and Federal funding for specific projects.

Resources for Rebuilding Lives are managed through a specially created "Funder Collaborative." Through the collaborative, individual funding agencies pool their resources to achieve mutually agreed-upon goals, establish common expectations about what outcomes are to be achieved, and specify what reporting requirements are needed to document progress towards those goals. In addition to the Community Shelter Board (which oversees the implementation of Rebuilding Lives, chairs the Funder Collaborative, and serves as the main fiscal agent for the initiative), many different types of agencies and organizations are on the Funder Collaborative:

- Alcohol, Drug and Mental Health Board, David Royer
- City of Columbus Administration, Trudy Bartley
- Columbus City Council, Charleta B. Tavares
- Columbus Foundation, Emily Savors
- Columbus Health Department, Tom Horan
- Columbus Mayor's Office, Erika Clark Ingram
- Columbus Medical Association Foundation, Phil Cass
- Columbus Metropolitan Housing Authority, Dennis Guest

- Corporation for Supportive Housing, Sally Luken
- Franklin County Department of Job & Family Services, Mary Lou Langenhop
- Franklin County Mental Retardation /Development Disabilities (MR/DD), Jed Morrison
- Franklin County Administration, Anthony Forte
- Franklin County Office on Aging, Antonia Carroll
- Mid-Ohio Regional Planning Commission, Kathy Werkmeister
- Ohio Capital Corporation for Housing, Hal Keller
- United Way of Central Ohio, Janet Jackson
- Veterans Service Commission, David Bradley
- Chairperson, Barbara Poppe, Community Shelter Board

Members include representatives of city and county government, all of the major public agencies, including many mainstream agencies such as the Metropolitan Housing Authority and the Departments of Job & Family Services and Health, other private agencies such as the Corporation for Supportive Housing, and philanthropic organizations such as the United Way. A key member of the collaborative is ADAMH (the Alcohol, Drug and Mental Health Board of Franklin County), which coordinates all community-based alcohol, drug addiction, and mental health services in Columbus. ADAMH does not provide any direct services, but contracts with a network of 45 public and private health care agencies to treat people in need. The Board meets quarterly and its primary responsibilities are to serve as the mental health, alcohol, and drug addiction planning agency for Franklin County; assess community needs, establish priorities, and develop a system of care to meet these needs; monitor and evaluate services for quality, accessibility, availability, effectiveness, and fiscal accountability; and advocate for and develop local financial support for mental health, alcohol, and drug addiction programs.[17] Since Rebuilding Lives was launched, the Funder Collaborative has met monthly and now meets every other month to address funding and system issues—it is the main mechanism for coordinating and monitoring the system.

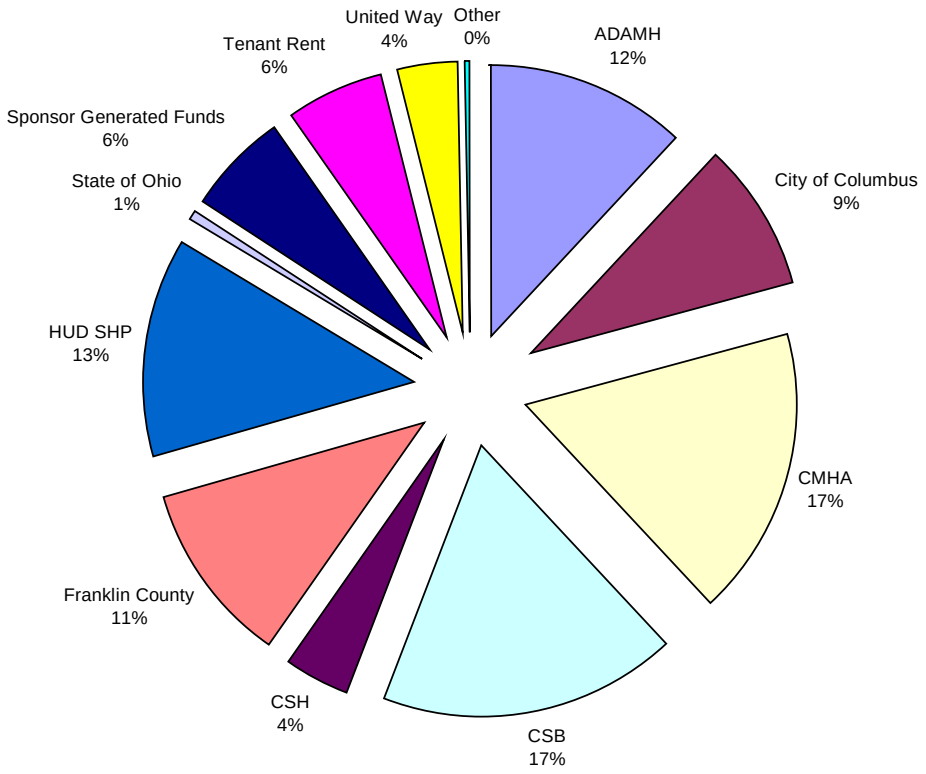
[17] Almost half of the ADAMH system's resources are drawn from a single property tax levy (approved by voters), and the remainder comes from state, Federal, and private sources.

Table C.6: Local Agency Investments In Ending Street Homelessness

	Type of Investment		
	Fund Services	**Staff Provide Services**	**Fund Housing**
Ohio Department of Development (ODD) ESG, HOPWA, HOME, state housing trust funds	X		X
Franklin County-ESG, HOME, CDBG, local housing trust funds, local tenant assistance funds, general revenue & development bonds	X		X
City of Columbus-ESG, HOPWA, HOME, CDGB, local housing trust funds, local A19tenant assistance funds	X		X
Columbus Metropolitan Housing Authority--Section 8 (tenant and project-based)			X
Columbus Department of Development-TIF			X
Non-Profit Grantees-SHP, SHELTER Mod Rehab + CARE, SRO	X		X
Southeast/Ohio Department of Mental Health--PATH	X	X	
Columbus Neighborhood Health Center-HCH	X	X	
Ohio Department of Mental Health/ADAMH-Medicaid, state MH services and treatment funds, local MH & SA treatment funds	X		X
VA Outpatient Clinic-veterans services		X	
Housing Finance Agencies (HFAs) LIHTC, state housing trust funds			X
Ohio Department of Drug and Addiction Services (ODADAS)--state substance abuse services and treatment funds	X		
Community Shelter Board-local foundations, businesses, corporations	X		X
Capital Crossroads-BIDs		X	
Lutheran Social Services-FEMA	X	X	
United Way	X		X

The Community Shelter Board funds individual projects with money from a variety of sources including city/county general funds, the United Way, and philanthropic donors. Projects also receive direct funding through HUD's Continuum of Care program, a small share of state dollars, and other funds. For the current year, the Rebuilding Lives budget is $5 million: this includes some resources for shelter reconfiguration but most of it is for permanent supportive housing. Figure C.1 shows the sources of funds for Rebuilding Lives for 2003 (it does not reflect any Medicaid funds, however) and it includes funds that CSB does not directly administer (i.e., funds that go directly to Rebuilding Lives programs and service providers). Major funders are the Franklin County Board of Commissioners, the City of Columbus, and the United Way of Central Ohio. The 17 percent of funds from CSB reflects the portion of CSB's funds dedicated to Rebuilding Lives including long-standing shelter services funds (CSB's traditional funders include the city, county, United Way, and philanthropic donations).

Chart C.1
Summary of 2003 Revenue Sources for
Operations and Services Costs of Rebuilding Lives



Faced with a shortfall in its budget for the upcoming year, the Community Shelter Board did not anticipate being able to adequately fund its current shelter and housing services for FY 2003. After consulting with various stakeholders, the Board of Trustees decided to maintain its funding emphasis on shelters and supportive housing; and if needed, reduce funding for supportive services in shelters and outreach, homeless prevention, and direct client assistance. Of its $5.5

million for program support, 57 percent will go to emergency shelters, 27 percent to supportive housing, 7 percent to prevention, and 8 percent to housing services (Community Shelter Board, 2003).

The Community Shelter Board does not fund capital grants but it does help agencies secure such grants. Now that it has a better sense of the actual costs, it is better able to predict the financial needs of a project (and operational and service costs have to be renewable). The costs are about $14,000 per unit per year for operations (mostly rent) and services.

HUD dollars are the only Federal dollars the Community Shelter Board uses to support Rebuilding Lives and there are no real restrictions on them: "they are flexible and we can use them well." There are some challenges associated with Federal guidelines (passed within the last several years) such as tenants not having any prior felony convictions; CSB is still working on resolving these kinds of barriers to housing.

Community Relations and Advocacy

Any successful permanent supportive housing effort must effectively balance the needs and concerns of shelter residents, service providers, and funders with those of the neighborhood and larger community where the housing is located. As part of the Rebuilding Lives initiative, Columbus convened a broadly representative Community Advisory Committee to seek the community's input and address any concerns. Community relations are addressed in multiple ways: (1) The Community Shelter Board has a rigorous shelter certification process to ensure that shelter programs meet high quality and accountability standards; (2) a Citizens Advisory Council monitors and evaluates services and programming within Rebuilding Lives programs; and (3) CSB works with all supportive housing and shelter operators to help them implement "Good Neighbor Agreements." The purposes of the Good Neighbor agreements are several:

- To promote communications, respect, and trust among neighbors, residents of the permanent supportive housing, service providers, and funders by assuring that the rights and responsibilities of all parties are understood and monitored;

- To assure that safety, security, codes of conduct, and property standards are established and upheld;

- To establish successful, long-term relationships while providing all stakeholders—neighbors, neighborhood organizations and agencies, neighborhood businesses, and other community-based groups—with the opportunity to be involved in planning, decision-making, monitoring, evaluating and re-negotiating the agreements; and

- To provide a structure and process for resolving conflicts and minimize litigation.[18]

[18] Good Neighbor Agreements do *not* include matters that are governed by law, such as fair housing laws and municipal codes. See Community Shelter Board, Community Advisory Committee, "Good Neighbor and Shelter Certification," DRAFT for Public Comment, Columbus, Ohio, November 30, 1999. Accessed on-line at http://www.csb.org/Publications/gnsc.pdf

The Community Advisory Committee has helped develop standards for the agreements, but each agreement is unique. Good Neighbor Agreements can cover many types of issues including those listed below.

Elements of Good Neighbor Agreements

- **Property**
  - Neighborhood property: maintenance and appearance standards (landscapes, trash and litter)
  - Design Input
- **Neighborhood Codes of Conduct**
  - Agency's responsibilities for informing all residents of neighborhood codes of conduct. All neighbors and residents uphold mutual behavior expectations such as neighborhood's codes of conduct.
- **Community Safety**
  - Community policing and crime prevention
  - Block watches
  - Security lighting
- **Communication and Information**
  - Marketing
  - Disclosure of information about provider's other facilities; communications about property concerns
  - Process for continued communications among parties
  - Participation in facility and neighborhood committees and boards
  - Mechanisms for sharing information and resources
  - Mechanism for informed planning and decision-making that is inclusive
  - Responsibility for management of media relations
- **Agreement Monitoring and Compliance**
  - Compliance mechanisms

- Responding to non-compliance
- Implementation of agreement provisions by the parties
- Enforcement of Federal laws, local codes, and state regulations
- Dispute resolution mechanisms
- Fair eviction procedures
- Re-affirming and re-negotiating agreements

The success Columbus has achieved in securing widespread community involvement in the Rebuilding Lives initiative is reflected in the number and breadth of agencies involved in the Rebuilding Lives Funder Collaborative, as well as the public's widespread support of the initiative. A 1999 winter newsletter published by the Coalition on Homelessness and Housing in Ohio (COHHIO) reported that "The public … strongly endorses a fundamental shift in overall policy, going from large emergency shelters to smaller, scattered site, permanent housing that includes job training and supportive services. In excess of 70 percent of the respondents felt that this strategy was an effective means of reducing homelessness" (The Coalition for Homelessness and Housing in Ohio, 1999).

Our site visit also revealed that there can be "community relations" issues within the service provider community itself. In addition to overcoming provider resistance to new theories and models of service (such as "harm reduction" and "housing first"), a number of frontline workers raised the issues of race and gender. Rebuilding Lives was originally intended to serve men only. About a year ago, the community decided to make the initiative gender neutral, both to address concerns about gender equity but also to resolve a variety a problems that arose around Fair Housing Laws. With its focus on chronically homeless people, Rebuilding Lives still serves mostly men (about 90 percent).

In addition to gender (one frontline worker commented that the system "penalizes women for accessing shelters"), several people mentioned concerns around race. A number of frontline workers pointed out the difference in the racial profile of those on the streets (or "on the land") and those who are getting into housing—some of this may be a reaction to the "old" supported housing, which still exists, and that has high eligibility standards related to sobriety and criminal histories that effectively screens out many African American people. Much of this housing was and is supported through Shelter Plus Care. The street and shelter population, by contrast, is predominantly (60 to 80 percent) African American. One observer noted that there are "only a few African American people with control over the rules and regulations," and "when a few people control who's going to get the housing, African Americans and women are not going to get the housing." Several frontline workers also noted that the mental health system does not serve people of color well (in one case voicing a perception that large African American men tended to be medicated and sedated more often or more heavily because of fear on the part of healthcare workers). Some providers tried to develop an African American committee within the homeless coalition to address equity issues around access to housing, but it was not well received. They would also like to see more African American housing developers become

involved in producing permanent supportive housing. Other communities would do well to be aware of the importance of race should they adopt similar initiatives, and to track the racial composition of those entering permanent supportive housing as compared to those who are on the streets or in shelter.

The Future—Maintaining and Enhancing the System

The key to maintaining and enhancing the Rebuilding Lives initiative is ensuring that the funds needed to maintain all existing units of supportive housing are there, and that additional funds for the new units needed to reach the communities goals of 800 units are also secured. In late 2002, the Community Shelter Board developed detailed estimates of both of these costs as well as funding gaps (see Table C.7) (Community Shelter Board, 2003). They also revised the time line to reflect the poor economic conditions the community is facing.

Table C.7
Summary of Operations & Services for Projects Currently Operating or Funded (372-412 Units)

Year	Total Cost	Funds Identified	Surplus/Deficit
2002	$6,339,327	$6,356,571	$17,244
2003	$7,003,454	$7,003,454	$0
2004	$6,762,513	$6,570,787	($191,727)
2005	$6,929,682	$6,683,037	($246,645)
2006	$7,101,868	$6,798,656	($303,212)
2007	$7,288,993	$6,927,519	($361,474)

These estimates are for operations (mostly rent) and services. Although they not directly supported by the Community Shelter Board or the Funder Collaborative, capital funds are also needed to develop the *new* units of housing. A more recent estimate by the Shelter Board puts this figure at just over $40 million (the higher figure of 388 additional units reflects a slight shortfall in new units in 2002 due to poor economic conditions) (Community Shelter Board, 2003).

Obviously, the community will need the ongoing support of its major funders, including the Franklin County Board of Commissioners, the City of Columbus, and the United Way of Central Ohio. City and county budgets, however, are developed annually and while it would be nice to have ongoing commitment from these sources, this is unlikely. In addition, some of initiative's initial investments were made in order to establish (and demonstrate to others) that permanent supportive housing works and is cost effective. Now that that these goals have been met, it is not clear if these investors can/will continue supporting the initiative at the same levels.

Table C.8
Total Estimated Funding Needs for Additional Rebuilding Lives Units

Units	Supportive Housing	Capital	Operations	Services
158	Rehab	$15,010,000	$923,352	$1,343,000
230	New Construction	$25,300,000	$1,344,120	$1,955,000
388	Total	$40,310,000	$2,267,472	$3,298,000

Note: Estimates are based on the following assumptions: Rehab costs $95,000 per unit, new construction costs $110,000 per unit, and annual operations cost $5,844 per unit ($487 is the Fair Market Rate for an efficiency unit). Services are estimated at $7,300 per unit (the median cost for currently operating units).

The community has identified a number of strategies that may help them as they move forward with the initiative. These include (Community Shelter Board, 2003):

Resource Development

The Rebuilding Lives Funder Collaborative will coordinate and guide sponsors' efforts to identify and submit competitive applications for state and Federal funding.

Sponsors will be expected to assist eligible tenants with accessing all appropriate entitlements and mainstream services.

The Community Shelter Board and the Corporation for Supportive Housing, along with appropriate Rebuilding Lives Funder Collaborative members, will work with state and Federal officials to identify opportunities for accessing under-utilized funding sources and crafting pilot programs aimed at increasing the availability of funding.

The Community Shelter Board, the Corporation for Supportive Housing, and appropriate Rebuilding Lives Funder Collaborative members will recruit representatives from relevant state agencies/departments to participate in Rebuilding Lives Funder Collaborative-sponsored projects.

Improving Cost Efficiency

The Community Shelter Board and the Corporation for Supportive Housing, along with appropriate Rebuilding Lives Funder Collaborative members, will provide technical assistance to project sponsors to operate more efficiently and effectively, and to access a greater number of mainstream services and funding sources.

The Rebuilding Lives Funder Collaborative will determine ways to streamline funding processes and reduce administrative costs, while still remaining accountable to investors.

Collaborative Investment Standards

Sponsors will access state, Federal, and other resources for capital development, operating subsidies, and service funding.

The Rebuilding Lives Funder Collaborative and sponsors will use the city, county, and United Way funds to leverage policy reforms at the state and Federal levels and advance pilot programs.

The development, operating, and service budgets along with the proposed service plan for all projects will be reviewed and approved by the Rebuilding Lives Funder Collaborative prior to any commitment of funds (conditional or final) by any Rebuilding Lives Funder Collaborative member.

The Rebuilding Lives Funder Collaborative will establish per unit limits on capital contributions by the city and county.

Generally, Community Shelter Board-administered funds from the city, county and United Way will not provide operating support for supportive housing.

Community Shelter Board-administered funds from the city, county and United Way will be used to provide services support for supportive housing. Rebuilding Lives Funder Collaborative will establish limits on Community Shelter Board-administered service support (per unit and percentage).

Evaluation

The Rebuilding Lives Funder Collaborative will complete an overall evaluation of the initiative by the end of 2004.

The Community Shelter Board will continue to conduct annual program evaluations.

Communication

Primary local funders will meet in the spring of 2005 to assess progress and adopt a plan for advancing the Rebuilding Lives initiative in 2006 and beyond.

The Community Shelter Board will routinely distribute the annual report card and program evaluation reports to keep all key parties informed.

Columbus Site Visit Participants

Participants	Organization
James Alexander	Maryhaven - Community Engagement Center
Chyna Dickerson	Maryhaven
Jim Downing	YMCA/Sunshine Terrace
Rick Ellere	YMCA
Rachel Ginsberg	YWCA
John Hahn	Columbus Metropolitan Housing Authority
John Hardiman	Community Shelter Board
Art Helldoerfer	YMCA of Central Ohio
Nina Lewis	Columbus Health Department
Jerry Pierce	
Barbara Poppe	Community Shelter Board
Eric Preuss	Faith Mission/Faith Housing
Amy Price	Southeast, Inc
Grant Schroeder	Maryhaven
Kathryn Spergel	Friends of the Homeless, Inc.
Cheryl Tucker	CSB-Data
Annabelle Van Meeter	Columbus Neighborhood Health Center
Susan Weaver	Community Housing Network
Tony Williams	Faith Mission

Columbus Acronyms

ADAMH	Alcohol, Drug and Mental Health Board
B.R.E.A.D	Building Responsibility, Equality, And Dignity
CMHA	Columbus Metropolitan Housing Authority
COHHIO	Coalition on Homelessness and Housing in Ohio
CSB	Community Shelter Board
FCDJFS	Franklin County Department of Jobs & Family Services
HTF	Housing Trust Fund
MORPC	Mid-Ohio Regional Planning Commission
MR/DD	Mental Retardation /Development Disabilities
ODRC	Ohio Department of Rehabilitation and Corrections
SRO	Single Room Occupancy
TANF	Temporary Assistance for Needy Families
UWCO	United Way Columbus

APPENDIX D: LOS ANGELES

Los Angeles—Brief Description

In 2002, the City of Los Angeles had a population of 3.8 million, making it the largest city in Los Angeles County, which had a population 9.9 million. Los Angeles City's unemployment rate was 10.8 compared to the nation's 5.8 and Los Angeles City's poverty rate for single individuals was 18.2 compared to the nation's 16.3 percent.[19] Exacerbating the combined effects of poverty and unemployment is the high cost of housing. An individual needs to earn close to $23,000 per year to afford an efficiency apartment in Los Angeles.[20] To put it in more concrete terms, a person earning minimum wage in Los Angeles needs to work 70 hours per week to afford an efficiency apartment. Overall, the consumer price index for Los Angeles is 35 percent higher than for the rest of the nation.[21]

The Los Angeles Homeless Services Authority (LAHSA), which provides funding and guidance for local nonprofit agencies with programs that address homelessness, coordinates the Los Angeles Continuum of Care (CoC) proposals. Beyond LAHSA, Los Angeles does not offer a single coordinated system for reducing chronic street homelessness and we therefore do not describe the history or other community-wide activities as we do for the other cities included in this report. What Los Angeles does offer, because of its immense size, is several specialized continuums to meet the needs of homeless individuals. Described in this chapter are three organizations that have been working diligently to end chronic street homelessness. They are the Department of Veterans Affairs (VA) Healthcare for Homeless Veterans Programs, Lamp Community, and the Assembly Bill (AB) 2034 program administered by the Los Angeles County Department of Mental Health (LAC-DMH) Adult Systems of Care. The Department of Veterans Affairs and Lamp Community both offer a comprehensive array of services for homeless individuals, while the AB 2034 Program provides funding for mental health services, including housing and personal and incidental needs. Although these programs do not all work in concert with each other, there is significant overlap among the systems. For example, Lamp Community is one of the 16 AB 2034 providers in Los Angeles County, and at least one VA partner agency collaborates with Lamp Community to provide housing for Lamp members. Another organization, Shelter Partnership, collaborates with both the AB 2034 Program and Lamp Community by providing technical assistance in many areas including housing development, funding, and grant writing. Shelter Partnership also touches many agencies through its advocacy for homeless individuals and its shelter resource bank, which provides surplus merchandise to homeless agencies.

During our site visit to Los Angeles from April 28 – May 1, 2003 we visited each of the three organizations and selected partner agencies, and interviewed 54 individuals representing administration and management, as well as case workers, outreach workers, and housing specialists. A complete list of persons interviewed during the site visit is available at the end of this appendix. During the site visit, we also toured several agencies and conducted two focus

---

[19] U.S. Bureau of the Census, http://ferret.bls.census.gov/cgi-bin/ferret .
[20] National Low Income Housing Corporation, http://www.nlihc.org.
[21] The Cost of Living Index for Selected U.S. Cities, http://www.infoplease.com.

groups of formerly homeless individuals who have been stably housed for at least six months. In writing this chapter, we used information from site visits, telephone interviews, written reports provided by the agencies, agency websites, and the Continuum of Care narrative.

Greater Los Angeles Department of Veterans Affairs

There are more homeless veterans in the Los Angeles County area than in any other county in the United States. Likewise, the VA Greater Los Angeles Healthcare System is the largest VA in the system. VAGLAHS has three sites: the LA campus (including the West LA Healthcare Center), the Sepulveda Ambulatory Care Center located in the San Fernando Valley, and the Los Angeles Ambulatory Care Center located in downtown Los Angeles. VAGLAHS treats over 6,000 homeless veterans each year, which represents about 10 percent of all homeless veterans served by the Health Care for Homeless Veterans Programs in the country.

Practices of Potential Interest to Other Jurisdictions

Each of the Los Angeles county programs offers practices of potential interest to other jurisdictions.

VA Greater Los Angeles Healthcare System (VAGLAHS)

- **Federal agency/ local provider partnership networks.** The VAGLAHS and its partners combine local VA funds with Federal Grant & Per Diem funds to create a collaborative network of agencies to provide a continuum of care. The VAGLAHS values the network to the point that if they no longer received Grant & Per Diem money, staff members believe they would find the funding for homeless programs and the network in the local budget. (Contact person: William Daniels, Director of Conference of Homeless Program and the vision homeless coordinator, William.daniels@med.va.gov, 310.268.3348.)

- **The Access Center.** Co-locates medical care, mental health assessment and treatment, and homeless services to address the many needs of homeless veterans immediately upon their first visit to the center. (Contact person: Mariquita McBride, Associate Leader of the Northside Care Center, Mariquita.mcbride@med.va.gov, 310.268.3348.)

Los Angeles County Department of Mental Health AB 2034 Program (AB 2034)

- **Flexible funding used to leverage services.** The San Fernando Valley AB 2034 program agency uses its DMH funding to leverage a variety of special services for clients, creating a comprehensive program that is able to meet all the needs of its clients. (Contact person: Bonnie Roth, Assistant Director of homeless services LCSW email: broth@sfvcmh.org, 818.901.4836.)

- **Non-capitated and flexible funding.** Provides the latitude to secure the most intense services where and when they are needed. Clients require less funding as they become

stabilized. (Contact person: Maria Funk, Mental Health District Chief, email: MFunk@dmh.co.la.ca.us, 213.738.4385.)

- **Housing Specialists.** Housing Specialists provide technical assistance and temporary financial relief for Section 8 landlords serving their clients, so that AB 2034 clients can resolve problems between tenants and landlords. Housing Specialists have made such an impact that some landlords have taken their names off the HUD Section 8 list and only rent to AB 2034 clients or lease to AB 2034 agencies. Some landlords are developing new property exclusively for AB 2034 agencies and their clients. (Contact person: Reina Turner, email: RTurner@dmh.co.la.ca.us, 213.739.6267.)

Lamp Community

- **A non-linear housing approach** enabling individuals to move between housing programs offering more or less structure has worked for seriously mentally ill and dual diagnosed homeless persons who have trouble moving through a linear program of decreasing structure. (Contact person: Mollie Lowery, info@lampcommunity.org, 213.488.9559.)

- **Social capital:** A life-long community rich in social capital enhances the individuals' sense of belonging and therefore their likelihood of remaining off the streets. (Contact person: Mollie Lowery: info@lampcommunity.org, 213.488.9559.)

- **Mental health provider/property management collaboration:** The key to housing mentally ill persons is close relations with the mental health providers and enhanced property management services. It is particularly important to have enhanced property management services during weekends when there is decreased access to mental health and case management services. (Contact person: Jim Bonar: info@skidrow.org, 213.613.0522.)

Primary Contact Persons

Department of Veterans Affairs
Bill Daniels
VA West Los Angeles Medical Center
11391 Wilshire Blvd. (10H5)
Los Angeles, CA 90073
Telephone: 310.268.3348
E-mail: William.Daniels@med.va.gov
Web Site: http://www.va.gov/homeless/

Los Angeles County, Department of Mental Health
Maria Funk, Ph.D.
Program Manager
Adult Systems of Care
550 S. Vermont Ave., 12th Floor

Los Angeles, CA 90020
Telephone: 213.738.4385

Lamp Community
Michele Yu
527 S. Crocker Street
Los Angeles, CA 90013
Telephone: 213.488.9559, ext. 46
E-mail: info@lampcommunity.org
Web Site: www.lampcommunity.org

VAGLAHS History and Context—How the Current System Evolved

During the late 1980s and early 1990s homeless service providers and advocates appealed to the VAGLAHS administration and demonstrated on the LA campus to obtain more services for homeless veterans. The group met resistance. At that point, the VAGLAHS homeless services were limited and the Domiciliary was the only transitional housing program available. Providers and advocates went to Washington, DC to inform congressional leaders about the lack of services for homeless veterans. This movement resulted in a congressional hearing on the grounds of the LA campus, with testimony representatives of the VAGLAHS and community agencies.

During the same time frame, staff from a community based organization, New Directions, wanted to begin providing services to veterans in one of the many empty buildings on the LA campus, but met great resistance to this idea. The organization worked to get an act of Congress to acquire a building on the campus, which occurred in 1989/1990.[22] The building is now the site of the New Directions South program.

In the early 1990s the VAGLAHS began to respond to this increase in demand for homeless veterans services (McGuire, et al., 2001). After the congressional hearing, a new administration was brought in and created a department focused on homeless services. The VAGLAHS leadership began to communicate with agencies about what veterans needed and how to develop a collaborative to address those needs. To further complicate the VAGLAHS's situation, the West LA Health Care Center was downsizing its inpatient health care services because of lowered resources at the same time that the VAGLAHS was trying to build the homeless service approach. The VAGLAHS recognized that it needed community organizations to adequately serve chronically homeless veterans who face many barriers to service. The VA proceeded to develop partnerships with community agencies from 1992 through 2000, resulting in a total of 930 new transitional housing beds for veterans in the community—up from the six beds that were available in 1992 and the largest number in the country connected to a VA facility.

[22] The lease was eventually signed in 1995, until then the program provided services to veterans in houses in the community.

VAGLAHS Approach to Chronic Street Homelessness

The VAGLAHS provides a continuum of care for homeless veterans through a collaborative network of agencies using resources in the Health Care for Homeless Veterans Programs (HCHV). The purpose of the HCHV is: (1) to provide outreach to severely mentally ill veterans who are not using VA medical services; (2) to link individuals to VA clinical services, contracted residential treatment programs, and contracted transitional or permanent supported housing programs; and (3) to provide treatment and rehabilitation services (Kasprow, et al., 2002). A comprehensive collaborative network has been built by combining the resources and capabilities of the VAGLAHS with those of other community agencies. Table D.1 lists the agencies involved in the collaborative network and the services provided by each. The rows represent the partner agencies and the columns represent the types of programs and services offered. An "X" in a cell indicates that the provider offers that program or service. An "F" indicates that a public agency funds a program or service, and an "E" indicates that the provider offers expert advice, technical assistance, or training.

The goal of the VAGLAHS collaborative network is to assist veterans to leave the streets and lead productive lives. Specifically, the network addresses four needs of homeless veterans: (1) access to health care and treatment; (2) income from benefits and/or employment; (3) stable housing; and (4) support networks. The collaborative network approach is based on the premise that no single agency can provide comprehensive services to meet these four needs. Therefore, the network includes programs that range from unstructured drop-in centers to treatment facilities.

Table D.1: Department of Veterans Affairs Network of Agencies Involved in Ending Chronic Street Homelessness

	Homeless-Related Programs and Services																						
	Prevention	Outreach/Drop In	Shelter	Safe Havens	Transitional Housing	Permanent Supportive Housing	Other Housing (non disabled)	Alcohol or Drug Services	Mental Health Services	Employment	Corrections	Public Assistance	Child Welfare	Advocacy	Food	Case Management	Cross-Agency Coordination of Service Access & Delivery	Planning	Staff Training	Data Documentation	P.R. Public Acceptance	Money Management
Agencies Serving Currently or Formerly Chronic Street Homelessness People (listed																						
St. Joseph's																						X
The Mary Lind Foundation					X			X														
New Directions, Inc.		X			X			X		X							X					
Single Room Occupancy Housing Corporation					X																	
People in Progress		X			X			X				X			X		X					
U.S. Vets, Inc		X			X			X		X												
The California Council for Veterans Affairs					X																	
L.A. Family					X				X	X						X	X					X
The Salvation Army			X		X			X		X							X					
Volunteers of America		X	X		X		X	X		X												
Weingart Association		X			X																	
Agencies Serving Currently or Formerly Chronic Street Homeless People																						
Homeless Veterans Health Care		F,X,E			F,E			F,X,E	F,X,E	F,X,E				X,E			F,X,E	X,E	X,E	X,E	X,E	
Housing and Urban Development							F															
Employment Development Department										X												
Social Security Administration												X										
L.A. County Department of Public Social Services	X											X										
L.A. County Sheriff's Department											X											
L.A. Police Department		X																				

X = Provider E = Expert TA Provider F = Funder

The VAGLAHS collaborative network approach addresses veterans' needs in the following ways:

- The VA provides health care and psychiatric and substance abuse treatment to veterans;
- Income is addressed through benefits and employment. Veterans are enrolled in VA benefits if eligible and if not eligible, the VAGLAHS staff members work with social security staff for expedited approval of social security benefits. The VAGLAHS has also partnered with organizations to provide job training and employment assistance to homeless veterans. Further, VAGLAHS staff members have set up a payee project with a local private nonprofit organization that most homeless veterans use for assistance with money management;
- A network of community-based programs provides housing. All the programs are transitional housing and work to move the veterans to housing that is more permanent or another program upon discharge. No homeless veterans are discharged to the street; and
- The VAGLAHS staff and each of the partner agencies work to develop new support networks for veterans and some agencies specifically focus on reuniting and/or improving veterans family relationships.

Since 1994, the VAGLAHS has been partnering with local community agencies through Project Community Homelessness Assessment, Local Education, and Networking Groups (CHALENG). Project CHALENG annually brings together agencies that provide services to veterans to share information and network. Some of the Project CHALENG agencies are also part of the Grant & Per Diem program, a group that has a much higher level of collaboration between agencies. [23] Each individual partner applies for Grant & Per Diem grants. The Grant & Per Diem programs formally meet on a quarterly basis, but individually have constant informal contact throughout the year with each other and the VAGLAHS staff. The VAGLAHS staff members notify partner agencies about funding opportunities and spend time educating other agencies about what the VAGLAHS offers to veterans.

The staff set policy around quality operations for partners and provide technical assistance to partners to meet the quality standards. As part of a quality improvement program, VAGLAHS staff members developed an incident reporting system that enables the partner agencies to track problems associated with the care of their clients. They also developed a discharge/service history database that provides the ability to track the service-use patterns of individual veterans.

Once funded through the Grant & Per Diem system, a master's level VAGLAHS liaison assists the partner agency in becoming operational. The liaison conducts a full review and inspection of the program and its structure, including nursing, dietician, fiscal, clinical reviews. The liaison

[23] The Grant & Per Diem Program is a funding mechanism for agencies providing homeless services for veterans. The Grant portion provides funds for up to 65 percent of the cost of facility renovation or construction. The Per Diem award goes to recipients of Grants and funds operational expenses for supportive housing up to a per diem of $26.95.

notifies the agency when it is ready to provide services and begin admitting veterans. Thereafter, liaisons perform annual safety and program inspections of each partner agency.

Additionally, the liaison works with the partner agency day-to-day throughout the year. VAGLAHS liaisons advocate to the programs on behalf of the veteran to ensure the program is delivering the services it promised. Depending on the partner agency and the need, the liaison staff might be located on site, might provide integrated case management services to clients along with case managers from the partner agency, or might review case files. Liaisons also meet with the veterans as a group to assess their perceptions of program operations. Finally, staff liaisons review veteran status in the discharge/service history database to ensure referral and service plans are appropriate.

On campus, the VA provides medical services as well as psychiatric and substance abuse treatment and transitional housing at the Domiciliary (321 beds). In addition, a number of nonprofit agencies provide services on campus. New Directions has two programs on campus including a long-term substance abuse treatment center (156 beds) and a dual diagnosis treatment program (43 beds). The Salvation Army has three programs on campus including a residential substance abuse treatment program (Haven I—60 beds), a recuperative care short stay facility (Haven II—30 beds), and a residential mental health program (Exodus—90 beds including 30 for extended post-inpatient psychiatric discharge planning and 60 board and care residential beds). Off campus, the VAGLAHS collaborates with U.S. Vets, Inc., which operates the Westside Residence Hall. The Hall has 450 transitional housing beds including 136 beds for a 90-day housing program and 314 beds for a long-term transitional supportive living program, 150 of which are also part of a work rehabilitation program.

The VAGLAHS collaborative network is structured so veterans can receive individualized services. The nonlinear structure of services allows homeless veterans to enter any part of the network and move into other parts of the network as needed. The VAGLAHS and its partner agencies coordinate with one another to fill the beds within the collaborative network so that people are being served based on their need and moved through the system when appropriate. Staff members try to keep the network as fluid as possible so individuals can move back and forth in the system as their needs change. In addition, by coordinating around the beds, the system prevents individual veterans who may happen to learn about a particular bed opening from being placed in it ahead of someone else who has been waiting.

A VAGLAHS case manager is assigned to each veteran in the system and assists the person who has been waiting to move from program to program as necessary. For example, the case manager works with veterans to develop discharge plans before they become residents of Exodus or Haven II because these are considered interim placements to a next step. The purpose of both Haven II and Exodus is to create access to the collaborative network, to prevent hospitalization, and to provide temporary housing while a veteran is waiting for a Domiciliary placement. If programs are filling or full, case managers investigate who is ready to move on to other more independent housing options such as the Westside Residence Hall.

VAGLAHS Selected System Components

The VAGLAHS collaborative network has services both on the LA campus and off campus (McGuire, et al., 2001).

Outreach and Drop-in

Street outreach. VAGLAHS staff members conduct street outreach throughout Los Angeles County. Outreach workers refer homeless veterans to the downtown drop-in clinic and to the Access Center on the LA campus. They provide bus tokens for transportation to the campus. The importance of street outreach is demonstrated by a marked decrease in the number of veterans using the Access Center and the downtown drop-in clinic during the annual outreach training session when no one is on the street engaging homeless veterans.

Outreach workers look for homeless veterans at the Department of Public Social Services, meal sites, food pantries, on the street, in parks, police stations, beaches, camps, and Alcoholics and Narcotics Anonymous meetings. The workers try to engage the veteran in conversation about VA benefits, enrollment status, and other issues they face. Many outreach workers are formerly homeless veterans themselves, and are able to engage the veteran and build trust and rapport.

Nine staff members conduct outreach in the mornings (two VAGLAHS and seven AmeriCorps staff) and return to the Homeless Access Center for the afternoon to follow up with individuals. One worker conducts outreach in the evenings and on weekends.

LA County Jail Outreach Program. VAGLAHS staff members (5.5 FTE) conduct outreach at the Twin Towers County Jail, which has a dedicated wing for veterans.[24] VAGLAHS staff members work with inmates conducting assessments and referrals to community programs. A VAGLAHS social worker is on site in the Inmate Reception Center. The worker engages offenders who are veterans as they come into the jail system and receives a daily list of veterans in the jail system. A VAGLAHS counselor is assigned to each veteran within the first 48 hours to assess service needs. About 24 veterans enter the jail system daily on weekdays and about 75 do so on weekends. Not all veterans are eligible for services (veterans are not eligible if they have a negative discharge status from the military or they did not serve long enough). The social worker and counselors find the veterans appropriate housing, work with diagnostic issues, check their service use in the discharge/service history database, and consult with judges about appropriate placements. The counselors will create discharge plans for homeless veterans straight into transitional housing, Haven II, or substance abuse treatment. Counselors work with the drug court and other courts to have veterans diverted to programs such as Haven I, if possible. They also refer veterans to the VAGLAHS's downtown drop-in clinic, about a half mile from the court and probation offices. Judges will make reporting to the clinic a condition of probation. Upon release from jail, the social workers reassess the veterans for substance abuse and mental health treatment and homeless services.

[24] The average custody stay at the jail is 44 days.

The Community Transition Unit of the Sheriff's department works to empower inmates so they can succeed once they leave custody. Homeless veterans are one of the unit's target populations. The unit staff members contact VAGLAHS to verify veteran status of inmates before assigning them to the veteran portion of the facility. Offenders can be in the veteran portion of the facility as long as they are not mentally ill or are not charged with murder or sex offenses. Mentally ill inmates are housed in a different portion of the facility. The VAGLAHS, US Vets, and the Salvation Army each have staff members who come into the facility to provide services and classes to veterans. Services include assessments for treatment, drug and rehabilitation classes, parenting classes, personal relationship classes, computer training, job skills, and resume building.

The Access Center. The Comprehensive Homeless Access Center—the Access Center—is located on the LA campus. VAGLAHS staff realized that homeless veterans had multiple needs and designed the Access Center to co-locate primary medical care, mental health care, and homeless services. The access center structure dramatically changed "business as usual" for VA medical services. Now, a nurse conducts a complete bio-psycho-social assessment including medical, treatment, and housing needs. The nurse will also review the person's history of using VA medical and homeless services within the LA system and the larger VA network. The veteran receives a comprehensive treatment plan addressing all bio-psycho-social issues including referrals to appropriate services. Referrals to services are then prioritized according to need.

Access Center clients receive same day appointments and immediate medications, which is very important to homeless individuals who may have difficulty keeping appointments. Homeless veterans can receive emergent, urgent, or routine medical care (such as physicals) the same day they visit the center. Those needing emergent or urgent care are transferred to the VAGLAHS West LA Medical Center on campus and those needing routine care are sent to the primary care facilities on the second floor of the building. The veterans shower and receive clean clothes before receiving medical care. Homeless veterans now have physicals the same day they come into the center as opposed to waiting six to eight weeks for a physical as they did before the center opened. They are also assigned a primary care provider to assure continuity of care and improve patient adherence with medical care. The primary care provider will provide acute and chronic disease state management as well as health prevention and promotion activities including Tuberculosis screening, HIV testing, vaccinations, cancer screenings, individualized patient education, and referrals to specialty care. Appointment scheduling is flexible allowing for same day walk-ins as well as scheduled follow-up appointments.

VAGLAHS staff members realize housing increases stability and stability increases the likelihood that veterans will follow up with additional medical services and appointments. Therefore, in addition to immediate medical care, homeless veterans accessing the center are linked directly to housing. Staff members find homeless veterans temporary housing in Haven II or other transitional programs that have openings and are appropriate to the needs of the particular veteran.

Veterans experiencing severe psychiatric problems such as delusions or suicidal ideations are sent to the psychiatric emergency room. Otherwise, psychiatrists conduct same day assessments for those experiencing less emergent psychiatric problems. The clients are then referred to the

mental health clinic's weekly orientation program. Access Center staff members work with the Psychiatry Department to increase the frequency of orientations to serve the needs of homeless veterans in a timelier manner because homeless veterans may not reconnect with the mental health clinic once they leave the Access Center. Twenty-four clinicians in the VAGLAHS mental health clinic have a total caseload of about 2,400 outpatient clients enrolled in the clinic at one time.

After the triage process described above, about 80 percent of the clients are referred to a social worker for more detailed assessments of complex issues. Together the veteran and social worker develop referral plans to address other needs, such as substance abuse treatment and social service needs. The social worker continues to provide case management and follow-up services with Access Center clients as long as necessary. The Access Center also provides the first time user with a hot lunch from the campus cafeteria. The Access Center plans to begin providing dental care to homeless veterans in the near future.

Access Center staffing includes a reception worker, a social worker, triage nurses, a patient relations assistant (a formerly homeless veteran who helps clients move through the triage system), a social service technician, an eligibility clerk, a veterans benefits counselor, and an on-call psychiatrist. The Access Center staff members not only have co-located offices but also integrate their services so that the medical, mental health, and homeless services are seamless (Each patient has an integrated treatment plan assessable through the computerized record). Staff members conduct case conferences to integrate their service approaches for individual veterans. Staff members also receive integrated in-service training.

When the Access Center first opened, the Primary Care staff members were not prepared to, and were somewhat reluctant to, work with the homeless population. Homeless veterans noticed the negative attitude of the staff members and stopped using the center. The administration then changed the Primary Care staffing approach and specifically brought in staff members who were interested and willing to work with the homeless population. As a result, more veterans are using the center again.

A number of Access Center staff members are formerly homeless veterans. These staff members report they feel they can connect with the homeless veterans and are able to assist them more effectively than other staff. They are able to read the person's survival behaviors and can help someone "tone it down" if the veteran is getting out of control. They focus on helping currently homeless veterans receive the same services that helped them.

Emergency Shelters

LA Family Housing operates a cold/wet weather emergency homeless shelter on the LA campus that was closed for the season during the site visit. Use of this shelter is not restricted to veterans. Services include food services, showers, case management, referrals, and a full range of supportive services.

Transitional Programs

The VAGLAHS collaborative network has a number of transitional housing and treatment programs for homeless clients (see Table D.2). The programs use different models of care but are all drug and alcohol free (abstinence is required).

The VAGLAHS Domiciliary. The Domiciliary is a 90-day rehabilitation program involving individualized treatment plans across five teams: medical, psychiatric, social work, vocational, and substance abuse treatment. Residents are involved in classes and community meetings as well as meeting the requirements of their individual plans. Residents spend their therapeutic day in VA services such as outpatient substance abuse treatment and vocational programs. In addition, some beds at the Westside Residence Hall are designated for people leaving the Domiciliary to continue their treatment. They transition into Westside for an additional 90 days for a total of 180 treatment days.

Salvation Army Programs. Haven I is a 90-day residential treatment program for veterans with substance abuse problems and Exodus is both a 30-day transitional psychiatric treatment program and a long-term residential living program for severely mentally ill veterans. Program staff members work with the VA liaisons on housing options when people are ready to move on to other programs or housing. Some beds at the Westside Residence Hall are reserved specifically for people leaving Haven I treatment, to provide a total of 180 days of treatment.

Haven II is short-term transitional "hoptel" housing where patients being released from medical services or substance abuse treatment can receive recuperative care for up to a week while they wait for either transitional or permanent housing placement. The priorities for referrals are discharged patients, those at risk for hospitalization, or those waiting for Haven I beds. Other priority residents include individuals waiting to be placed in substance abuse treatment programs or working with social workers to find appropriate housing.

Table D.2
Supportive Housing Developed by the Greater Los Angeles VA and Community Partners

Project	Project and Resident Characteristics	Model and Services	Community Partners and Roles
Domiciliary	Project: 321 bed, 90-day transitional housing program on the LA campus Residents: Homeless veterans with sobriety	Clean and Sober. Social Rehabilitation Model 1) Medical services 2) Psychiatric services 3) Substance abuse treatment 4) Social work services 5) Vocational services	VAGLAHS: Property manager and primary service provider
Haven I	Project: 60-bed, 90-day alcohol & substance abuse residential treatment program on the LA campus Residents: Homeless veterans with alcohol & substance abuse problems	Social Rehabilitation Model 1) 12-step recovery program 2) Short and long-term housing placements/ discharge planning	Salvation Army: Property manager and primary service provider VAGLAHS: Landlord & secondary service provider.
Haven II	Project: 30-bed, 1 to 7 day hospital-hotel (hoptel) lodging on grounds of WLAHC Residents: Patients discharged from inpatient ward or unit; ambulatory surgery patients; and homeless and housed patients living far from WLAHC	Recuperative care model 1) Recuperative care 2) Short and long-term housing placement/discharge planning 3) Lodging	Salvation Army: Property manager and primary service provider VAGLAHS: Landlord & secondary service provider.

Table D2 (Cont.)

Project	Project and Resident Characteristics	Model and Services	Community Partners and Roles
Exodus House	Project: 30-day transitional psychiatric treatment (90-bed) and long-term residential living program (60-bed) program located on the LA campus Residents: Seriously mentally ill veterans	Psychiatric recuperative care & board and care models 1) Short-term psychiatric treatment 2) Long-term supportive living environment	Salvation Army: Project manager, service provider, and property manager VAGLAHS: Landlord
New Directions Regional Opportunity Center	Project: 156-bed, long-term residential treatment program with short-term detoxification, on the LA campus Residents: Veterans with substance abuse problems & forensic patients	Therapeutic community model 1) Substance abuse rehabilitation 2) Long-term housing placement/ discharge planning	New Directions: Project manager and service provider VAGLAHS: Landlord
New Directions North	Project: 43-bed dual diagnosis program typical stay is about 1 year Residents: Veterans diagnosed with substance abuse and mental health disorders	Therapeutic Community 1) Medication Management 2) Job training 3) Money Management 4) Theater work 5) Computer Training	New Directions: Project manager and service provider VAGLAHS: Landlord

Table D2 (Cont.)

Project	Project and Resident Characteristics	Model and Services	Community Partners and Roles
Westside Residence Hall	Project: 136-bed, 90-day housing program & 314 –bed long-term transitional supportive living program located in community (150 beds are a work rehabilitation program) Residents: Homeless veterans with 90 days sobriety	Therapeutic community & vocational rehabilitation models 1) Transitional housing with Vocational Rehabilitation services 2) Long-term transitional housing with some VA clinical services on-site	Cantwell Anderson, Inc.: Developer, landlord, and property manager LAVETS (US VETS): Primary service provider VAGLAHS: Secondary service provider
VA Supported Housing (VASH)	Project: Housing voucher & case management program Residents: Homeless veterans	Referral-case management model 1) Housing vouchers 2) Long-term case management	HUD: Housing voucher service provider VAGLAHS: Project manager, case management service provider

Sources: Interviews and McGuire, J., Berman, S., Daniels, W., Tran, A.N., and Mares, A. (2001). *Creating VA-Community Partnerships for Housing Homeless Veterans: The VA West Los Angeles Healthcare Center Experience.* Los Angeles, CA: Mental Illness Research, Education, & Clinical Center, West Los Angeles VA Healthcare Center, VA Greater Los Angeles Healthcare System.

Volunteers of America. The Volunteers of America program has a number of services for homeless veterans. It operates a residential substance abuse treatment program in Hollywood with 15 beds paid for by the VAGLAHS to serve veterans. The program has 80 beds of transitional housing in Skid Row to assist veterans in the transition from treatment to housing. It also operates the Department of Labor's Homeless Veterans Reintegration Program, working with veterans in transitional housing to find employment and permanent housing opportunities.

Further, Volunteers of America operates a drop-in center in Skid Row, where about 12 percent of the clients are veterans. The Veteran Service Center is part of the drop-in center and is a place where veterans can meet with their case managers daily. Finally, the program works with the Sheriff's Department to assist chronically ill homeless veterans in the Community Transitions Unit.

New Directions. New Directions works with chronically mentally ill and chemically dependent homeless veterans through two programs housed on the VA West Los Angeles campus. New Directions Regional Opportunity Center is a 156-bed substance abuse treatment facility and New Directions North is a 43-bed program for veterans dually diagnosed with substance abuse and mental illnesses. New Directions staff members provide the case management and substance abuse treatment services. VAGLAHS staff members provide psychiatric and medical care.

New Directions North devotes 24 beds to a social (as opposed to medical) detoxification facility. Clients detoxify from most types of substances for 7 to 10 days. Methadone detox, however, is 21 days. The program treats 700 people a year, of whom about 250 enter into the full New Directions Regional Opportunity Center program.

The program has 68 phase one beds. Phase one consists of six months of comprehensive substance abuse treatment and intensive case management, daily schooling, and educational assessments. Phase two has 64 beds, of which 24 are Shelter Plus Care. Phase two includes vocational training (such as culinary arts training, handy worker, computer, and maintenance training),[25] transition to employment skills, life skills, case management, and permanent housing assistance.[26] New Directions oversees the job development and job placement services and operates four social enterprise businesses where clients can gain employment experience: catering, the Veterans' Village Diner (on the LA campus), construction, and retail on E-Bay. Phase two can last up to 18 months but the average stay is about one year.

Westside Residence Hall. Westside Residence Hall is a 2-year transitional housing program with a full range of services including case management, vocational rehabilitation, medical and psychiatric care, and addiction counseling provided by both US Vets and seven VAGLAHS staff members who are located on site. Staff members facilitate 30 groups a week ranging from life skills training to 12-step programs to medication management groups. At 12 months, residents construct a transition plan to start the process of moving toward other permanent housing options.

Residents pay a portion of the rent and must save money while they reside in Westside. About 30 percent of the Westside beds are for residents who receive public benefits, while the remainder of the residents are employed. Westside also operates the Veterans In Progress (VIP) program. Individuals in this program become residents of Westside once they leave substance abuse treatment (such as those leaving the Domiciliary). The VAGLAHS through the Grant & Per

[25] Residents in SPC beds are not on the vocational track because these are reserved for people with multiple problems who are not expected to be able to work.

[26] If staff members are unable to find clients permanent housing solutions, they will refer people to Westside Residence Hall.

Diem funding pays for the veteran's stay in the residence until the person can find a job and become self-sufficient.

Staff members estimate that most of the residents were chronically homeless individuals, many of whom have a history of substance abuse and/or mental health problems. Staff members assign one individual who is dually diagnosed with substance abuse and mental illness with two other individuals who do not have dual diagnoses within a suite of rooms. Living with other higher functioning individuals seems to improve the dually diagnosed person's level of functioning.

To be eligible for residency at Westside, individuals must have 90 days sobriety. Westside uses a therapeutic community model and has zero tolerance polices for using substances. Residents are tested for drug use monthly. When a person relapses, staff members will find treatment options for the individual. If the individual refuses treatment, they try to find a sober living facility for the resident. If sober living options are also refused, the individual is on his own. An individual has to have 90 days of sobriety after the first relapse to return to Westside. After a second relapse, the individual must remain out of the residence for six months and receive substance abuse treatment. After a third relapse, the individual must remain out of the residence for a year and receive 90-day inpatient substance abuse treatment. Despite strict requirements, veterans will return to Westside even after a third relapse.

Westside staff members also provide alumni services to ex-residents through support, continued case management, the use of the facilities, and structured activities. Many alumni continue to use the services offered. For example, Westside staff served meals to 1,000 people for Thanksgiving 2002. It is particularly important for the programs to be available to veterans during holidays, as the relapse rate increases to about 10 percent during the holidays. The relapse rate during other times of the year is 3 to 5 percent.

Employment

VAGLAHS staff members aggressively work with formerly homeless veterans to help them find employment. The VAGLAHS itself hires a number of formerly homeless veterans either directly or through the Compensated Work Therapy program. The VA also partners with AmeriCorps for jobs for formerly homeless veterans and hires about 7 or 8 formerly homeless veterans per year through this process. The veterans work as outreach workers on the street, in the Access Center, and in many other locations on the LA campus. In addition, the community agencies in the collaborative network all provide vocational services to veterans.

Additionally, the VA also has a Therapeutic Employment Placement and Support Program – an adaptation of a nationally proven model based on Individualized Placement and Support (IPS). This program is staffed by a Job Developer who identifies jobs in the community for formerly homeless veterans and follows them on the job to provide job support when necessary

Case Management

The Discharge/Service History Database. The VA has an administrative requirement that a homeless veteran is only eligible for three complete treatment episodes in residential programs.

If a person requires more than three episodes in housing, then the VA is required to seek a waiver to continue services. To keep track, VAGLAHS has developed a discharge/service history database for use with its partners. Participating agencies are able to see a person's history in the treatment system on a case-by-case basis. VAGLAHS programs in the collaborative network (including the partner agencies) submit data about each person they serve. In addition, VAGLAHS staff members frequently call programs to collect information about their enrolled participants.

The discharge/service history data are used whenever a veteran enters a program. VAGLAHS program and partner agency staff members contact the VAGLAHS database coordinator to learn about a new enrollee's history of service receipt. If a person has reached the limit, staff members from the VAGLAHS and collaborating programs, as well as the veteran, come together in a clinical case conference to develop an approach to care to meet the person's needs at that point. If necessary, they will apply for a waiver.

HUD-VASH. The VA Supported Housing program (HUD-VASH) is an intensive case management program for homeless veterans. The program serves 75 clients from the LA campus with two case managers who will follow clients for up to five years. Frequency of contact depends on the person's needs. Some clients are seen only once a month while others are seen every few days. The program does not take homeless veterans who are just off the street, but will take them once they become stabilized in some type of housing such as Westside Residence Hall or an Single Room Occupancy (SRO).

Potential clients are screened extensively to ensure they are ready for the program. Eligible veterans must have six months sobriety and must be diagnosed with a substance abuse or mental health disorder. Although the clients are not eligible for HUD-VASH until they are sober and somewhat stably housed, about 80 percent have been street homeless at one time and about half have been homeless more than once. About 80 percent of clients are dually diagnosed with substance abuse and mental health disorders. The program has an 80 percent success rate. The clients that are not successful either drop out of services or end up back on the street.

The HUD-VASH program is a permanent housing case management program. The case managers are able to expedite the enrollment and eligibility process for the Housing Authority so all the HUD-VASH clients are able to be housed in Section 8 apartments. Case managers go with clients to appointments at the Housing Authority and a specific staff person serves as the liaison for the HUD-VASH program clients. Section 8 vouchers are earmarked for the program so clients do not have to wait. Clients receive vouchers within a few weeks after the application is submitted. The voucher attaches to the client and not the program, thus the extensive screening process before admittance into the program.

Once clients have Section 8 vouchers it is very challenging to find landlords willing to accept them. Property owners can get rents above the fair market rent—$967 per month for a two bedroom apartment (U.S. Department of Housing and Urban Development, 2002). They do not want to accept less money for their properties and contend with the inspections required by the Housing Authority. The HUD-VASH case managers accompany the clients to assist them in locating housing and to advocate to landlords on the client's behalf.

Once in housing, the program includes mandatory monthly home visits. Other case management services include crisis intervention, family therapy, survival services, advocacy, life skills coaching, as well as referral to employment and training and services, and in-home supportive homemaker services. The case managers work to identify and assist with all the client's needs. Case managers will refer people to the VA's Compensated Work Therapy Program or to volunteer work if the person has trouble finding employment and training opportunities. The program staff members conduct random urine tests when they see clients on campus. If clients relapse, case managers will refer the person into treatment and make sure their rent is paid out of their VA benefits so they do not lose their housing. If people cannot find an apartment, they lose their vouchers.

St. Joseph's. St. Joseph's, a nonprofit homeless service provider, is funded by the VAGLAHS to provide money management services to veterans. St. Joseph's staff members are located on the LA campus, making it convenient for veterans to use the service. The St. Joseph's staff members develop rapport and trust with the veterans to give them as much control over their money as possible and provide money management classes for veterans. VAGLAHS has documented that using money management reduces hospitalizations for homeless veterans.

VAGLAHS Documenting Reductions to Chronic Street Homelessness

Developing housing alternatives for veterans allows VAGLAHS staff to use inpatient medical, surgery, and psychiatric beds appropriately. (McGuire et al., 2001) show that increasing housing options for homeless veterans, along with other changes in the system, helped to reduce the length of stay in medical, surgical, and psychiatric beds between 1994 and 1998 (McGuire, et al., 2001). The length of stay was reduced in medical beds by 28 percent, in surgery beds by 7 percent, and in psychiatric beds by 35 percent. Not only are programs assisting the VAGLAHS in decreasing the length of stay in its treatment and medical facilities, but the programs have also assisted the VAGLASHS so it is not discharging patients to the streets, from which they will quickly cycle back. Both community program and VAGLAHS representatives report that the collaborative allows them to serve veterans better, and in a more cost-effective manner.

Staff members in community partner agencies and the VAGLAHS also believe that veterans are more likely to be successful in programs that are veteran-focused. Programs with mixed populations are more difficult for veterans. In veteran-specific programs, clients can identify with one another given the commonality of their experiences and the problems they may face as a result.

Finally, the VAGLAHS is currently trying to understand the effectiveness of the services it provides and the effectiveness of the collaborative network. It is involved in four ongoing evaluations that will examine the impact of the collaborative network. First, it is part of a longitudinal study of veterans who leave residential care to examine housing stability. Second is a demonstration project examining the outcomes of the Access Center users. A third study focuses on homeless female veterans who are dually diagnosed with substance abuse and mental health disorders to compare residential and case management services only to residential and case management services along with cognitive therapy. A fourth study is examining individual

placement for seriously mentally ill veterans, comparing normal VA services with vocational rehabilitation to psychiatric vocational rehabilitation.

Results are not yet available from these studies, but a national evaluation of VASH showed that over a three year period of time, the HUD-VASH veterans spent 16 percent more nights housed than veterans receiving case management only and spent 25 percent more nights housed than veterans receiving standard care (Rosenheck, et al., n.d.).

VAGLAHS Community Relations and Advocacy

A VAGLAHS staff member is a member of the Community Police Advisory Board and attends meetings as a city resident and as a representative of the VA. Other VA staff members, including the director, attend city council meetings when a new building or program is opening or when there have been a particularly large number of complaints about homeless veterans. Other VA staff members attend neighborhood meetings to discuss the VA's plan and programs with the community and receive feedback.

The VAGLAHS collaborative network faces some challenges. First, agencies are unable to serve all veterans because of the VA eligibility requirements. For example, veterans must have been in the service for two continuous years or have been in combat, and have a positive discharge status to be eligible for homeless services. Second, funding and services for women veterans are less available than for men. Third, funding for money management services, while present, is low. Finally, the VAGLAHS does not have a year-round emergency shelter for veterans.

Focus group participants said:

- *The VA services assisted them in getting off the street and becoming clean and sober.*
- *The VA services provided many opportunities that they never knew existed.*
- *The VA staff members understand the difficulties veterans have and understand that many have criminal records because of substance abuse histories, etc.*
- *If it wasn't for the VA services, some of them would not be alive today.*
- *It takes a tremendously long time to achieve stability after living with substance abuse and homelessness for many years.*
- *Succeeding in services and succeeding at becoming self-sufficient requires patience.*
- *Even though they are successfully housed and employed, they are still only one or two paychecks from the street because of the difficulty finding affordable housing in Los Angeles.*

Los Angeles County AB 2034 Program

The Los Angeles County Jail has approximately 2,500 severely mentally ill inmates. Even though only 1 to 2 percent of the general population suffers from serious mental illness, seriously mentally ill persons comprise 10 to 20 percent of prisoners and, at least 30 percent of people who are chronically homeless. In response to the number of homeless people that have a psychiatric disability but have been unable to access the traditional mental health system, including those who are caught in the revolving door of the criminal justice system, the California legislature passed AB 34 in October 1999 to fund a Demonstration Program in three California counties. The purpose of AB 34 was to provide outreach and integrated mental health services to seriously mentally ill persons who are homeless, recently released from county jail or state prison, or others who are untreated, unstable and at significant risk of incarceration or homelessness unless treatment is provided to them.

LAC-DMH was one of the three counties selected to implement the AB 34 Program and had a target of enrolling 834 clients within six months. The goal of the AB 34 Program was to help these individuals integrate into the community and to improve their quality of life by reducing homelessness, psychiatric hospitalizations, and incarcerations and by obtaining benefits to which they were entitled and obtaining and maintaining employment. To implement the programs LAC-DMH initially selected 12 community-based mental health providers with extensive experience in providing integrated services to people who are chronically, severely mentally ill. Agencies selected had proven performance records with LAC-DMH by numerous years of collaboration with various on-going programs providing community-based integrated services. Special attention was paid to allocating funding to the eight service areas of Los Angeles County, proportionate to each area's level of poverty and homelessness, as determined by available data.

After a successful first year the AB 34 Program was expanded and changed from a pilot program to a normally funded program through AB 2034. The Program allocates on average $12,000 of State General Fund revenues per client annually, with flexibility to address the areas of housing, personal and incidental needs, vocational, and program/socialization needs in addition to more traditional therapeutic services to support and maintain the client's highest level of functioning. The AB 2034 Program sets no time limit on receiving services and assistance. Clients maintain service eligibility even after receiving Section 8 housing assistance. This program assists clients in learning self-sufficiency by teaching them how to access services. Clients are disenrolled from the program when they graduate, move out of the County, are unable to be located for 90 days, or are sentenced to prison for more than a year.

LAC-DMH AB 2034 staff works closely with contract agencies to monitor performance and provide guidance and consultation. LAC-DMH holds bi-monthly meetings with the AB 2034 providers to facilitate the development of a comprehensive and coordinated system of care for the target population. LAC-DMH provides on-going training to AB 2034 providers to ensure that necessary resources are identified, developed, and utilized to assist in improving the AB 2034 clients' quality of life. Additionally, the Housing Specialists meet monthly with the DMH AB 2034 Housing Coordinator.

Table D.3: AB 2034 Network of Agencies Involved in Ending Chronic Street Homelessness

	Homeless-Related Programs and Services																							
	Prevention	Outreach/Drop-in	Shelter	Safe Havens	Transitional Housing	Permanent Supportive Housing	Other Housing (non-disabled)	Alcohol and/or Other Drugs	Mental Health	Health	Employment	Corrections	Public Assistance	Child Welfare	Advocacy	Food	Case Management	Cross-Agency Coordination of Service Access & Delivery	Planning	Staff Training	Data/Documentation	PR, Public Acceptance	HIV/AIDS Healthcare	Money Management
Nonprofit Programs/ Services/ Agencies Serving Currently or Formerly Chronic Street Homelessness People (listed Alphabetically)																								
Lead Agency																								
Los Angeles County Department of Mental Health	F	F	F	F	F	F	F	F	F		F	X/F	X		X	F	F	X	X	X/F	F	X		F
Contracted Agencies																								
Didi Hirsch CMHC	X	X			X			X	X		X	X			X	X	X	X	X	X	X	X		
Enki Health and Research Systems La Puente	X							X	X		X	X			X	X	X	X	X	X	X	X		
Enki Health and Research Systems Los Angeles	X							X	X		X	X			X	X	X	X	X	X	X	X		
Exodus Recovery, Inc.	X	X			X	X		X	X		X	X			X	X	X	X	X	X	X	X		
Hillview Mental Health Clinic, Inc.	X	X			X	X		X	X		X	X			X	X	X	X	X	X	X	X		X
Kedren Community Mental Health Clinic	X	X			X			X	X		X	X			X	X	X	X	X	X	X	X		
Lamp Community, Inc.	X	X		X	X	X		X	X		X	X			X	X	X	X	X	X	X	X		X
Mental Health Association Lancaster	X	X				X		X	X		X	X			X	X	X	X	X	X	X	X		X
Mental Health Association Long Beach	X	X						X	X		X	X			X	X	X	X	X	X	X	X		X
Pacific Clinics	X	X						X	X		X	X			X	X	X	X	X	X	X	X		X
Portals, Inc.	X	X			X			X	X		X	X			X	X	X	X	X	X	X	X		X
SFV Community Mental Health Clinic, Inc.	X	X			X	X		X	X		X	X			X	X	X	X	X	X	X	X		
South Central Health and Rehab. Prg (SCHARP)	X	X				X		X	X		X	X			X	X	X	X	X	X	X	X		X
Special Services for Groups	X	X						X	X		X	X			X	X	X	X	X	X	X	X		
Step Up on Second Street	X	X				X		X	X		X	X			X	X	X	X	X	X	X	X		X
Telecare Corporation, Inc. Los Angeles	X	X						X	X		X	X			X	X	X	X	X	X	X	X		X
Telecare Corporation, Inc. Norwalk	X	X						X	X		X	X			X	X	X	X	X	X	X	X		X
Tri-City Mental Health	X	X			X	X		X	X		X	X			X	X	X	X	X	X	X	X		X
Verdugo Mental Health Center	X							X	X		X	X			X	X	X	X	X	X	X	X		
Shelter Partnerships	X/E		E	E	E	E	E								X	X		X/E	X/E	X/E	X/E	X		

X = Provider E = Expert Techical Assistance F = Funder

AB 2034—Access to the System

A critical component of the outreach effort is conducted within the criminal justice system. LAC-DMH AB 2034 clinicians are stationed at Twin Towers Correctional Facility (TTCF) to identify, evaluate and refer homeless seriously mentally ill inmates to one of the AB 2034 contracted programs. To be referred, mentally ill inmates must meet the following criteria:

- Presence of a major Axis I diagnosis indicating serious and persistent mental illness;
- Homeless or at risk of becoming homeless, including living in a temporary shelter or crisis residential facility;
- Lack of a current prison sentence or other forensic hold; and
- Not currently connected to mental health services.

All inmates identified as being mentally ill are housed in the mental health modules of TTCF. Some clients, however, reported during our focus group that they chose not to disclose mental illness at intake because they feared not being treated equitably in the mental health areas. Prospective clients are identified and referred by Jail Mental Health staff, the courts, and family members. Inmates scheduled for release who meet the eligibility criteria and have consented to participate in the AB 2034 Program are assessed and referred to one of the AB 2034 providers. Mentally ill inmates who do not meet all of the eligibility criteria are referred back to the referring jail mental health clinician.

When a referral is made to providers, AB 2034 team members enter the jail and initiate an engagement process with the referred client that includes a thorough psychiatric and needs assessment. AB 2034 team members are expected to meet with their incarcerated AB 2034 client at least weekly, including attending court hearings to advocate for them and to work with the Sheriff's Department to coordinate an effective release/discharge plan from TTCF. When inmates leave the jail, AB 2034 team members are given discharge treatment summaries and prescriptions for medication, to ensure continuity in care in the community.

At the time of release, AB 2034 case managers transport clients to predetermined living arrangements and continue to assist them in community integration. Even though the jail does not have a policy requiring housing upon release, the agencies participating in the AB 2034 program are required to locate housing and provide transportation to wherever the client will be living upon release. If housing is not available in the client's desired area, he is placed close by and has the option of receiving outpatient treatment in the program of his choice until housing becomes available. Once in the program, the individual may transfer between programs as the need arises.

Checks are in place to assure that the AB 2034 incarcerated client is not discharged to the streets. If the agency does not contact the Inmate Reception Center (IRC) within 48 hours prior to release to make transportation arrangements, the IRC staff contacts the AB 2034 office at the jail. There have been a few instances where the coordination of discharge planning was unsuccessful, especially where an AB 2034 client was court-ordered for an immediate release when their sentence was truncated. Also, during the site visit, respondents reported that

discharges would be smoother for AB 2034 clients if deputies and IRC staff were more familiar with the Program. However, one of the problems in educating deputies and IRC staff about the Program is that the supervisory staff varies from shift to shift and there is an on-going rotation of deputies in the IRC area.

AB 2034—Housing

All participating agencies provide assistance in obtaining emergency, transitional and/or permanent housing for AB 2034 clients. Some agencies master-lease apartments or houses to provide emergency, transitional and/or permanent housing, while other agencies provide payments for shelters and SRO hotels. Most agencies provide temporary rental subsidies while clients await approval for General Relief, Supplemental Security Income or other benefits to secure housing. One agency has purchased two four-unit properties as permanent housing for clients. Overall, AB 2034 agencies emphasize providing housing at small apartment buildings or at scattered sites.

The AB 34 Pilot Program demonstrated that finding and securing appropriate housing is a critical part of the program's overall success. LAC-DMH contracted with Shelter Partnership, Inc. to develop a housing strategy and to assist participating agencies in obtaining the skills necessary to effectively identify and secure appropriate housing for their clients. The agencies initially focused on understanding the importance of housing in the client's recovery process, and on the function of a housing specialist. LAC-DMH encouraged each agency to use allocated funds to hire or designate a staff person as a housing specialist.

Under the guidance of Shelter Partnership, Inc., LAC-DMH assessed the training needs of agencies in order to design an educational program to equip the housing specialists with the skills necessary to identify and secure housing. As a result, the Adult Systems of Care Housing Coordinator conducts monthly meetings to provide training on topics such as master leasing, identifying available housing resources, developing partnerships with private, non-profit agencies, and marketing strategies. This meeting also includes opportunities for monthly problem-solving and networking. Networking continues outside these meetings, as housing specialists share referrals and housing leads on an informal basis.

Affordable housing is a recognized need in Los Angeles and this is especially true for clients with criminal backgrounds who may not qualify for Section 8 housing, or who may be viewed as undesirable tenants. To recruit landlords willing to rent to AB 2034 clients, LAC-DMH hosted a landowner/property developer's breakfast during which a panel of speakers presented on topics such as the availability of low interest loans for the acquisition or rehabilitation of low income housing, the availability of mental health professionals that assess the mental health needs of tenants and offer assistance to avert possible eviction, financial incentives to rent to AB 2034 clients, and rental subsidies through HUD.

The Adult Systems of Care Housing Coordinator provides technical assistance to the agencies in completing applications for Section 8 housing vouchers. The Housing Coordinator scrutinizes each application thoroughly to ensure that it complies with HUD's eligibility guidelines and regulations in order to submit applications that will be approved. The Housing Coordinator also

works with the Los Angeles City and County Housing Authorities on a case-by-case basis to advocate exemptions for clients with criminal histories.

The Housing Authority of the City of Los Angeles, through its Special Needs Program, is able to provide housing vouchers as early as two weeks after the submission of a Section 8 application. However, those waiting for vouchers either from Los Angeles County or from the City of Long Beach have a much longer wait—sometimes nine months to a year for the County or as long as seven years in Long Beach. When a client applies to the Long Beach City Housing Authority for a Section 8 voucher, the client can still face an extended period on the waiting list even after an application is accepted because vouchers are distributed using a lottery system. Upon receiving a housing voucher, the client still faces the daunting challenge of finding a place to live. Frequently, the Housing Specialists acting on a client's behalf must apply for an extension because the client cannot locate housing during the time the housing voucher is valid.

Not all of the problems faced in securing Section 8 housing are directly related to AB 2034 clients. Property owners are resistant to becoming Section 8 providers due to the bureaucracy and the housing market. Depending on the particular Housing Authority, it may take several months for the Housing Authority to inspect a site once the landlord's application is received. Frequently, prospective landlords are not willing to wait for inspections or wait for an extended period of time before receiving their first rent check from the Housing Authority. This is particularly true in a tight housing market in which property owners could rent a building very quickly outside the Section 8 program.

AB 2034 funds give Housing Specialists the flexibility to overcome property owner resistance by employing such innovative strategies as paying the Housing Authority's portion of the rent until the landowner receives his/her rental subsidies, offering to pay a slightly higher security deposit and placing an early deposit on a housing unit so the property owner will have funds available to make necessary repairs to bring the building up to Section 8 standards. The Housing Specialists can also intervene if an eviction is imminent or use AB 2034 funds to repair damage done by a client. In addition to financial incentives, AB 2034 agencies offer 25-hour on-call services to intervene if a problem should arise.

AB 2034—Documenting Reductions to Chronic Street Homelessness

One of the strong points of the AB 2034 program is its ability to collect real-time data. AB 2034 Program (CAMINAR) data system, self-reported case level baseline data is collected on each client for a 12-month period prior to enrollment into the AB 2034 program. A client's record is then updated each time there is a status change and again annually. Status changes include changes in place or type of residence, hospitalizations, incarcerations, and changes in employment. In addition, objective quality-of-life indicators are collected in the areas of residence, employment, education, criminal activity, income, control over one's own life (conservator/payee), social support, and physical health.

The following data from the "AB 34/2034 Program One Year Outcomes" report is based on 720 Los Angeles clients who are or were in the program for at least one year. It compares data from the 12 months prior to enrollment to 12 months after enrollment in the program. There was a 77 percent increase in permanent housing, 65 percent decrease in number of days consumers were

homeless, 65 percent reduction in number of consumers incarcerated, 62 percent decrease in number of incarcerations, 80 percent decrease in total days of incarceration, 33 percent reduction in number of hospital admissions, and 74 percent decrease in total number of hospital days.

With the expansion of the Program in FY 2000–2001, LAC-DMH selected four additional community-based mental health providers to participate in the AB 2034 Program. The AB 2034 program now contracts with 16 agencies at 20 locations within Los Angeles County. See Table D.3 for a complete list of contracted providers.

AB 2034—Model of Care

The principal philosophical component of both the Assertive Community Treatment (ACT) and Integrated Service Agency models is the use of non-traditional methods to achieve the desired goal of outreach and engagement of the hard-to-reach mentally ill population. Through utilization of an ACT model, the AB 2034 Program ensures a comprehensive response to the needs of the client. Since AB 2034 services are provided "where the client is" in the community, AB 2034 team members spend the majority of their workday in community locations such as jails, parks, shelters, dual diagnosis recovery homes, emergency rooms, social services agencies, and/or wherever homeless individuals congregate.

Program Components—San Fernando Valley Community Mental Health Center

We visited one AB 2034 contracted agency in Los Angeles County that receives a large number of AB 2034 jail referrals—The San Fernando Valley Community Mental Health Center (CMHC), Inc., which we use as an example in our discussion of program components.

San Fernando Valley Community Mental Health Center, Inc. The San Fernando Valley CMHC operates one of the AB 2034 programs in Los Angeles County. Its program approach includes an integrated community care system providing intensive case management services for homeless mentally ill individuals who were recently released from jail and who are at risk for recidivism (Hunter et al., 2002). The Center's AB 2034 Program, located at the Cornerstone Multi Service Homeless Drop-In Center, serves about 105 clients in a year, although its DMH contract is to serve 78 clients.

Staff members provide comprehensive services and case management to meet client needs and collaborate with other community agencies as needed. The staff members estimate that many of the AB 2034 clients have been on the street, sometimes for many years. San Fernando Valley CMHC is able to accommodate the housing needs of the AB 2034 clients through the program's own master leased transitional housing sites, the Center's satellite townhouse apartments, or through the Center's Independent Living Program's Section 8 contract with the City of Los Angeles.

Outreach

The program receives referrals from the Los Angeles County jail for 80 percent of its clients. Referrals also come from emergency shelters in Los Angeles County, hospitals, parole,

probation, and the general intake process of the Cornerstone program. AB 2034 case managers go to the jail to conduct assessments when they receive referrals from the AB 2034 DMH Evaluator stationed at the jail.

Emergency Shelters

The AB 2034 program has eight designated beds (four for men and four for women) at the local Valley Shelter for clients who need immediate housing. The Valley Shelter is always open and provides three meals every day, so clients have no need to leave during the day except to attend mental health services at the AB 2034 program site.

Transitional Program

The San Fernando Valley CMHC AB program operates master-leased, scattered-site units, with lengths of stay ranging from short-term transitional (28 days) to more long-term options (three months to one year). The program requires clean and sober living for a minimum of three months before admission into housing and has a zero tolerance policy for substance use once in residence. Residents found to be using drugs or alcohol during random drug tests are asked to leave the residence for two weeks with a number of options that would allow the resident to come back into housing earlier if she or he complies with a harm reduction plan of action, which includes drug and alcohol treatment. Residents are also required to save money in preparation for their eventual transition into Section 8 housing.

Program staff members will also place clients into other transitional housing programs if no openings are available in the Center's own housing continuum. For example, until they find a Section 8 living accommodation, some clients are placed in sober living homes.

Permanent Supportive Housing

The AB 2034 program has access to permanent supportive housing units in a number of different low-income housing buildings in the area, supported by SRO Mod Rehab, city Section 8 homeless vouchers and city and county Section 8 Shelter Plus Care vouchers. The Center program in partnership with A Community of Friends (a low-income, special needs housing developer) will place AB 2034 clients into a new permanent housing building scheduled for opening in January, 2004. Residents will be able to live independently but will be required to be involved in meaningful activities a minimum of 20 hours a week.

Supportive Services

AB 2034 services are available 24 hours a day, seven days a week and include medication support, substance abuse services, mental health counseling, housing location assistance (including temporary, transitional, and permanent housing both on and off the Cornerstone program site), vocational and employment services, benefits assistance, money management, showers and hygiene services, laundry facilities, meals, telephone and voice mail access, advocacy in the criminal justice system, advocacy in the mental health court, life skills training,

and crisis intervention (Hunter, et al., *n.d.*). Staff members meet with their clients regularly, perhaps even daily, depending on the needs of the client. If program clients return to jail, case managers advocate for them during the court hearing to request a conditional release back to the program. Staff members carry caseloads of 16 clients, about 4 to 5 of whom live independently but still receive case management services.

AB 2034—Community Relations and Advocacy

The San Fernando Valley CMHC finds that when it comes to neighbor relations, the key to successfully placing housing units in existing neighborhoods is having resident managers on site. Resident managers are able to monitor residents for program compliance and safety of the community. Another key component to reducing resistance to housing homeless individuals in neighborhoods is listening to the community concerns. After listening to the community's concerns and participating in a Resident Council Meeting about clients loitering on the streets in front of its housing unit, the program staff placed a gate between the residence and the Cornerstone property to reduce the visibility of its clients in the neighborhood.

This is not to say that there have been no difficult experiences with neighbors. The San Fernando Valley CMHC met neighbor opposition when moving to its current location in 1997 and when developing a transitional housing program. In both cases, a local neighbor advocated against homeless programs and complained to the city council about the program location. As there were no complaints on record about the program residents in either situation, the city council did not act to change the locations. Since that time, the Neighborhood Council embraced the program and the Center's resident managers are a visible part of the Neighborhood Watch Group.

Lamp Community

Renowned as being an industrial hub for entertainment, technology, tourism, trade, manufacturing, finance and communication, Los Angeles is also a city of extremes. Adjacent to its financial district sits Skid Row, a 40 square block area that holds a concentration of Los Angeles' poorest, most difficult to serve homeless people. A member of the focus group commented that when he first came to Skid Row someone said to him, "Welcome to the gates of Hell. If you can stay sober here, you can stay sober anywhere." Lamp Community serves this population using a model of care specifically designed to serve hard-core homeless individuals with serious mental illnesses and substance abuse problems.

Lamp Community History

Homelessness became a major issue in Los Angeles after the deinstitutionalization of people with mental illnesses followed by severe budget cuts to mental health programs. Many formerly institutionalized mentally ill men and women became homeless and were sent to the missions on Skid Row, but had no safe place to spend their time during the day. In response to this problem, Mollie Lowery partnered with Frank Rice, vice-president of Bullocks department store in 1985 to found L.A. Men's Place as a drop-in center. Since then Lamp has evolved into its current

form, offering a full continuum of services from outreach to permanent independent housing at several locations within Skid Row.

L.A. Men's Place was not overtly an abstinence-based program when it opened although it encouraged sobriety and referred its members to local drug and alcohol treatment programs. It soon discovered that mentally ill persons had difficulty with 12-step programs because they were not allowed to take prescription medications. Consequently, it developed its own drug treatment program with funds from the County Department of Mental Health and developed the harm-reduction model of treatment.

In 1985, L.A. Men's Place shortened its name to LAMP to be more inclusive of women, and in recent years changed its name again to Lamp Community to reflect the community approach to working with homeless men and women.

Lamp Community Model

Lamp's Community Model[27] uses a low demand philosophy and fosters a sense of life-long community by offering multiple levels of housing, street outreach, and employment opportunities with a high degree of client participation in programmatic decision-making processes. Many staff members are program participants. The program specifically tailors itself to serving homeless individuals with chronic mental illnesses by employing a non-linear housing model with voluntary supportive services. Lamp refers to its clients as members and its case managers as advocates. Lamp considers that an individual is successful when he does as much as he can do at that time. Based on this philosophy, individuals have no failures.

Lamp Community Components

Although the individual components of Lamp Community operate independently, they also interconnect with one another. Members have the option of using different combinations of services and housing, moving among the various components within the community as the need arises. Lamp Community also collaborates with many other agencies to provide services, housing, and employment for its members. See Table D.4 for a complete list of these agencies.

Street Outreach

Although not a specific component of the Community Model, street outreach provides access into the community. Lamp does not need to conduct outreach activities in "The Row" because homeless individuals on "The Row" already know about Lamp Community and have access to its Drop-In Center. Historically, outreach is conducted primarily in the business districts and is commonly (although not exclusively) done in cooperation with Los Angeles System-wide Mental Assessment Response Team (SMART) collaborative units. These are specialized units

[27] Much of the information in this section is from *The Philosophical Framework of the Community Model: an Approach to Providing Comprehensive Housing and Services to Homeless Individuals with Chronic Mental Illness,* Lamp Community 2002. Los Angeles.

consisting of police officers and licensed clinicians from the Department of Mental Health that respond to police calls having a mental health related component. Lamp provides specialized training to the police officers on the SMART team on methods for approaching and engaging homeless mentally ill persons.

Typically, the SMART team contacts the Lamp outreach workers when they identify a homeless person with mental illness who is not in need of hospitalization. Lamp then attempts to engage the individual to accept services, using the harm reduction approach of meeting a person "where he is at" and doing whatever it takes to link the individual to services. If the individual is unwilling to come in off the streets, Lamp provides street case management, even accompanying the member to appointments if needed. Lamp outreach workers contact the SMART team when they find an individual who is assessed as needing hospitalization, but is unwilling to go.

Lamp also provides outreach services at the Twin Towers County Jail. Prior to the inception of AB 2034, Lamp Community was the primary referral agency for clients from the jail, receiving about 40-60 referrals each week. However, since the implementation of the AB 2034 program, Lamp now receives 8-12 referrals each week, as more jail inmates are referred to program partners throughout the county. One of the hallmarks of Lamp is that it does not turn anyone away. Unlike other AB 2034 programs, Lamp Community will continue accepting prospective members from the jail even after reaching its maximum capacity of AB 2034 clients.

Recently, Lamp has scaled back its outreach activities due to diminishing funding and resources. Now outreach is more concentrated on AB 2034 clients at the jail and hospitals, at other homeless agencies and shelters, and at board and care homes. Lamp members interviewed report connecting to Lamp through referrals from other agencies, the police, the jail, and through Lamp's Drop-In center.

Interviews with outreach workers indicate that the "hook" to engage homeless individuals is food. Outreach workers distribute sack lunches as part of their outreach activities. This takes care of an immediate need for the homeless person and provides an avenue for engagement. Other dimensions of the engagement process include:

- Establishing a trusting relationship and identifying the individual's self-perceived immediate needs;

- Providing concrete goods and services such as toiletries, clothing, or transportation; and

- Addressing clinical, social service, and other supportive service needs as appropriate. It is not unusual for an individual to be willing to accept case management services on the street but not be willing to come in from the cold. Low Demand Transitional Housing

Table D.4: Lamp Community Network of Agencies Involved in Ending Chronic Street Homelessness

	Homeless-Related Programs and Services																							
	Prevention	Outreach/Drop In	Shelter	Safe Havens	Transitional Housing	Permanent Supportive Housing	Other Housing (non disabled)	Alcohol and Other Drugs	Mental Health	Health	Employment	Corrections	Public Assistance	Child Welfare	Advocacy	Food for Non-Residents	Case Management	Cross-Agency Coordination or Service Access & Delivery	Planning	Staff Training	Data Documentation	PR, Public Acceptance	HIV/AIDS Healthcare	Money Management
Nonprofit Programs/ Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People (listed alphabetically)																								
Lamp Community		X		X	X	X,F		X	X,E		X	E			X	X	X,E	X,E	X	X	X		X	X
Skid Row Housing Trust						X	X								X		X	X	X				X	
Volunteers of America		X	X			X	X	X							X									
Mental Health Association						X			X,E		X				X		X	X	X	X	X,E	X		X
Shelter Partnership	X,E		E	E	E	E	E								X		X,E	X,E	X,E	X,E	X,E	X		
Corporation for Supportive Housing						E,F	E,F								X,E		X,E,F	X,E,F	X,E,F	X,E	X,E,F	X		
Los Angeles County Dept. of Mental Health	X	F,X	F		F				X,E,F										X	X,E,F	X,E,F	X		X
Prototypes		X			X			X,E	X,E						X,E		X	X		X,E			X	
Homeless Healthcare L.A.								X,E		X					X,E		X,E	X,E		X				
L.A. Coalition to End Hunger and Homelessness	X,E														X,E		X,E	X,E	X,E	X,E		X		
AIDS Healthcare Foundation										X													X,E	
John Wesley County Hospital (JWCH)										X							X	X		X				
Government Programs/ Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People																								
Los Angeles Homeless Services Authority (LAHSA)	X,E,F	X,F	F	F	F	F	F				F						X,E,F	X,E,F	X,E,F		X,E,F	X		
Los Angeles Police Department		X										X,E												
L.A. County-University Of Southern California Medical Center 5P21(LAC-USC 5p21) Clinic										X													X,E	

X = Provider E = Expert TA Provider F = Funder

Lamp Community was one of the original save haven providers that worked with HUD in the early 1990s to develop the definition of a save haven in the Stewart B. McKinney (now McKinney-Vento) Homeless Assistance Act. Although the McKinney-Vento Act defines a save haven in terms of a funding program, providers are able to decide on specific methods of implementation. For example, save havens are required to provide low-demand services, but the level of expectations and rules vary among programs. Lamp's Respite Shelter/ Drop-in Center operates as a save haven using a harm reduction approach.

The Lamp philosophy furthers the belief that substance abuse is a health issue rather than a legal one. People under the influence of drugs and alcohol may enter the save haven but using illegal substances on the premises is prohibited. Within this framework, certain behavioral expectations exist. Members must respect each other and the staff, and must refrain from violence to property and other people. Any rule violation results in temporary exclusion from the site for specific amounts of time ranging from several hours to several weeks.

The drop-in component of the save haven is the point of engagement into Lamp's community. This is where homeless persons can come for food, showers, telephones, and supportive services, or simply to socialize with other members or staff members. Even though services are voluntary, members are encouraged to complete an intake interview during which their medical, psychological, and substance abuse histories are assessed upon entry into the save haven. Staff Advocates make themselves available to members and remind them of activities that are taking place throughout the Lamp Community.

In its current configuration, the first floor of the save haven serves as a drop-in center in the daytime and a respite shelter at night. In the evening, 12 semi-private bed spaces are set up on the first floor and six beds are set up on the second floor. An additional 13 beds are available at the Ballington Hotel, which is adjacent to the Drop-in Center. Shelter guests pay a voluntary fee if they receive SSI or welfare benefits. Members who can care for an apartment and share a room with another person are encouraged to stay at the Ballington. All beds are available on a first-come, first-served basis. If members do not return to the shelter by a certain time of night, they forfeit their bed.

The staff at the save haven consists of a program director, eight full-time and two part-time staff members, and one relief person. Many staff members are former or current members who work as "Peer Advocates." A contracted psychiatrist from the Los Angeles County Department of Mental Health also visits once a week.

Lamp Community Housing

Housing options at Lamp are more flexible than those found in traditional programs. Lamp offers both transitional and permanent housing, with supportive services attached to both. However, in keeping with its philosophy, supportive services are optional. Members have the option of moving from one housing program to another, as need dictates, without jeopardizing their place within the community. Lamp believes that housing is a right, not a privilege, so housing is not contingent upon sobriety or accepting services.

Transitional Housing. Lamp's transitional housing is structured and well suited for individuals who prefer a structured environment while addressing their health issues, particularly substance addictions. In addition to the basic rules of no violence, no stealing, and no drug use, there are additional rules such as curfews, quiet hours, and permission to leave overnight. The transitional housing program also requires members to commit to a contract (called a service plan) in which they establish a set of self-initiated goals, and to commit to a treatment plan. Those who choose to work on reducing their substance addiction are asked to stay voluntarily on the housing premises except for chaperoned outings for 30 to 90 days in order to separate themselves from the culture of drug use on the streets.

At Lamp, transitional housing is more than simply a bridge between emergency shelter and permanent supportive housing. It is transitional in the sense that some members will transition to permanent supportive housing while other members may wish to remain there indefinitely. Due to the cyclical nature of mental illness and substance addiction, some members leave their permanent home temporarily to stay in the transitional housing program in order to live in a more structured environment while working on specific aspects of their recovery. Once stabilized, they are able to return to their permanent home.

The transitional housing program is at Lamp Village, a 50-bed facility with semi-private accommodations. Staff includes a Program Director, eight full-time staff, one part-time staff, and one relief person (called a rover).

Permanent Supportive Housing. Lamp's permanent housing is much less structured than its transitional housing program and offers the highest degree of privacy of any of its housing programs. Participation in activities and services is not mandatory but many members maintain connections with their advocates and participate in services connected to the save haven and the transitional housing program.

Lamp offers three supportive housing facilities all within walking distance of the other Lamp facilities. Lamp Lodge, which Lamp Community owns and operates, provides 43 studios and 7 one-bedroom apartments all fully furnished with full baths and kitchens. Lamp master leases 10 units at the Ballington from the Volunteers of America. These are partially furnished apartments with full baths. Lamp also holds 17 units at the Pershing Hotel in collaboration with Skid Row Housing Trust. These are single room occupancy rooms consisting of a small sleeping-living area with shared kitchen and bathroom facilities outside the units themselves. These units are reserved for Lamp members under a special agreement between Lamp Community and Skid Row Housing Trust. Additionally, Lamp members occupy another 10 market-rate units at the Pershing. Unlike the Ballington where Lamp holds the lease for the tenants' rooms, the tenants at the Pershing enter into a lease agreement directly with Skid Row Housing Trust. Lamp is currently planning several other collaborative housing programs with other local nonprofit housing developers with the goal of making an additional 100 units available to homeless persons by 2005.

A Housing Program Director oversees all the independent housing programs. Additionally, Lamp places resident advocates with a caseload of 15 tenants each to provide support services at both the Ballington and the Pershing Hotels. The Lodge Manager has one part-time and one full-time advocate on staff with a caseload of 15.

The Pershing Hotel, managed by Skid Row Housing Trust, also offers case management services to its tenants but at a ratio of approximately 40:1. The Pershing residents can use Lamp's advocate services at a lower intensity than the Lamp members; they frequently ask to become members of the Lamp Community. At this point, they get thorough screening for the presence of mental illness, and are accepted into the community if certain criteria are met.

Skid Row Housing Trust staff members reported that the key to housing mentally ill persons is close relations with the mental health provider and enhanced property management services, particularly over the weekends when member advocate services may not be available. Lamp meets weekly with the property managers at the Pershing to discuss property management and case management issues.

Member-Operated Business and Other Employment Services

Member employment is a unique feature of the Community Model. The Lamp Community businesses include a linen service, showers, toilets, and a laundromat. The linen service provides clean linens to local nonprofit hotels, shelters, and other businesses. It employs 20 members and maintains a waiting list of prospective member employees. Lamp's showers and toilets are open to the Public. One or two member employees oversee the operation. Lamp's laundromat is the only laundromat open to the public in the Skid Row area. Lamp Community employs eight members between the laundromat and public showers.

Lamp also employs six members as advocates to provide case management and advocacy services. Peer Advocates receive training in ethics and confidentiality, professionalism, boundaries, case management, suicide and homicide interventions, and other crisis interventions.

Supportive Services

Lamp provides a wide array of voluntary supportive services. Most are components of the transitional housing program and the drop-in center but are available to all members. Members residing in independent housing must go to Lamp Village, which is within easy walking distance of their residences, to receive services that their resident advocate cannot provide. Lamp members are referred to outside agencies for medical and dental services.

Lamp advocates report that immigration status and language barriers increase the difficulties in linking members to outside services. Without appropriate citizenship documentation, it is impossible to get public assistance for housing or medical services. Finding mental health services for foreign speaking persons is challenging at best.

Lamp offers the following services:

- Money management and a Representative Payee Program for SSI benefits: Lamp will act as representative payee for individuals receiving SSI benefits upon request. This is not a requirement for the program, rather a service offered to the members. Additionally, Lamp will manage a member's money. The member "deposits" his money into an

account, Lamp then draws on this account to pay bills or give the individual the money needed to pay specific bills and/or provide the member with a weekly allowance.

- Meals, clothes, hygiene products, showers, and laundry facilities for their members as needed. However, the laundry facilities and showers are open to the public.

- Mental health services: these include group and individual counseling, psychiatric diagnosis, and medication management.

- Voluntary drug testing: some members choose to participate in voluntary drug testing as part of their approach to recovery. The ability to participate in programs or housing options is not dependent on either participation in voluntary drug testing or upon its results.

- Psycho-educational groups: Lamp offers groups related to harm reduction education, health, and drug education, and relapse prevention.

- Support groups: several 12-step recovery groups happen every week.

- Case management: this is a large component of member advocacy. In addition to benefits advocacy and referrals to necessary services outside the Lamp Community, Lamp also provides specialized HIV case management. A valuable component of case management is that the advocate will do whatever it takes to get services for members, often accompanying members to appointments until they can do this independently.

- Employment training and placement: 90 percent of staff members at Lamp's three businesses are member employees; half of Lamp Community employees are former or current members.

- Socialization activities: Lamp offers frequent opportunities for social and recreational outings and events, creating an atmosphere of community. A member of the focus group commented that Lamp has the best parties, especially during the holidays.

- Art and performance instruction: The Lamp Art Project includes a professional level art studio, serving members from beginners to highly advanced artists. Field trips to working artists' studios, museums, public murals, and places of natural beauty are open to all members.

Lamp Community—Documenting Reductions to Chronic Street Homelessness

Lamp currently does not have a computerized database of all of its members although it does collect several measures at the point of intake for all members. Lamp is in the process of expanding to all its participants the CAMINAR database program that it uses to keep data for the AB 2034 program. Lamp does have data on members associated with the AB 2034 program, and data associated with other specific grants.

Lamp's AB 2034 data demonstrate a 59 percent decrease in incarceration days and a 79 percent reduction in time spent homeless on the streets among the members served through the AB 2034 jail outreach program.

Data for people benefiting from the California Department of Mental Health Supportive Housing Initiative Act (SHIA) Supportive Housing Project indicate that 87 percent of program participants (those residing at the Pershing and the Ballington) remain housed after one year, 7.7 percent are in jail, and the whereabouts of 5.1 percent are unknown. Participants in the study realized a 57 percent decrease in acute hospitalization incidents over a period of one year. All of the permanent housing residents enrolled in the project consistently participate in mental health treatment and 89 percent of the residents with active drug or alcohol addictions participate in recovery groups and related services.

Separate data based on 2002 statistics on all residents at the Pershing indicate that 85 percent of the residents remained stably housed at the Pershing at the end of one year. Unfavorable reasons for leaving were due to either eviction (4.5 percent) or abandonment (3.0 percent). Favorable reasons for leaving included moving to a better apartment (3.0 percent), moving into a recovery program (3.0 percent) or moving in with family (1.5 percent).

Lamp Community—Community Relations and Advocacy

Gentrification of Skid Row is having an impact on the available housing and services to homeless individuals in the area. Consequently, the acceptable area for homeless individuals to spend their time during the day is shrinking as the vacant apartment buildings and warehouses are converted into market rate (i.e., expensive) lofts. Although the executive director of Lamp Community reports that NIMBY is not an issue in Skid Row, tensions between several Business Improvement Districts in the area and homeless advocates in Skid Row persists. "Not in *MY* Backyard" is turning into "not in *YOUR* Backyard" reports an executive from Skid Row Housing Trust, as he describes the attitude of the developers who are moving into Skid Row. The developers do not want homeless individuals loitering around buildings and they work diligently with the police to move homeless individuals away from properties. In response to this, the more advocacy-driven board members of Skid Row Housing Trust worked with the American Civil Liberties Union (ACLU) to pursue lawsuits against the police and private security guards "who were acting more like Gestapo than police." The courts granted a temporary restraining order against the police this spring to prohibit unlawful sweeps of Skid Row in search of probation and parole violators without reasonable suspicion.

Los Angeles Site Visit Participants

Participants	Organization
Celina Alvarez	L.A. Men's Place Community
Michael Alvidrez	Skid Row Housing Trust Property Management Co.
Deirdre Anderson	Portals, Mental Health Rehabilitation Services Community Living Program
Judyth Balhesteros	L.A. Men's Place Community
John Best	L.A. Men's Place Community
Joan Brosnan	VA West Los Angeles Health Center
Marla Brundies	VA West Los Angeles Health Center
Tracee Cameron	VA West Los Angeles Health Center
Adam Chidekel	Portals
Donald Coopentu	L.A. Men's Place Community
Debra Dyckoff	VA West Los Angeles Health Center
Sharon Eddington	L.A. Men's Place Community
Raul Jr. Espinosa	VA West Los Angeles Health Center
Craig Fenner	Skid Row Housing Trust Property Management Co.
Robert Fiese	Portals, Mental Health Rehabilitation Services
Diane Figgins	Villiage USA
Bob Friedman	Greater Los Angeles Department of Veterans Affairs
Mara Funk	County of Los Angeles Department of Mental Health Adult Systems of Care
Peter Graves	VA West Los Angeles Health Center
Vivian Hiver	VA West Los Angeles Health Center
Curley Holden	Step Up on Second
Karen Howard	Department of Veterans Affairs
James Howat	Volunteers of America
Mary Taylor Johnson	VA West Los Angeles Health Center

Chu Kim	County of Los Angeles Department of Mental Health Adult Systems of Care
Anthony Leon	Los Angeles County Sheriff's Dept.
Mollie Lowery	L.A. Men's Place Community
Nick Maiorino	St. Joseph Center
Marquita McBride	VA West Los Angeles Health Center
Jim McGuire	Homeless Program
Gerald N. Minsk	L.A. Men's Place Community
Herman Jr. Mitchell	VA West Los Angeles Health Center
Willie Montgomery	Department of Veterans Affairs
Shannon Murray	L.A. Men's Place Community
John Nakashima	Department of Veterans Affairs Los Angeles Ambulatory Care Center
Anita Nazareth	San Fernando Valley Community Mental Health Center, Inc.
Thomas Ola	VA West Los Angeles Health Center
Anthony Oliver	San Fernando Valley Community Mental Health Center, Inc.
Dwight Raocliff	United State Veterans Initiative (US Vets)
Toni Reinis	New Directions Inc.
Cathy Aryon Rice	St. Joseph Center
Mary Richards	VA West Los Angeles Health Center
Eluid Rivera	Los Angeles Sheriff's Department
Stuart Robinson	L.A. Men's Place Community
Bonnie Roth	San Fernando Valley Community Mental Health Center, Inc.
Marie Tavares	L.A. Men's Place Community
Reina Turner	Los Angeles County Department of Mental Health Adult Systems of Care
Don Watts	L.A. Men's Place Community
Lee Wessof	San Fernando Valley Community Mental Health Center, Inc.
Faye Williams	ENKI Health & Research Systems

Tamika Woodard	VA West Los Angeles Health Center
Betty Zamost	VA West Los Angeles Health Center

Los Angeles Acronyms

AB	Assembly Bill
ACT	Assertive Community Treatment
ACLU	American Civil Liberties Union
CAMINAR	The data collection system used by the AB 2034 program
CHALENG	Community Homelessness Assessment, Local Education, and Networking Groups
CMHC	Community Mental Health Center
FTE	Full Time Equivalent
HUD-VASH	The VA Supported Housing Program
HCHV	Health Care for Homeless Veterans
IPS	Individualized Placement and Support
IRC	County Jail Inmate Reception Center
JMH	Jail Mental Health
JWCH	John Wesley County Hospital
LAC-DMH	Los Angeles County - Department of Mental Health
LAHSA	Los Angeles Homeless Services Authority
SHIA	Supportive Housing Initiative Act
SMART	System-wide Mental Assessment Response Team
SRO	Single Room Occupancy
TTCF	Twin Towers Correctional Facility
VIP	Veterans In Progress
VAGLAHS	VA Greater Los Angeles Healthcare System
WLAHC	West Los Angeles Health Care

APPENDIX E: PHILADELPHIA

Philadelphia—Brief Description

Philadelphia is the nation's 5th largest city, with a population in 2000 of 1.5 million. The city has been losing population[28] and experiencing economic disinvestment for several decades. 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 downtown and many residential neighborhoods (Kromer, 2001), the city still faces circumstances that generate homelessness. Its 2000 poverty rate was twice that of the nation as a whole (22.9 versus 11.3 percent) and its average 2002 unemployment rate was also higher (7.5 versus 5.8 percent).[29]

Along with a few other cities (such as Baltimore, New York City, St. Louis, San Francisco), Philadelphia is its own county, with city agencies serving both city and county functions. Political will, supported by advocacy and coupled with control of city and county public resources, prompted Mayor Wilson Goode in 1988 to create the Office of Services for the Homeless and Adults. The office director eventually became a "homeless czar," a position that next two mayors have maintained and expanded. The current "czar's" official designation is the Deputy Managing Director for Special Needs Housing. Having someone in this position means there is a single person whose obvious job it is to resolve issues about homeless services. This is the Mayor's point person on homeless issues, held responsible for emergency shelter directly but also expected to interact with mainstream systems and coordinate activities more broadly to address homelessness. 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.

A major focus of Philadelphia's efforts has been people experiencing chronic street homelessness. The network of programs and services developed to encourage people to move from the streets into housing includes extensive outreach, entry-level safe havens and other no demand residences, emergency shelters, transitional housing programs, permanent supportive housing programs of various configurations, and supportive services purchased from or supplied directly by city agencies. These latter services include outreach, mental health and substance abuse treatment and intensive case management, and primary health care. Pennsylvania, and therefore Philadelphia, still makes some public cash benefits available to disabled single individuals, and local public funds are used to meet some material needs (such as furniture, move-in money) and provide some rental assistance for families. Community development corporations (CDCs), including several created and run by homeless assistance providers, have been active in creating affordable housing that may be occupied by formerly homeless and other households.

---

[28] 1970-2000, -22.2 percent; 1990-2000, -4.3 percent; 1980-1990, -6.0 percent; 1970-1980, -13.4 percent. Calculated from data obtained at www.census.gov/population/cencounts/pa190090.txt; accessed March 23, 2003.

[29] 2000 poverty statistics for Philadelphia, quickfacts.census.gov/qfd/states/42/42101/html; for United States, quickfacts.census.gov/states/00000.html; 2002 unemployment statistics for Philadelphia, www.bls.gov/ro3/fax_9527.pdf; for United States, www.bls.gov/cps/home.htm#overview. All accessed March 22, 2003.

On our visit to Philadelphia on March 17-20, 2003, we interviewed almost 90 people. They represented city agencies; nonprofit outreach, drop-in, shelter, and housing providers; agencies serving homeless people through casework, mental health and substance abuse treatment, health care, and job readiness/training/employment; community development/neighborhood revitalization organizations; legal aid, housing, and other advocacy organizations; and data managers and analysts. People who had experienced chronic street homelessness were included in a separate focus group. A full listing of persons interviewed, other than focus group participants, may be found at the end of this appendix.

The next section describes Philadelphia's approach to ending chronic street homelessness, including documentation of progress to date. Thereafter we give more detail on selected system components, examine funding mechanisms, describe how the current system evolved and where it is going, and describe issues that have arisen with respect to community relations.

Practices of Potential Interest to Other Jurisdictions

- **Concerted plan to address street homelessness.** In response to the Sidewalk Behavior Ordinance, Philadelphia instituted a serious, focused effort to develop the strategies and programs that would help people move off the streets and out of homelessness. The strategy involves an organized outreach effort, development of safe havens, and expansion of permanent supportive housing. (Contact person: Rob Hess, Deputy Managing Director, robert.hess@phila.gov.)

- **Major investments by mainstream agencies.** Philadelphia makes a serious commitment of public funds to homeless programs and services, over numerous departments and administrations, aided by continuing public support. (Contact person: Rob Hess, Deputy Managing Director, robert.hess@phila.gov)

- **Outreach Coordination Center (OCC).** The OCC offers a coordinated point of contact for street homeless people. Outreach workers linked to the OCC are able to offer a wide array of services, and feel confident that the people they contact will receive the services if they are willing to accept them. The OCC also maintains a database of contacts with street homeless people that give Philadelphia an excellent picture of who is out there and what their needs are. (Contact person: Genny O'Donnell, Director, Outreach Coordination Center, gennyodonnell@projecthome.org.)

- **Single point of responsibility for homeless issues, and extensive coordination mechanisms.** The position of Deputy Managing Director for Adult Services consolidates responsibility for planning, organizing, and delivering programs and services to end homelessness in Philadelphia in one obvious place. The Director and Adult Services are aided in their mission by the network of coordination mechanisms in the city, including its own data system and Housing Resource Center, the OCC, housing/neighborhood revitalization through the Office of Housing and Community Development (OHCD), Behavioral Health System through (BHS), primary health services through the Department of Public Health (DPH) and the Philadelphia Health Management Corporation (PHMC), and planning and implementation through the Mayor's Task Force

and the Blueprint. These arrangements appear to work well—people know whom to call, for both individual client advocacy and more programmatic issues. (Contact person: Rob Hess, Deputy Managing Director, robert.hess@phila.gov.)

- **Data collection, analysis, and use to shape policy.** To aid its planning and coordination efforts and its decision making about new investments, Philadelphia makes good use of its extensive data on outreach and emergency shelter populations. It also pays attention to research done elsewhere. Evidence of chronicity and extensive service use is driving the city's current shift of direction toward reducing emergency shelter beds, freezing transitional housing development, and concentrating on permanent supportive housing. (Contact person: Rob Hess, Deputy Managing Director, robert.hess@phila.gov.)

In addition to these specific practices that may be of interest to other jurisdictions, several points about Philadelphia's approach to ending chronic homelessness are also important to note. First, people involved with homeless services, planning, and advocacy in Philadelphia have ***long*** histories in the city, in services, and with each other. There have been some extremely adversarial moments, but basically people have learned to work with each other, compromise, and move forward. Even potentially contentious situations such as the Sidewalk Behavior Ordinance have been turned to good advantage.

Second, for at least the last decade, strong public support has been developed and sustained for helping homeless people and committing local resources to the task. This does not preclude occasional NIMBY responses to specific project locations, but even those issues have been handled with reasonable aplomb, especially since the city lost the 1515 Fairmount dispute.

Finally, even with Philadelphia's history and local commitment, funding issues can still strike hard. The new state budget devastated the state's Human Service Development Fund (HSDF) and funding for social services and drug and alcohol treatment. It is not clear at this time whether final allocations will look as bad as they do at this writing (late spring 2003), but if they do it has the potential to really undermine homeless assistance in Philadelphia.

Primary Contact Person

Robert Hess
Deputy Managing Director, Special Needs Housing
Managing Director's Office—Adult Services
1321 Arch Street, 5th Floor
Philadelphia, PA 19107
E-mail: robert.hess@phila.gov

History and Context—How the Current System Evolved

Two elements strike one as essential in explaining Philadelphia's activities related to homelessness—how long the key players have been involved, and how well they have learned to get along. These two elements have allowed Philadelphia to take advantage of situations and turn potentially hostile confrontations into opportunities for progress.

Many Philadelphia providers, advocates, and even government officials date their involvement in efforts to help homeless people from the late or even early 1970s. Further, most have occupied more than one role over the years or at the same time, moving from advocate to provider to government position and back again, or moving among providers and among types of programs as they develop. Mayors and key government officials have been activists themselves, or providers, or both. Drawing on a wealth of experiences and the contacts that the years provide, they have accommodated rather than feared tension among different interests, seeing it as a basic engine of progress. They have focused and planned for the long term and created structures and investments to make it happen, learned from experience, and refocused as new evidence has pointed toward the need to redirect resources and service structures.

Mayoral Support and Public Leadership

Philadelphia's programs to help street homeless people evolved from the beginning as a partnership between city government and providers. As the effects of mental hospital closures began to make themselves apparent with the appearance on the streets of people with serious mental illness, providers were the first to respond, first with street outreach and then with permanent supportive housing (PSH). Some of Philadelphia's PSH goes back to this era (Women of Hope opened in 1985 for mentally ill "bag ladies," and Bethesda Project opened three permanent supportive housing programs in 1983, 1986, and 1988). Even that early, Philadelphia's mental health agency was supporting specialized housing for formerly homeless people with mental illness.

When the city decided that it had to respond to increasing homelessness, officials came to the providers to ask what they should do. In January 1987, Mayor Goode, feeling pressure from homeless advocacy groups, media attention to shelter conditions, and lawsuits against the city, created the Mayor's Public/Private Task Force on Homelessness, which included advocates, providers, business people, and city officials in its membership. This Task Force had the initial assignment of identifying roles for the city. It had the further assignment of monitoring city actions to see whether city agencies were living up to their commitments. The Task Force met regularly and agency heads reported their progress to all members, who could (and did) question, suggest, challenge, and otherwise fulfill their monitoring role.

One result of the Task Force was bureaucratic reorganization and a new mission. In 1988 Goode passed Executive Order 6-88 transforming what had been Adult Services and Aging into the Office of Service to the Homeless and Adults (OSHA). OSHA was mandated to "eliminate homelessness and other conditions that threaten survival through the assurance of access to housing, jobs, and other resources to enable families and individuals to attain the highest level of independence and self-sufficiency" (Office of Emergency Shelter and Services, 1997). OSHA put city resources into emergency shelter and established central intake and payment mechanisms.

In 1992, Mayor Ed Rendell initiated strategies that included coordinating approaches, shifting the focus from emergency shelter to prevention, transitional housing and self sufficiency and getting additional Federal, state, and private support for homeless initiatives (City of Philadelphia, 1996). In 1996, OSHA became the Office of Emergency Shelter and Services

(OESS) under Rendell, a change in name that represented the city's attempt to coordinate all city homeless services. The OESS mission statement was changed to "provide comprehensive case management, support services, referrals to housing, emergency assistance to persons in need of shelter and other types of assistance in order to maintain or regain housing" (Office of Emergency Services, 1996).

In 2000, the city created Adult Services (AS), so named to indicate responsibility for adult well-being and not just for homelessness. OESS and much of OHCD homeless-related work was brought under the Adult Services aegis. Adult Services now also includes the newly minted Housing Support Center (described below).

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 ten years increased her breadth of control until she became the Deputy Managing Director for Social Services. She started the weekly meetings of department heads described below, and tracked plans and progress on many fronts. With particular relevance for homelessness, she pushed for the current configuration of BHS, including the creation of Community Behavioral Health (CBH), the city's own managed behavioral health care system. She also saw from the beginning that housing was part of the answer. Directors of Office of Mental Health (OMH) and Coordinating Office of Drug and Alcohol Abuse Programs (CODAAP), who ultimately answered to her, supported development of housing and service options that continue to play preventive roles in keeping more disabled people off the streets. Many city officials we interviewed considered themselves to be following Richman's example, "doing the right thing" first and handling bureaucratic consequences as they arise.

On the housing side, John Kromer served as director of OHCD from 1992 to 2001, thus also having ten years to pursue a long-term strategy of neighborhood reinvestment and serving as the first housing director to use OHCD resources to develop housing for homeless people (Kromer, 2001). OHCD controlled Federal Emergency Shelter Grant (ESG) funds, which by design were used for homeless services. It also controlled other important Federal funding sources (Community Development Block Grant (CDBG), Housing Opportunities for Persons with AIDS (HOPWA), and HOME funds (a HUD block grant program)) that it used to increase housing options for homeless people. Where the social services side of city government could and would supply the supportive services, Kromer committed OHCD to supply the housing. Philadelphia had underspent its CDBG allotment for a number of years, so when Kromer took office he had money available to support transitional and permanent housing development. Due to the intricacies of how CDBG money is allocated and accounted for, he was able to support most proposals that came to OHCD during the critical period in the early 1990s when demand for options other than emergency shelter were increasing. Philadelphia was thus able to develop an array of PSH before major homeless-specific Federal funding was available through the McKinney-Vento Act.

Demonstration Program Participation

The system of care currently available for ending street homelessness in Philadelphia has benefited from the city's participation in a number of national demonstration programs. It is also true that Philadelphia's early independent efforts to develop appropriate types of support for street homeless people put it in an excellent position to write winning proposals for these national demonstration programs. The city's continuous involvement in one or more demonstrations throughout the 1990s meant that one way or another, it was routinely and systematically attending to services and system integration and long-term planning for homeless people, and most particularly for those with serious mental illness.

RWJ's Program on Chronic Mental Illness. In the late 1980s, the Robert Wood Johnson Foundation (RWJ) wanted to invest in a major national demonstration program to stimulate the development of community-based residential systems of care for people with serious mental illness. Foundation representatives came to Philadelphia to observe the residential settings that already existed for chronically homeless street people (Women of Hope, Bethesda Project sites), before designing its request for proposals from communities around the nation for its Program on Chronic Mental Illness. The RWJ demonstration, which functioned in the first half of the 1990s, combined foundation funding and HUD commitments of Section 8 vouchers to cover much of the rent for housing options, and required that the local public mental health agency commit its own resources to supportive services and case management. While not specifically designed to end or prevent homelessness, in effect the systems of services resulting from the RWJ effort did both for people with serious mental illness.

As important as ending or preventing homelessness for specific individuals was the effect of the RWJ initiative on building organizational capacity for developing PSH. Philadelphia became one of nine communities to participate in the RWJ demonstration. A new CDC—the 1260 Housing Development Corporation—was developed in Philadelphia to create much of the housing (something that happened in several RWJ communities). OMH and several service providers gained considerable experience in developing PSH through this initiative, and the city gained a variety of new housing options with supportive services.

The Cisneros "Initiative" Projects. Henry Cisneros, President Clinton's first HUD Secretary, took to heart the idea of a continuum of care for homeless people and committed Federal funds to stimulate cities to develop such a continuum. Washington, DC got the first of these "Initiative" grants in 1993; Philadelphia was one of four cities to receive the other grants. Philadelphia received $8 million over five years to mobilize the public and private agencies addressing homelessness, undertake systematic needs assessment and long-range planning, and use Initiative funds to fill out its continuum by increasing its range of options for transitional housing and PSH. When HUD made the concept of a continuum of care the centerpiece for its funding through the Supported Housing Program from 1996 onward, Philadelphia had already been working to expand its continuum for several years. It was thus in an excellent position to do very well in the new "Super Notice of Funds Availability" application process. Between 1992 (before the Initiative) and 1997, Federal funding coming into Philadelphia for homeless-related services increased from $49 million to $70-71 million.

ACCESS. In the late 1990s, the Center for Mental Health Services in the U.S. Department of Health and Human Services launched a demonstration program to see whether systematic outreach with integrated mental health and other services could help bring homeless street people with serious mental illness off the streets and help them maintain housing. Philadelphia was one of nine demonstration sites, which, along with nine comparison sites in the same states, make up the Access to Community Care and Effective Services and Support (ACCESS) demonstration program.

Turning Points and the Role of Advocacy—No Movement Without Tension

Along with a number of other cities, advocacy stimulated Philadelphia to pass a right-to-shelter ordinance in the early 1980s. "Right" implied public provision; which at its peak in the early and mid-1980s meant that the city paid for around 5,000 people a night to occupy emergency shelter beds. This ordinance is still technically on the books, although it has undergone considerable reinterpretation with the acquiescence of advocates. The crack epidemic of the mid-1980s changed the balance of the street homeless population from one with predominantly mental health or alcohol problems to one with a large proportion of crack abusers. CODAAP data indicate that the city had 79 clinical treatment admissions for crack cocaine in 1980, which rose to more than 10,000 in 1989. Debates about whether providing unlimited shelter was just facilitating addiction led in the late 1980s to the imposition of behavioral requirements and length of stay limits and had the effect of cutting the number of emergency shelter beds approximately in half, to about 2,300, only slightly more than the number that exists today.

The Struggle for 1515 Fairmount

In 1991, Project H.O.M.E (standing for Housing, Opportunity, Medical Care and Education) started to acquire the building at 1515 Fairmount Avenue and turn it into a PSH residence for 48 formerly homeless people, a cafe, catering business, thrift shop, and headquarters offices for the organization. Stiff local opposition from politically well-connected people, including the mayor, led to a four-year legal battle that eventually involved the U.S. Department of Justice and Federal courts. Local advocacy, call-in campaigns to the mayor, protest marches and arrests, offers along the way by Project H.O.M.E. to compromise over supervision of the building and its activities, all failed to resolve the issue out of court, although they kept issues related to disabled homeless people, PSH, and neighborhood relations in the forefront of the news. When the city lost and had to pay about $1 million in Project H.O.M.E.'s legal costs, legal efforts to block development of future projects were severely curtailed.

The Sidewalk Behavior Ordinance

In 1998 a City Council member introduced a bill to criminalize many of the behaviors and actions of homeless street people. The proposed legislation galvanized the homeless advocacy community and brought a great deal of pressure to bear on the Council. The city ordinance eventually passed, but by that time it had been changed in major ways and carried with it significant new funding to provide alternatives to street homelessness.

The response to the sidewalk behavior legislation was a remarkable example of what Philadelphia respondents mean by their assertion that problems can be resolved because "we all continue to talk with each other." Downtown businesses wanted to do something to decrease the odds that people coming downtown to shop, do business, attend conventions, or visit tourist attractions would encounter panhandlers or people living on the streets. Advocates countered with two tacks—1) arresting people would just add a criminal record to their other difficulties in leaving homelessness, and 2) if you want to get people off the streets, you have to offer some alternatives that they are willing to take. After a good deal of controversy, the results were:

- An ordinance passed, and is still city law.

- Proscribed sidewalk behavior is not criminalized, however. Instead, police may issue a ticket similar to a parking ticket, and then only after making several attempts to offer shelter or other assistance themselves, calling an outreach worker, and having the individual refuse any type of assistance from the outreach worker.

- New services were authorized to provide alternatives to living on the street, and about $5 million annually in new money was authorized to pay for them. The services include:

  - The Outreach Coordinating Center (OCC), its management and oversight activities, and its outreach teams;

  - Four new safe haven residences, comprising 85 new low/no demand beds for substance abusers, mentally ill individuals, and those with co-occurring disorders; and

  - New commitments to PSH.

  - The police department's Homeless Outreach Team, which had been around for several years, was instructed to work with OCC outreach and respond to street emergencies.

Even with this agreement, and new funds flowing into programs to help people move from the streets to housing, advocacy proved necessary to stop police harassment of homeless street people. Police had been giving homeless people citations for "obstructing the highway." Advocates set up observers and photographed incidents to show that the people arrested had not been obstructing the highway. Homeless people found "not guilty" filed a class action suit in Federal court claiming that they were being illegally arrested as a form of harassment. The case was settled out of court with no admission of guilt on the city/police's part, arrested people were given cash settlements, and the attorneys were given the oversight of all similar citations issued in Center City to make sure that this practice did not continue. At present, the "ticket" authorized by the ordinance is rarely issued and the police outreach team works well with teams from the OCC.

Approach to Chronic Street Homelessness

This section briefly describes the network of programs and services focused on reducing or ending chronic street homelessness among single adults. It also examines characteristics of people the system serves, how services are coordinated, and approaches or models in current and anticipated use. Continuum of care components addressing chronic street homelessness are described in more detail in the section entitled "Selected System Components," along with activities and investments related to preventing homelessness and increasing the stock of affordable housing.

Program and Service Network

Philadelphia has a large and complex network of programs and services designed to reduce homelessness among chronically homeless people who spend significant time on the streets. Table E.1 shows this network at a glance. [30] Rows represent different providers, arraying first nonprofit providers of residential programs, then supportive services, then advocacy. The remaining rows represent government agencies that fund homeless-related services, offer services with their own staff, or both. Columns represent the types of programs and services offered. An "X" in a cell indicates that the provider offers that program or service. An "F" indicates that a public agency funds a program or service, and an "E" indicates that the provider offers expert advice, technical assistance, or training.

Table E.1 makes clear that a handful of providers have developed mini-continuums of their own, offering everything from outreach to PSH. A few (such as Project H.O.M.E., Resources for Human Development (RHD)) have even become CDCs so they can pursue goals of revitalizing neighborhoods and increasing the availability of affordable housing. These programs handle both the housing management and service provision in PSH sites. Other homeless assistance providers supply the supportive services in housing developed and managed by the 1260 Housing Development Corporation (hereafter, "1260"). 1260 came into existence in the early 1990s to develop special needs housing as part of the Robert Wood Johnson Foundation's nationwide project to expand community-based residential settings linked to services for severely mentally ill people, when it became clear that the more traditional CDCs were not likely to fill these needs.

All of the large and complex homeless assistance providers in Table E.1 offer programs designed to meet the long-term residential needs of formerly homeless people with chronic mental illness, substance abuse, and multiple diagnoses. Several of these providers (for example, RHD, Horizon House) also offer extensive residential and nonresidential services for never homeless people with mental disabilities, including major mental illnesses and developmental disabilities. Homeless people with appropriate diagnoses or conditions have reasonable access to these programs, especially to a type of low-demand entry-level housing supported by the OMH called

[30] Table E.1 does not represent the entire network of homeless assistance programs and services in Philadelphia. These and other providers may also offer programs and services for homeless families with children and homeless youth.

Progressive Demand Residences (PDRs), which function much like safe havens. Some providers (for example, One Day at a Time) specialize in working with substance abusers.

Involvement of Mainstream Agencies

As a conscious part of Philadelphia's approach to ending chronic street homelessness, many city agencies are involved in the homeless assistance system serving this population. Most use their resources to fund homeless assistance programs or supportive services and case management; many also offer some programs and services with their own staff (see Table E.1). All participate in one or more of the coordination mechanisms described below.

Shelter and Housing. Homeless assistance programs fall primarily under the responsibility of OHCD and Adult Services. OHCD receives ESG, CDBG, HOPWA, and other Federal resources, and conducts the annual Consolidated Plan process. It transfers Federal resources to AS for funding emergency shelter and additional transitional housing. City, state (Homeless Assistance Program), and Federal funds flow through Adult Services and its component parts, the OESS, the newly created Housing Support Center (HSC), Riverview Home (a city-owned personal care residence for elderly and/or vulnerable Philadelphians) and the Office of HIV Planning (a body responsible for coordinated planning for Federal funding from the Centers for Disease Control and Ryan White Title I). AS is also the city's convener for the annual Continuum of Care application. Some other agencies—OMH, CODAAP, and the Department of Human Services (DHS), (the child welfare office)—maintain small numbers of units that are closer to "housing plus services" than to treatment, and that accept homeless people as residents.

OESS maintains two central intake systems, one for single men and one for women with or without accompanying children. When the city decided to do central intake, around 1989, it did so to assure that regardless of individual problems, people received shelter beds, and to increase the efficiency of shelter use. Emergency shelter occupancy went from about 80 percent to 97 percent once the central intake system was fully operational.

While it does not run any shelters or transitional programs itself, the city pays for shelter for all people that OESS places into emergency or transitional programs. The intake databases link to a management information system that can provide an unduplicated count and other information about people served, going back to 1989. At present the city pays for about 2,100 shelter beds a night, comprising about 80 percent of the city's emergency shelter capacity. This number is down about 10 percent from 2001, in a deliberate effort to switch occupancy from emergency to permanent supportive housing for chronic shelter users. These OESS shelters served about 10,000 different single adults and 14,000 adults and children in families from November 2001 through October 2002 (unduplicated counts).

Table E.1: City of Philadelphia: Agencies Involved in Reducing/Ending Chronic Street Homelessness

	Homeless-Related Programs and Services																			
	Prevention	Outreach/Drop-in	Shelter	Safe Havens	Transitional Housing	Permanent Supportive Hsg.	Other Housing (non-disabled)	Alcohol and Other Drugs	Mental Health	Health	Employment	Public Assistance	Child Welfare	Advocacy	Case Management	Cross-agency Coord. of Service Access & Delivery	Planning	Staff Training	Data/Documentation	PR, Public Acceptance
Nonprofit Programs/ Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People (listed alphabetically)																				
1260 Housing Devel. Corp (housing devel/mgmt)					X	X	X													
Asociasion de Puertorriquenos en Marcha (APM)			X		X	X	X								X	X				
Bethesda Project		X	X	X	X	X		X	X	X	X				X	X				
night shelter (280 beds, primary route to TH and PSH)		X	X					X	X							X				
Transitional Housing (36 units in two sites)					X			X	X						X	X				
PSH/Ind Lvg (106 units in several sites)						X		X	X						X	X				
Catholic Social Services	X		X	X	X										X					
St. John's Hospice (men)		X	X						X	X					X	X				
McAuley House (women)					X					X					X	X				
Women of Hope						X			X						X	X				
Dignity					X	X	X	X	X	X						X				
Horizon House		X	X	X	X	X		X	X		X				X	X		E	X	
Engagement Center at Arch St. United Meth Church		X						X								X				
Street outreach, night outreach		X						X								X			X	
Transitional Treatment Program			X					X	X							X				
Shelter + Care (several sites)						X		X		X	X				X	X				
Mental Health Association		X							X		X			X	X	X		E		
West Philadelphia Access		X							X						X	X				
One Day at a Time (several sites)			X	X				X							X	X				
Philadelphia Committee to End Homelessness		X	X											X			X	E		
Phila Health Management Corporation		X			X	X				X	X				X	X			X	
Project H.O.M.E.	X	X		X		X	X	X	X	X	X			X	X	X	X	E	X	X
Outreach Coordinating Center (OCC)		X														X	X	E	X	
Safe Havens (50 units in two sites)				X				X	X	X					X				X	
Transitional Housing (62 units in two sites)					X			X			X				X	X			X	
PSH (121 units in several sites)						X		X	X	X	X				X	X			X	
Home Ownership/Economic Development							X													
Resources for Human Development (RHD)					X			X	X	X	X				X	X		E	X	
Ridge Ave Shelter/First Step/Connections/TH		X	X		X			X	X	X	X				X	X				
Kailo Haven				X				X	X	X					X					
Always Have a Dream					X				X	X	X				X					
PSH/various disabilities and combinations						X		X	X	X					X	X				
Home Ownership/Economic Development							X													
Salvation Army/Eliza Shirley House/Ivy Bridge		X	X		X			X	X	X	X				X	X				
SELF, Inc.		X	X		X			X							X	X				
Women's Community Revitalization Project	X					X	X				X			X			X	E		X
Other Providers																				
Hall Mercer CMHC		X						X	X						X					
Philadelphia Veterans Multi-Service & Ed Ctr		X																		
VA Medical Center Outreach Team		X																		

X = Provider E = Expert TA Provider F = Funder

Table E.1: (Continued)

	Prevention	Outreach/Drop-in	Shelter	Safe Havens	Transitional Housing	Permanent Supportive Hsg.	Other Housing (e.g. non-disabled)	Alcohol and Other Drugs	Mental Health	Health	Employment	Public Assistance	Child Welfare	Advocacy	Case Management	Cross-agency Coord. of Service Access & Delivery	Planning	Staff Training	Data/Documentation	PR/Public Acceptance
Ready, Willing, and Able					X			X			X				X					
Phila. Workforce Development Corp (PWDC)											X, F					X	X			
Prof. Healthcare Institute (E&T)											X									
Awbury Arboretum (E&T)											X									
Related Activities and Advocacy																				
Center City Business District		X									X					X	X			X
Corp for Supportive Housing (CSH)						E											E			
Blueprint to End Homelessness														X		X	X	E	X	X
Pennsylvania Low Income Housing Coalition														X		X	X			x
Homeless Advocacy Project	x													X						
Kensington Welfare Rights Unioin														X						X
Regional Legal Housing Services														X						
Tenants Action Group	X																			
Energy Coordinating Agency	X																			
University of Pennsylvania																	E		X	
Government Programs/Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People																				
Office of the Mayor																	X			X
Mayor's Task Force on Homelessness																	X			X
Office of Adult Services (OAS)																X	X	E	X	X
Housing Support Center																X	X		X	
Office of Emergency Shelter and Services (OESS)	F	X, F	X, F	F	F	F		F			F				F	X	X		X	
Pennsylvania Dept. of Public Welfare, Homeless Assistance Program (HAP), through OAS	F		F		F										F					
Office of Hsg and Cmty Dev (OHCD)/Hsg Neigh Pres					F	F	F								F	X	X			
Philadelphia Housing Authority (PHA)						F	F									X	X			
Redevelopment Authority							X, F									X	X			
Dept of Community and Economic Dev (DCED)	F		F														X			
Department of Public Health (DPH)	X, F	X, F						X, F	X, F	X, F						X	X	E		
Behavioral Health System (BHS)	X, F	X, F						X, F	X, F						X	X	X	E		
Community Behavioral Health (CBH)	X, F	X, F						X, F	X, F							X	X			
Coord Off of DAA Progs (CODAAP/BHS)	X, F	X, F						X, F							X, F	X	X	E		
Office of Mental Health (OMH)	X, F	X, F				F			X, F						X, F	X	X	E		
Access to Alternative Services					X	X			X, F						X, F	X	X			
Dept of Human Services (DHS)	X,F					F							X			X	X			
Philadelphia County Assistance Office												X				X	X			
Philadelphia Police Department		X														X	X			

X = Provider E = Expert TA Provider F = Funder

The Housing Support Center is a new program just getting under way within Adult Services. When fully operational, it will bring together resources from Adult Services, DHS, CBH, the County Assistance Office (cash assistance), the Philadelphia Housing Authority (PHA), and other public agencies whose clients face challenges to housing stability. It will serve as the city's central referral point for all households needing help because they are experiencing homelessness or facing homelessness, including families whose involvement with child welfare arises chiefly from their lack of housing.

Supportive Services. Agencies under the Behavioral Health System offer prevention, outreach, substance abuse, and mental health services through their own staff and by contracting with nonprofit homeless assistance programs. CODAAP and OMH are city offices whose staff provide care directly and who also pay for services and shelter/housing through contracts for people meeting their eligibility criteria. Both work closely with the outreach teams under the OCC run by Project H.O.M.E., as well as supporting outreach teams of their own. Direct mental health and substance abuse treatment is also supplied through Community Behavioral Health (CBH), the city's nonprofit managed behavioral health care entity covering poor people with behavioral health disorders, whether Medicaid beneficiaries or not. All are components of Philadelphia's BHS.

Who Is Served?

Philadelphia has a major focus on reaching and serving men and women experiencing chronic street homelessness. Most have one or more disabilities. None is excluded on principle, although there are far from enough units to serve all who need them. Programs have been created for people with mental illness, co-occurring disorders, fragile HIV/AIDS victims with or without other problems, and other special groups. There is even a unit (the Transitional Treatment Unit, run by Horizon House) designed specifically for people who have been banned from using shelter due to repeated episodes of disruptive behavior exhibited during prior shelter stays, which works with residents to help them adopt acceptable behavior. Mainstream mental health and substance abuse services have been expanded to address the needs of homeless people with those problems, and specialized services have been developed for the large proportion of people who do not fit neatly into pre-existing categories because they have two or more co-occurring disorders.

Philadelphia's focus on chronic street homelessness begins with outreach, as indicated by the high proportion of organizations in Table E.1 engaged in outreach and/or offering drop-in services. First-entry residential services also have developed accommodations for people with a variety of disabilities, especially those with low tolerance for the rules or the large numbers of people crowded together in mass emergency shelters. A variety of damp and wet shelters exist, as well as those requiring sobriety. Safe havens have been developed and PDR slots made available to homeless people whose mental illness, substance use, or both make them unwilling or unable to respond, at least initially, to case plans and goal-setting. Finally, the past two decades have seen the development of many varieties of permanent supportive housing able to accommodate people with a variety of chronic conditions.

Coordination Mechanisms

Philadelphia has several coordination mechanisms, ranging from those in most immediate contact with homeless people to those that concentrate on mainstream agency coordination and long-range planning. These include two mechanisms operating at system entry, two that coordinate specialized services, two that coordinate the efforts of city agencies, and three that focus on planning and system development citywide. Overlapping memberships and an open attitude toward developing and maintaining cooperative relationships keep the coordinating mechanisms in touch with each other.

***System Entry*.** Two coordination mechanisms operate at the point of system entry—the Outreach Coordination Center run by Project H.O.M.E., and central intake run by OESS.

The OCC coordinates most of the city's outreach efforts. These include a 24-hour homeless hotline, five outreach teams, up-to-date lists of shelter availability, and regular street counts. The hotline receives calls from businesses, civic and neighborhood associations, and private citizens about homeless people in need, and dispatches outreach workers to assist. The five largest outreach efforts[31] cover Center City and west and southwest Philadelphia, where the majority of chronically homeless individuals who avoid shelters are found. Representatives of all teams meet monthly to review activities and needs. Through radio contact with teams, the OCC facilitates resolution of the immediate needs of any homeless person in contact with an outreach worker that the worker cannot handle independently. OCC workers have conducted street counts of homeless people every quarter since 1998.

Since its inception in 1998, the OCC has maintained a database of all persons contacted by the participating outreach teams, averaging about 2,000 unduplicated individuals annually. OCC teams repeatedly see about one-fourth of those they contact over a span of years. These are the chronic street homeless people the teams try hardest to induce off the streets. Through common identifiers, the OCC database can be linked with the OESS database that chronicles most emergency shelter and some transitional housing stays. Using this link, OCC workers can see whether any of their consumers have used shelter, and how much. Conversely, OESS analysts can assess the proportion of people making heavy use of emergency shelter who are also well known to outreach workers.

Recent analyses for a proposal in response to the Federal Chronic Homelessness Initiative NOFA (which Philadelphia just won) made just these comparisons, indicating the power of these types of tracking databases and what one can learn from them to help shape policy. Analyses of the OESS database showed that 2,731 individuals were chronically homeless. Over the four years from 1999-2002, 2,404 individuals who are still homeless were chronic users of emergency shelter, and street outreach staff repeatedly encountered 572 persons. A match of databases indicated that 245 persons qualified in both categories; counting these people only once brought the total to 2,731. The disability status of the total sample (2,731) was explored using various methods, and it is estimated that approximately 30 percent have a serious mental illness,

[31] The OCC coordinates one comprehensive response team, two mental health specialty teams, and two substance abuse specialty teams (one peer and one professional). It has a case management component and access to the OESS list of available shelter beds.

approximately 30 percent have a chronic substance use disorder, and approximately 30 percent are dually-diagnosed with serious mental illness and chronic substance use disorder.

Central intake mechanisms, an up-to-date inventory of available shelter beds, and a shelter-tracking database provide further coordination for system entry, if the system being entered is emergency shelter. At present, units in safe havens, some transitional housing, and most permanent supportive housing are outside of this database. Future plans for a homeless management information system include bringing these units into the database, however they are funded. However, just because the current database does not account for some resources does not mean that they are outside a system of coordination through Adult Services. For instance, the PHA makes some Section 8 "Good Neighbor" vouchers available for permanent supportive housing. Adult Services manages referrals to PHA, packages the Section 8 applications, and shares a database with PHA that indicates the status of each individual who has been referred. Adult Services considers these vouchers to be "inside" its system, even though they are not, as yet, included in one overarching database.

Specialized services. Philadelphia has a history of reorganizing its city agencies to improve performance and efficiency in addressing homelessness as well as other issues. Coordinating entities affecting homelessness include the Adult Services and the Behavioral Health System. Within the Behavioral Health System, OMH and CODAAP both support continuums of care, including residential care, for qualifying individuals, and have mechanisms for qualifying chronically homeless street people through arrangements with outreach and other programs.

Interdepartmental coordination. Heads of agencies under the aegis of the Deputy Managing Director for Social Services meet weekly to review activities, develop and monitor plans, handle bottlenecks, and work together on cross-agency issues. These agencies include all of the "usual" types of social services plus agencies responsible for prisons, aging, disabilities, recreation, and mural arts. Ending chronic street homelessness is only one of the many issues these meetings address, but when interagency barriers impede progress toward this goal, these meetings are the forum for developing solutions. When these meetings started in 1999, most agency heads did not have a history or inclination to identify ways they could help each other. They had to "get to know each other and learn to play together," in the words of several respondents who participated in early meetings. These meetings still serve an important coordinating function at the agency-to-agency level.

A second interdepartmental coordinating mechanism is the monthly meeting the current mayor holds with social services managers and directors. The mayor never misses these meetings, which he uses to learn how plans are progressing, whether problems are being resolved, and other issues. Both the weekly and monthly meetings of agency heads offer opportunities to develop cross-departmental working relationships. Issues related to homelessness and homeless programs and services arise regularly at these meetings, where the first steps toward resolution can occur.

For the future, the city is implementing an Integrated Data Information System (IDIS), a computer program that brings together all client-related data from the city's social service agencies. Agency staff working with clients, and data analysts, will be able to log into the program to find out what services are being provided to clients, and by which agencies. The

homeless management information system will link into this IDIS, allowing the city to determine where intervention might have prevented homelessness, which city resources are most used by homeless people, and where clients who have left one part of the system may have appeared in another part.

Citywide coordination and planning. Three citywide coordination and planning mechanisms exist, with many of the same individuals involved in two or all three. Two address chronic street homelessness in the context of all homelessness; the third focuses specifically on chronic street homelessness. The first, now organized by AS, is the annual process for developing the Continuum of Care application to HUD. The second is the committee structure of the *Blueprint to End Homelessness*, orchestrated by the Greater Philadelphia Urban Affairs Coalition. The *Blueprint* itself was published in 1998. Committees (for example, Shelter and Services, Housing, Employment, Housing Trust Fund) meet monthly to report back on their progress in implementing various *Blueprint* objectives, to share concerns, and to alert members to upcoming issues and events. Reports to the *Blueprint*'s Implementation Committee include one from the third citywide coordinating entity, the Mayor's Task Force on Homelessness.

John F. Street, the current mayor, established the Mayor's Task Force on Homelessness even before he took office. It is one of several responses to the introduction and ultimate passage in 1998 of the Sidewalk Behavior Ordinance. With almost 70 members representing every possible interested party, the Task Force addresses issues related to street homelessness, especially in the center city area. These issues include outreach, access to shelter resources, police/community/ homeless person relations, differentiating between panhandling and homelessness, running public education campaigns, services delivered "on the street," and similar issues. Members include representatives from the city council, businesses, faith communities, neighborhood and civic associations, homeless services providers, relevant government agencies, the Chamber of Commerce, legal and housing advocates, universities, the Convention Center and Visitors Bureau, the Center City [Business Improvement] District, and private foundations.

Pathways to Housing, Approaches and Models

Philadelphia's homeless assistance network has historically been organized on the assumption that people will move through steps or stages. However, transitional housing and even emergency shelter is not always one of the steps for single disabled adults who have been chronically homeless and on the streets. Outreach and service workers interviewed (at least 20 people from many organizations) reported that there are no one or two "typical" pathways from the streets to permanent housing, as accommodations can be and are made depending on individual needs. Nevertheless, we can try to typify the more usual routes.

- *Outreach to safe haven to housing, or outreach directly to housing*. One of the goals of the OCC is to help chronically street homeless people *bypass* the emergency shelter system altogether and enter directly into housing. The housing may be a safe haven (Philadelphia has four safe havens connected to the OCC, and several other no-demand small residential settings for people with disabilities). If the person has a severe and persistent mental illness, the housing could be any one of several residential settings paid for by OMH through contracts with providers. CODAAP also maintains some residential

slots for substance abusers. There are also a few residential settings for people living with HIV/AIDS, with or without other conditions.

- *Outreach to emergency shelter to transitional housing to "regular" housing*. This is a more common progression for substance abusers who are not also mentally ill. This is a "dry" route, meaning that each step after outreach requires the person to be clean and sober—with strong support offered to help people recover from relapses. If people cannot or will not refrain from using drugs or alcohol, they are more likely to follow the safe haven/no demand route, which includes various forms of "damp" and "wet" housing.

Philadelphia is just starting its first program based on a pure "Housing First" approach, bypassing even the safe haven stage of moving from street to housing. Research evidence on housing first models has convinced officials that this is an important model to try. Further, analyses by Dennis Culhane and colleagues from the University of Pennsylvania of data from Philadelphia's own shelter tracking database reveal the large numbers of chronically homeless people who, in effect, make their home in the system, or going between the system and the streets. In Philadelphia as elsewhere, 10-15 percent of shelter users are absorbing half or more of shelter resources, at significant public expense. The idea that these people could be moved to housing and helped to maintain it through supportive services is appealing, in that it would help people leave the streets and save emergency shelter resources for true emergencies.

Documenting Success

Philadelphia has been tracking its progress through street counts of the homeless and by the success of programs in moving homeless individuals into housing.

Street Counts

Police have conducted monthly or bi-monthly street counts in the center city area since the mid-1990s. Since 1998, outreach workers coordinated through the OCC have conducted quarterly street counts over a broader area that includes all of downtown and west and southwest Philadelphia. The peak police street count of 824 occurred in June 1997. Earlier police street counts for center city had fluctuated between winter lows below 200 and highs around 300 (Greater Philadelphia Urban Affairs Coalition, 1998).

Street counts conducted by the OCC between 1998 and the present show the effects of concerted efforts to develop alternatives to the streets for chronically homeless people with disabilities, including safe havens and permanent supportive housing. Summer counts went from 395 in 1998 to 320 in 1999 and 228 and 240 in 2000 and 2001, respectively.[32] August 2002 witnessed an increase to 356 and in August 2003 the count rose to 370, as street homelessness reflects the poor economic conditions of the larger society. February figures are considerably lower, as

[32] These and the following statistics are taken from *Year 29 Preliminary Consolidated Plan (FY 2004)*, page 25, http://www.phila.gov/ohcd/cconplan.htm.

Philadelphia increases outreach efforts and expands access to emergency shelter beds on winter days when the temperature falls too low for safety. Figures for February 1999, 2000, and 2001 vary little, from 167 to 172. However, the count for February 2002 was higher, at 235, mirroring the summer increases for the most recent year. Temperatures in the 30s and 17 inches of snow on the ground reduced the street count to 32 in February of 2003.

Movement of Street Homeless into Housing

Permanent supportive housing is one avenue that may help chronically homeless people with disabilities move off the streets and into stable housing. We asked the major PSH providers if they had data that could document whether residents of their PSH units had been chronically homeless and whether they had achieved housing stability in PSH programs. Two providers, Project H.O.M.E. and RHD, were able to provide relevant data.

Project H.O.M.E. provided data about residents in the two safe haven programs and two transitional residences (with 80 beds) that are coordinated through OCC, and about residents in its five PSH projects (with 121 units) for single adults. Since July 1, 1999, the safe havens have served 539 clients. All safe haven residents are either mentally ill, substance abusers, or both, as well as being likely to have physical health and other problems. Data on length of homelessness before entering a safe haven are available for 160 people, of whom 47 percent had been homeless for longer than one year, with 32 percent being homeless for two years or more. Among the 399 people for whom previous living situation is known, 30 percent came from the streets and other non-housing locations, 17 percent came directly from mental health or substance abuse treatment facilities, and 36 percent came from emergency shelters or a different safe haven. Among the 537 people whose length of stay at a safe haven is known, 52 percent stayed for six months or less, and 30 percent stayed for more than one year, with an average length of stay of 1.3 years. Information about current living situation is available for 516 people, of whom 23 percent still live at the safe haven, 36 percent moved to better housing situations (for example, PSH, own housing, with family), 2.5 percent died; 22 percent left for situations that were similar or less desirable, and current whereabouts could not be ascertained for 18 percent.

Project H.O.M.E.'s PSH programs have served 187 people since July 1, 1999. Among the 122 people for whom length of previous homelessness is known, 67 percent had been homeless for one year or more, with 44 percent of these experiencing homeless spells of at least two years. Length of stay in PSH is available for all 187, among whom:

- 136 (73 percent) stayed for at least 1 year;
- 93 (50 percent) stayed for at least 2 years;
- 51 (27 percent) stayed less than one year; and
- Average length of stay is 3.2 years.

Of the 90 people who left Project H.O.M.E.'s PSH, current whereabouts are known for 86 percent. Of these, only 13 percent are living in situations that would be considered homeless, including on the streets, in emergency shelters, safe havens, or transitional housing programs. The rest are in a variety of stable housing situations.

RHD has served 121 consumers since 1995 in its Supported Adult Living Team program and another 25 (since 1989) in its Boulevard Apartments. RHD provides supportive services to seriously mentally ill people living in scattered-site residential units or multi-unit building rent-subsidized apartments. Of these 146 consumers, 45 came directly from homelessness. Most of the remainder, all in the Supported Adult Living program, had significant periods of homelessness although their immediately prior residence was various transitional housing situations. Of these 146 individuals, 72 percent stayed for one year or more, including:

- 61 (42 percent) who stayed for at least 2 years;
- 23 (16 percent) who stayed for at least 18 months but less than 2 years; and
- 21 (14 percent) who stayed for at least 12 but less than 18 months.

Selected System Components

Prevention

Philadelphia funds a variety of programs to prevent homelessness, including budget and housing counseling, rent/mortgage/utility assistance, employment assistance, security deposits, and small loans. Most programs focus on preventing crisis rather than chronic street homelessness, and on families rather than singles. Residential program opportunities through OMH and CODAAP, described below under safe havens and no/low demand residences, offer the most meaningful prevention resources for people who have been or might become chronically homeless street people.

Outreach and Drop-In

The OCC's coordination of five teams' outreach activities has already been described. Some of the primary outreach teams are generalists while others specialize in either mental health or substance abuse issues. The primary outreach teams have access to specialized backup that will respond in the event someone they are working with has a health, mental health, or substance abuse crisis. In addition to the outreach teams operating through OCC, quite a number of other agencies in Philadelphia conduct street outreach, as reference to Table E.1 indicates several drop-in centers also serve as contact points for chronic street homeless people, including that of the Philadelphia Committee to End Homelessness, the Engagement Center at Arch Street United Methodist Church (in conjunction with Horizon House), and the Philadelphia Veterans Multi-Service and Education Center. A high proportion of the people the drop-in centers attract are substance abusers.

Outreach in Philadelphia operates mostly during the day and evening hours, with an on-call night outreach capacity accessed through Horizon House. Outreach used to be mostly at night, but workers found that the most they could do for people at night was offer them transportation to a shelter. During the daytime outreach workers can help people connect to a wide variety of benefits and services, which they have found is more effective in keeping people off the streets once they make the decision to accept help.

Outreach teams help street-homeless consumers access public benefits (cash assistance, food stamps, medical assistance), health care (including dental and eye care), detoxification and other substance abuse treatment, safe havens and other low demand residences, medications and other mental health treatment, and the basics (food, clothing, blankets, showers, laundry facilities, and so on). Outreach not linked through the OCC includes teams operating from the Center City District (a Business Improvement District) and the Philadelphia Police Department, which maintains a Homeless Service Detail whose officers call the OCC when they encounter a homeless person who needs assistance. Since 1998, the OCC has maintained a database of all persons contacted by the participating outreach teams. Through common identifiers, this database can be linked with the OESS database that chronicles most emergency shelter and some transitional housing stays.

Safe Havens and Low Demand Residences

Part of the compromise that led to passage of the Sidewalk Behavior Ordinance was commitment to creating low demand residences or safe havens. Under the aegis of the OCC, two agencies run the safe havens and transitional residences developed as a result. These include one with 25 beds for men and women with co-occurring mental health and substance use disorders, one with 25 beds for substance-using men, one with 15 beds for substance-using women, and one with 20 beds for mentally ill women with minimal substance use. The typical route into these safe havens is through contact with outreach.

In addition to these safe havens, Philadelphia agencies offer several other low demand residential programs serving chronically homeless people with disabilities. These include several that are specifically for homeless people but were operating before the Sidewalk Ordinance. They also include the array of progressive demand residences supported by OMH that are available to severely mentally ill individuals whether they enter from homelessness, institutions, or other venues.

Emergency Shelters

Although Philadelphia does a lot to help chronically homeless street people with disabilities bypass emergency shelters in favor of safe havens and other low demand facilities, it does provide almost 900 beds of emergency shelter for singles, through 24 facilities operated by 18 agencies, not counting overflow beds during cold weather. The city has deliberately been reducing the amount of emergency shelter it supports, down about 10 percent in 2002 from 2001 as it switches to more safe havens and PSH for chronically homeless people. Placement into these facilities is through central intake for singles, and payment comes from the city. Analyses of the management information system attached to central intake indicates that about six times as many singles pass through the shelter system in a year's time as are present on any particular night. Further, chronicity occurs in emergency shelter as well as on the streets, with about 10 percent of sheltered singles using 180 or more days of emergency shelter a year and absorbing about three times the number of shelter nights as their proportion in the population (Culhane et al., 1994). Many of these same individuals probably sleep on the streets during the nights they

are not in shelter—thus reducing chronic street homelessness is also likely to reduce demand for shelter beds.

Transitional Programs

Philadelphia has close to 1,900 transitional housing slots for singles, including almost 400 beds in residential programs supported by OMH and CODAAP that offer transitional living situations. All of the large homeless service providers addressing the needs of street homeless people offer one or more options for transitional housing, most of which focus on the needs of substance abusers. Most are shorter than two years, although people can stay that long in some of them. Most have graduated steps or mechanisms for affording increasing privileges or desirable living situations to people as they gain greater time and confidence in their sobriety. These steps include leadership positions, greater privacy, and greater autonomy to control one's daily schedule. Many have an emphasis on employment and building up to the ability to get and hold a job, including finishing a G.E.D., learning computer skills, developing a resume, gaining interviewing experience, and other typical job readiness activities. Often the same provider organizations operate several programs, some of which are purely "homeless" in the origins of their residents while some focus more exclusively on people with similar disabilities who have not (or have not recently) been homeless. Philadelphia is not supporting development of any more transitional housing units, as its emphasis has shifted to permanent supportive housing.

Permanent Supportive Housing

Philadelphia's 2003 CoC application lists about 1,300 PSH units for singles, in 30 programs run by 11 agencies. OMH is one of these agencies, responsible for 138 units of PSH. Not all of these units are occupied by people who once were chronically homeless street people, but many are. Another 90 units are in the pipeline from 2002 CoC funding. Clients access most of this PSH from emergency shelter, safe havens, or transitional housing programs. Until very recently Philadelphia did not have any programs that followed a "housing first" model, unless one wants to consider safe havens as pretty close to that approach, but with a time limit. However, research evidence has convinced homeless services planners that they ought to consider housing first as an option, and the first such program was just getting under way at the time of our site visit.

Very early on (pre-McKinney), Philadelphia had already made significant investments in PSH, and helped develop the model through its involvement with the Robert Wood Johnson Foundation program in the early 1990s. This is not surprising given the city's long-standing concern for helping chronically homeless people to leave the streets. Expanding PSH is the top priority of homeless assistance planners in Philadelphia, whether of the housing first or the more traditional approach.

Supportive Services

In addition to the many supportive services that city agencies supply or purchase under contract to help maintain formerly homeless people in housing (described above, "Involvement of Mainstream Agencies"), housing providers and other agencies offer additional supports. The

Philadelphia Health Management Corporation (PHMC) runs a clinic, outreach, and other health services funded by Health Care for the Homeless and city dollars, and also provides case management and some job readiness and training activities. Several other agencies provide education and employment-related services, and many housing providers also offer employment-related services, computer labs for job readiness and training activities, and actual employment opportunities as staff, caterers, shop operators, renovation/construction workers, and other jobs. The Center City District has made a point of hiring formerly street homeless people, as part of its commitment to "put its money where its mouth is" to end street homelessness in center city.

Affordable Housing

Due to Philadelphia's long economic slide during the 1970s and 1980s and continued (if slowed) population loss, many long-term vacant and abandoned housing units exist in the city. While these units appear to offer the opportunity for developing affordable housing; compared to many other cities, significant public resources (an average of $75,000-$100,000 per house) are needed to subsidize the cost of new construction and rehabilitation. Compared to the incomes of Philadelphia's many poor households, houses at this price are still out of reach. The city's 2003 housing budget of $213 million drew funding from CDBG, Section 108, HOPWA, HOME, the State of Pennsylvania, local bond funding for the mayor's Neighborhood Transformation Initiative (NTI), and other sources. Eight percent (about $17 million) of the budget is earmarked for affordable housing production.

The NTI is Mayor Street's plan to preserve and rebuild Philadelphia neighborhoods by removing blighting conditions, creating opportunities for redevelopment and investment, and improving the delivery of city services and resources to neighborhoods. Creating 3,500 new units of affordable housing is one of NTI's objectives. Homeless advocates are concerned about homeless people's access to these units, because the affordability criterion has been set for households with incomes of around $32,000 (50 percent of area median income), not for the incomes of most homeless or formerly homeless people, or even of the poorest households (those with incomes below $20,000, or 25-30 percent of area median income) (Hiller and Culhane, 2003). In support of NTI, Adult Services and a broad-based Implementation Committee engaged the Corporation for Supportive Housing to help develop a five-year housing development agenda. The agenda proposes 3,400 units of new supportive housing by 2006, 1,500 of which are suggested to be part of NTI.

After our visit, at the urging of the Philadelphia Affordable Housing Coalition, the Philadelphia City Council authorized an additional $10 million in new money for the city's 2003-2004 OHCD/NTI budget that will be earmarked for affordable housing. The $10 million will be distributed as $2.5 million to the Neighborhood-Based Rental Production program, which will help finance an additional 100 units of affordable housing; $5 million to the Basic Systems Repair Program, which will repair and preserve at least 1,000 homes for low-income owner-occupants, and $2.5 million to make 175 homes wheelchair accessible for disabled individuals.

To create more housing affordable to the very lowest income households, several of Philadelphia's large homeless assistance providers have also become housing developers. As CDCs, they create or renovate housing for households with incomes below $20,000, most of

whom will not have been literally homeless before occupying the units. NTI bond proceeds are being used to finance the acquisition of vacant properties, some of which may become available to these CDCs at nominal cost. Because these developers also create training, employment, and recreation opportunities in the neighborhoods they develop, which they have selected because they are the neighborhoods that generate the most homelessness, they contribute to homelessness prevention as part of neighborhood revitalization.

Public Funding

Many Philadelphia public agencies support the city's efforts to move chronically homeless street people into permanent housing situations. They do this through direct funding of homeless assistance providers and/or committing public agency staff to supply supportive services, and covering housing (as opposed to supportive services) costs through several mechanisms. Table E.2 shows the departments involved, the types of financial investments they make in ending street homelessness, and which Federal and state resources they control that are being used for homeless-related activities.

Philadelphia's CBH also provides a unique source of public funding for homeless services. CBH is a city-operated managed behavioral health care organization. Part of its structure to insurers, including Medicaid, that help pay for services is a "profit" margin. As a city agency, CBH is committed to investing a part of this "profit" margin into homeless assistance services such as outreach that are not reimbursable on a fee-for-services basis, and in housing.

Maintaining and Enhancing the System

As detailed in our description of Philadelphia's mechanisms for coordinating homeless assistance, responsibility for maintaining and enhancing the system has a number of centers. In 2000, under the leadership of Estelle Richman, Philadelphia created Adult Services and brought under its rubric OESS and many of the homelessness prevention and funding responsibilities that had been located in OHCD. The "homeless czar" position was created to increase access to mainstream resources for people who experience homelessness. Responsibility for organizing and submitting the city's annual Continuum of Care application to HUD has been transferred to Adult Services, and responsibility for overseeing the system on a day-to-day basis and for implementing long-range plans rests with Adult Services. Adult Services is supported in these responsibilities by the work of the Blueprint Implementation Committee and the Mayor's Task Force on Homelessness. City officials, providers, and advocates work closely together in all of these efforts, but providers and advocates may also challenge decisions or plans if they believe that some overall goal is not being well served.

Table E.2: Local Agency Investments In Ending Street Homelessness

Agency	Type of Investment		
	Fund Services	Staff Provide Services	Fund Housing
Adult Services (AS) – ESG, state HAP, HSDF*	X	X	X
Office of Mental Health (OMH) – MHBG, PATH	X	X	X
Coordinating Office of Drug and Alcohol Abuse Programs (CODAAP) – SABG	X	X	X
Community Behavioral Health (CBH)	X	Soon	X reinvesting "profits"
Department of Public Health (DPH)	X	X	
Department of Human Services – TANF, child welfare	X-direct and $ transferred to AS	X	X-for chronically homeless families
Philadelphia Workforce Development Corporation (PWDC—nonprofit agency responsible for Workforce Investment Act funds)	X		
Philadelphia Health Management Corporation (PHMC—nonprofit agency)		X	
Office of Housing and Community Development (OHCD) – SHELTER PLUS CARE	X-direct and $ transferred to AS	X	X-direct and through $ transferred to AS
Redevelopment Authority	X		X-acquires and develops properties
Philadelphia Housing Authority – SRO Mod Rehab+Section 8	X-$ transferred to AS	X-case management support for Good Neighbors	X-rent subsidies
Mayor's Office of Community Services—SSBG	X		
Philadelphia Police Department		X-outreach	
Department of Recreation			X-temp shelter in winter
Licensing and Inspection		X-assure building safety	
Public Property and Cooperative Programs		X	X
Bond funds	X		X
Department of Veterans Affairs	X	X	

* State resources—HAP = Homeless Assistance Program, which has been cut 10% for the 2003-2004 fiscal year; HSDF = Human Services Development Funds, which have been paying for drug treatment of uninsured people and for OESS case managers and programs, but which have been completely eliminated in the 2003-2004 state budget.

Developing or Adapting New Approaches

Philadelphia's history in the homeless arena attests to its willingness and ability to entertain new ways of doing things when the situation warrants. Over the years the city has thoroughly changed its approach to outreach (from night to day, and much-increased coordination), and developed targeted responses to street homelessness in its low demand programs. As noted earlier, it began developing PSH in the early 1980s, long before McKinney funds became available for this purpose.

These developments grew out of continuing dialogue among all the players about what was working and not working, and what was needed that was not available. Knowledge has played a significant role in many of these developments. For instance, in the early 1980s outreach teams identified 86 women living on the streets with mental illness who were afraid to use shelters. OMH became convinced that these women would benefit from a permanent supportive housing program (a concept that had not been fully formulated at that time), and invested in Women of Hope. Ultimately, all of these women were assisted to leave the streets and obtained permanent housing, often at Women of Hope.

The city is just beginning to invest in the "housing first" approach to permanent supportive housing. Factors influencing this decision are the research evidence from housing first demonstrations (most notably the New York/New York Initiative), plus analyses of the city's own data from OCC and OESS shelter databases. These sources document the number of chronic shelter users and street homeless people who would be appropriate for a housing first approach. The Adult Services Deputy Managing Director meets monthly with researchers who know both the city's data and the broader field of homeless services research, to discuss implications for what Philadelphia should be doing next.

Budget Cuts

No matter how forward-looking and devoted a community is to supporting homeless-related programming, its opportunities rely on funding from many sources. Philadelphia, along with some of the other communities visited for this study, is facing severe cuts in the state budget that may affect its supports for ending chronic street homelessness. Much of the funding for OMH's and CODAAP's supportive services, and even residential programs, comes from the state, where initial budget actions have made drastic cuts.

Community Relations and Advocacy

Having few resources available early on for either homeless individuals or individuals at-risk of becoming homeless, Philadelphia witnessed a drastic increase of chronic street homelessness. Initially, public attitudes were negative toward this population and programs to meet their needs. In this section, we address how the city's advocates for programs to reduce chronic street homelessness assembled the necessary community support for their work.

Initial Resistance

At the same time that the city, nonprofit agencies, and advocates were moving to develop options to address homelessness in the early 1980s, many Philadelphia residents and elected officials opposed programs that assisted chronic street homeless individuals. In 1984 police arrested several service providers and advocates for giving food to homeless individuals in a Philadelphia train station. Also in that year, community residents sought to ban the opening of Women of Hope, one of the earliest programs to offer permanent supportive housing in the form of a "safe haven" for mentally ill women living on the streets. Opposition went so far as bomb threats to force relocation. Women began residing at the program as scheduled, and staff and residents worked hard to ease the fears of neighbors.

The initial antipathy toward chronic street homeless persons and programs to meet their needs was a substantial challenge. Over time city officials, service providers, homeless advocates, and community and faith-based organizations came together to improve community relations for programs meeting the needs of homeless people. Their success was clear in the 1515 Fairmont dispute, when members of the public articulated their support for the building at the Mayor's public appearances, during radio call-in shows, and in many other ways.

In 1997 following the closure of several community-based shelters, Project H.O.M.E. formed an ad hoc group known as the "Open Door Coalition" to develop viable plans for permanent long-term supportive housing for homeless individuals. The Open Door Coalition was also responsible for soliciting support from the media and community residents to the Sidewalk Behavior Ordinance when it was first proposed. Citizens representing many interests have participated in activities focused on planning and implementing approaches for ending homelessness, including the Blueprint (starting in 1996), and the current Mayor's Task Force on Homelessness. Business, in the form of the Center City District, has been active since at least 1991 in addressing street homelessness, including providing jobs for homeless and formerly homeless people and funding street outreach.

Set-aside funding in response to the Sidewalk Behavior Ordinance to expand street outreach was an additional approach the city used to improve relations between the business community and service providers. Street outreach has been crucial in helping homeless individuals move off the street; which was an objective of the business community to improve downtown visiting attractions.

Another more forceful approach to overcoming public resistance was the Mayor's 2001 NTI to revitalize the neighborhoods of Philadelphia. One NTI objective is to foster the development of mixed-income housing units community-wide. NTI will preserve several neighborhoods by stabilizing, acquiring, and refurbishing certain vacant buildings. The NTI strategy is to help neighborhoods thrive by developing clean and safe places for residents to live and work. Although many advocates expressed concerns during the site visit that NTI will not do much to improve the housing needs of homeless people, the city's efforts have lessened the conservative fear that providing low-income housing will cause a decline in property values. In fact, Project H.O.M.E. is developing 144 units of affordable housing in one of the most upscale Center City neighborhoods, Rittenhouse Square, with substantial, active community support and no opposition.

Several efforts have focused on giving citizens an avenue for expressing concerns about particular programs and services in their neighborhoods. The Department of Public Health, the Department of Human Services, and the University City Community Council formed a pilot project called the Good Neighbor Policy in 1998 to respond to neighborhood concerns or complaints regarding residential group homes within their communities. The Good Neighbor Policy has a help line for neighbors to call when they have an issue about a certain group home in their neighborhood. All complaints are handled by an appointed community point person who documents the complaint as well as the method used to resolve the issue. In addition to community complaints, the Good Neighbor Policy also handles issues related to safety, public transportation, and zoning requirements for residential group homes, which may include residences for formerly homeless people.

Philadelphia also has a call-in line for issues relating to tenants with Section 8 housing subsidies. Section 8, one of the major sources for housing subsidies that help pay the rents of people residing in PSH, evidently has a very bad reputation in Philadelphia. Citizens appear to expect the worst behavior from households with Section 8 vouchers, which may be a general backlash against "welfare" or, as some suggested on our visit, may have racial overtones and reflect fears of neighborhood transition. To respond, the Philadelphia Housing Authority has a hotline that

citizens can call to report disruptive activities in particular housing units. Someone follows up on these calls and takes whatever steps are necessary to resolve the issues if they involve Section 8 voucher holders. As often as not the calls turn out to be about people who do not have a Section 8 voucher, but the level of antipathy to Section 8 is reflected in the tendency of citizens to attribute anything bad that happens on their block to a Section 8 voucher holder. These attitudes make it hard to site new PSH programs, since their residents often rely on Section 8 to cover the cost of their housing.

Good Neighbors Make Good Neighborhoods is a unique collaboration between Adult Services and the PHA. More than 400 families in the last 18 months have received Housing Choice (section 8) vouchers from PHA; with Adult Services providing intensive case management services for up to a year to stabilize these formerly homeless families in permanent housing. The case management role, in addition to helping the families directly, smoothes the relationships between families and landlords and possibly also between families and neighbors, contributing to both residential stability for the families and good interactions with neighbors. Through a grant from DHS, these families can receive up to $1,300 worth of furniture and household items for their new homes. In 2002, PHA committed an additional 300 vouchers to continue the program. To date, no families have been evicted from units in the program.

Continuing NIMBY Issues

As supportive as the general public's attitudes are toward assisting homeless people, in the abstract and in terms of supporting the city's continuing financial investment in programming, resistance still arises to specific programs that are proposed for specific blocks. The outcome of the 1515 Fairmount court case dampened enthusiasm for attempts to block development outright, but prospective neighbors still need to be approached with openness and delicacy. When Women of Change was proposed for the Logan Square neighborhood and neighbors voiced anxiety, program sponsors and city officials met with the neighbors to address their concerns and find ways to demonstrate that the program would fit smoothly into the neighborhood. They jointly formed an advisory board, which included city officials, neighbors, and the program sponsor, developed a legally binding grievance procedure. Happily, the grievance procedure has never been used since Women of Change (WOC) opened.

Role of Consumers in Advocacy and Shaping Policy

Homeless people themselves have been involved from the beginning with Philadelphia in advocacy and actions to bring attention to the needs of people without shelter for the night. In the early 1980s, homeless people under the leadership of Chris Sprowl, Leona Smith, and Alicia Christian formed two organizations called Dignity and Fairness for the Homeless and the Union of the Homeless. They were very successful at organizing direct actions such as picketing shelters for inhumane treatment of people who were homeless, the lack of shelter, and the need for housing and jobs. Their efforts resulted in a "Right to Shelter" ordinance, the right of homeless people to vote, and Dignity Housing, a program to provide transitional and permanent housing run by those who have experienced homelessness.

Throughout the 1980s several public actions brought the plight of homelessness to the public's attention. In the fall of 1987, Joe Rogers, a mental health consumer and a formerly homeless person who is a long-time leader in the mental health consumers movement, and Sister Mary Scullion, an advocate, invited people who were living on the street to join them in a vigil outside the State Office Building to testify to the need for more supported housing for those who were mentally ill and living on the street. Governor Casey sent the state's Secretary of Public Welfare to meet with those encamped outside and agreed to develop and provide operating support for 150 units of housing that winter. In the following winter of 1988, homeless people and their supporters took over the basement of the Philadelphia Municipal Services Building to provide shelter for those who had none that winter, and refused to leave until the city made provisions for those still living outside. This move by homeless advocates brought attention to the issues of homelessness and the need for public support to assist in finding solutions to end homelessness.

In the 1990s, the focus was on addressing the critical need for affordable housing for single people and families as well as the need for jobs that paid living wages. Much of the activism arose from discrimination that faced those without a home, and used slogans such as "It is not a crime to be homeless," "People are more important than sidewalks," and "Homelessness is the crime not homeless people" to catch public attention and support. When Philadelphia's new Convention Center was set to open in the mid-1990s, anxiety focused on whether conventioneers would be reluctant to come because of people sleeping on the streets. Fortunately, the first convention was the National Conference of Mennonites. Local advocates met with some of the Mennonite leadership and they agreed to march with homeless people from the Convention Center to 1515 Fairmount to City Hall in solidarity with the plight of those who are low-income and without a home. This drew great press because it was the antithesis of what the city expected from conventioneers—a march on behalf of those who were sleeping outside.

The role of the homeless advocates has also been very successful in rallying community support on the issues of homelessness in the political arena. For example, during the 1999 election of Philadelphia's mayor, homeless advocates formed a nonpartisan coalition called "Election '99: Leadership to End Homelessness," to educate the community through forums and workshops on the issues of homelessness, in addition to registering to vote over 2,000 homeless and low-income individuals. Members of the coalition also organized a forum with the mayoral candidates on homelessness and housing to examine the candidates' strategies for creating additional affordable housing units as well as obtaining their commitment to find solutions to end homelessness. The Candidates' Forum on Homelessness and Housing was attended by more than 800 people; in addition, members of the coalition published and distributed throughout the community more than 10,000 copies of the Voters Guide on Homelessness and Housing.

The efforts of the coalition continued during subsequent elections, in which members of the coalition lobbied to place homeless issues on the agenda of candidates seeking election in the 2000 election of Philadelphia's State Senators and the 2002 election of the Pennsylvania Governor. Through websites, newsletters and pamphlets, members of the coalition have been able to educate voters on the election process and the candidate's political stances concerning the issues of homelessness and affordable housing.

Continued Vigilance

The give and take of working together but still looking out for individual interests continues in Philadelphia. In 1999 an ad hoc group called the "Sidewalk Ordinance Task Force" began monitoring how police enforced the Sidewalk Behavior Ordinance and the commitment of the city to providing additional services that assisted homeless individuals. Through this task force, members of the community formed "Street-Watch," a collaborative of members from various organizations, to monitor the streets and ensure that homeless individuals were being treated with dignity and respect. Through evidence gathered during this monitoring, advocates were able to document less than complete adherence of police to the spirit of the Ordinance, and apply pressure to get the police to comply. Thereafter the police department began working with community outreach teams to assist homeless individuals obtain shelter and services.

Philadelphia Site Visit Participants

Participants	Organization
Jenlene Arringon	Philadelphia Health Management Corporation
Stephanie Baralecki	Project H.O.M.E.
Lou Barnett	SELF, Inc.
Matthew Berg	OESS
Carl Browne	St. John's Hospice
Jenny Burns	Mary Howard Health Center/HCH/PHMC
Emily Camp-Landis	Office of Adult Services Managing Director's Office
Marsha Cohen	Homeless Advocacy Project
Beverly Coleman	Philadelphia Neighborhood Development Corporation
Brenda Cooper	Horizon House
Kathleen Coughey	Philadelphia Health Management Corporation
Mike Covone	BHS
Gerard Devine	Office of Adult Services Philadelphia Housing Support Center
Susan Dichter	Bethesda Project
John Domzalski	Department of Public Health
David Dunbeck	Horizon House
Leticia Egea-Hinton	Office of Adult Services
Jonathan Evans	MHA/Access, West Philadelphia
Kim Flaville	Connelly Foundation
Elaine Fox	Philadelphia Health Management Corporation
Gloria Guard	People's Emergency Center
Elaine Harmon	OESS Intake for Single Men
Harriet Herman	1260 Housing Development Corporation
Liz Hersh	Pennsylvania Low Income Housing Coalition

Rob Hess	Office of Adult Services Managing Director's Office
Linda Hicks	One Day at a Time
Keith Johnson	SELF, Inc.
Frank Jost	BHS/AAS
William Kaiser	Project H.O.M.E.
Dee Kaplan	Philadelphia Workforce Development Corporation
Gerald Kaufman	Awbury Arboretum Association
David Koppisch	Women's Community Revitalization Project
John Kromer	Fels Institute of Government, University of Pennsylvania
Walt Kubiak	1260 Housing Development Corporation
Lynn Lampman	Episcopal Community Services
Winnie Lau	United Way of SEPA
Marvin Levine	BHS/CODAAP
Paul Levy	Center City Business District
Wes Lilly	Horizon House/Kailo Haven
Jeannine Lopez	Project H.O.M.E.
William Maroon	RHD/Ridge Avenue Shelter
Sharmain Matlock-Turner	Greater Philadelphia Urban Affairs Coalition
Alba Martinez	Department of Human Services
Joan McConnon	Project H.O.M.E.
Mary Melaragni	Office of Housing and Community Development Policy and Planning
Jennine Miller	Project H.O.M.E. Eduction and Advocacy
Dainette Mintz	Office of Housing and Community Development
Jennifer Mitchell	Ready, Willing, and Able
Genny O'Donnell	Project H.O.M.E. OCC
Tom O'Hara	OMH

Barnabas Okeke	OMH/MR Research and Information Management
Sandy Orlin	Mary Howard Health Center/HCH/PHMC
Jeff Petraco	Office of Social Services
Jim Piasecki	RHD
Susan Pingree	Office of Social Services
Joe Pinhak	St. John's Hospice
Harvey Portner	Professional Healthcare Institute
Joye Presson	People's Emergency Center
Emily Riley	Connelly Foundation
John Ross	Philadelphia Police Department
Gregory Russ	Philadelphia Housing Authority
Joyce Sacco	RHD/Ridge Avenue Shelter
Sam Santiago	Project H.O.M.E. OCC
Will Sassaman	Hall-Mercer CMH/MRC of Pa. Hospital/UPHS
Mark Schwartz	Regional Housing Legal Services
Sr. Mary Scullion	Project H.O.M.E.
Angelo Sgro	Bethesda Project
Roberta Sharpe	Office of Adult Services Managing Director's Office
Susan Sherman	Independence Foundation
Linda Staley	Philadelphia Housing Authority
Carla Stanford	Horizon House Homeless Services
Marilyn Stewart	Defender Association of Philadelphia
David Thomas	Redevelopment Authority
Steve Thomas	Corporation for Supportive Housing
John Thompson	HUD
Melody Tingle	Horizon House, Homeless Services

Bridgette Tobler	OMH/Access to Alternative Services
Deborah Wagner	Catholic Social Services Holy Family Center
John Wagner	Catholic Human Services Archdiocese of Philadelphia
Laura Weinbaum	Project H.O.M.E.
Sharon Welsh	OMH/Access to Alternative Services
Mark Whiteman	RHD/Kailo Haven/RHD Homeless Coalition
Jeff Wilush	Horizon House

Philadelphia Acronyms

AS	Adult Services
BHS	Behavioral Health System
CBH	Community Behavioral Health
CDC	Community Development Corporations
CODAAP	Coordinating Office of Drug and Alcohol Abuse Programs
DCED	Department of Community and Economic Development
DHS	Department of Human Services
DHSS	Center for Mental Health Services
DPH	Department of Public Health
HFF	Housing For Families
H.O.M.E.	Housing, Opportunity, Medical Care and Education (Project H.O.M.E.)
HSC	Housing Support Center
HSDF	Human Service Development Funds
IDIS	Integrated Data Information System
MOU	Memoranda of Understanding
NTI	Neighborhood Transformation Initiative
OCC	Outreach Coordinating Center
OESS	Office of Emergency Shelter and Services
OHCD	Office of Housing and Community Development
OMH	Office of Mental Health
OSHA	Office of Service to the Homeless and Adults
PHA	Philadelphia Housing Authority
PHMC	Philadelphia Health Management Corporation
PWDC	Philadelphia Workforce Development Corporation
RHD	Resources for Human Development
RWJ	Robert Wood Johnson Foundation

APPENDIX F: SAN DIEGO

San Diego—Brief Description

San Diego is the nation's 7th largest city, with a 2000 population of 1.2 million in a county of 2.8 million. The city has been gaining population steadily for several decades, [33] and passed the 1 million mark with the 1990 census. The 2000 poverty rate for the city of San Diego was 14.6 percent, higher than the nation's and San Diego County's, which were both 11.3 percent. The average 2002 unemployment rate for the San Diego MSA was lower than the nation's (4.1 versus 5.8 percent).[34] The military comprises an important part of San Diego's employment, even after base closings, and the city remains the main Navy port on the West Coast. Many military personnel and ex-military people live in San Diego, a fact echoed in its homeless population. About 40 percent of San Diego's single homeless people are veterans, compared to 26 percent for single homeless people in the whole country.

San Diego's downtown area has undergone considerable redevelopment in recent years, adding a convention center, considerable waterfront development, office buildings, and both market rate and affordable housing. With development of each major downtown section, the homeless street people who frequented the area found themselves displaced. As downtown became revitalized, the issue of street homelessness and what to do about it became a focus of discussion. Some activities to address street homelessness were already under way when the decision was taken to build a new major league ballpark downtown, in an area that had become the most recent center of street homelessness. The impending ballpark development galvanized San Diego businesses and government agencies to get serious about reducing street homelessness in a responsible way.

On our visit to San Diego on April 22-24, 2003, we interviewed 55 people. They represented city and county agencies; nonprofit outreach, drop-in, shelter, and housing providers; agencies serving homeless people through casework, mental health and substance abuse treatment, health care, and employment services; community development/neighborhood revitalization organizations; and law enforcement. People who had experienced chronic street homelessness were included in a separate focus group and as representatives of organizations for which they now work. A full listing of persons interviewed, other than focus group participants, may be found at the end of this appendix.

Practices of Potential Interest to Other Jurisdictions

San Diego's Special Needs Homeless Initiative has several practices that may be of interest to other communities; some it started and others were ongoing programs that the Initiative tapped.

---

[33] http://www.census.gov/prod/2002pubs/00ccdb/cc00_tabC1.pdf.

[34] 2000 poverty statistics for San Diego City, http://censtats.census.gov/cgi-bin/pct/pctProfile.pl; poverty statistics for San Diego County, http://factfinder.census.gov/servlet/BasicFacts; for United States, quickfacts.census.gov/states/00000.html; February 2003 unemployment statistics for San Diego County, http://data.bls.gov/cgi-bin/surveymost; for United States, www.bls.gov/cps/home.htm#overview.

- **Police approaches—HOT, SIP.** The San Diego Police Department has long been known as an innovator in developing approaches to resolve community issues. With respect to the chronic street homeless population, it participates with other agencies in two outreach teams that cover the major disabilities of mental illness and substance abuse. Homeless Outreach Team (HOT) combines uniformed officers, a mental health worker, and a benefits eligibility worker, who connect with the hardest-to-serve street homeless with mental illness, assess their needs, qualify them for services, and help place them in suitable programs. The Serial Inebriates Program (SIP) teams follow a Drug Court model, with officers who work as "probation officers" in enforcing court mandates, the San Diego Superior Court, the City Attorney's Office and the Public Defender to give chronic public inebriates living on the streets a choice between up to 180 days in custody or an alcohol treatment program, and caseworkers who follow people once they are in treatment. These programs have a high success rate and recover their costs by reducing expenditures on arrests, transportation, bookings, detox and emergency services. (Contact person: for HOT—Scott Bender, Sergeant, San Diego Police Department, sebender@pd.sandiego.gov; for SIP—Rich Schnell, Sergeant of Western Division and Police, San Diego Police Department, rschnell@pd.sandiego.gov; same phone number for both—619.692.4800.)

- **Integrated Services for Mentally Ill Homeless People—REACH.** This county and city collaborative has placed over 250 mentally ill and dually diagnosed homeless persons into downtown housing and intensive case-managed treatment. San Diego Housing Commission (SDHC) helps fund the housing portion of the program while the state-funded AB 2034 program operating through the county Mental Health Services (CMH) funds mental health and other services through a flexible funding pool that will cover "whatever it takes." The county and city contract with non-governmental agencies to provide case management and supportive services. Nonprofits are assisting in the development of housing. (Contact person: Piedad Garcia, Project Manager, REACH, County of San Diego, piedad.garcia@sdcounty.ca.gov, 619.563.2763.)

- **Ad Hoc Committee on Downtown Homelessness.** An Ad Hoc Committee emerged when the downtown business association, city staff, county staff and developers needed to address the displacement of homeless persons anticipated from building a new downtown baseball park. The committee has no formal existence, and provides an open forum in which to establish goals, discuss issues and work out collaborative solutions. The participants are high-ranking individuals within their own agencies, with the power to make decisions and commit resources. The informal work of the Ad Hoc Committee has been the foundation for formal agreements and collaborative proposals to funding sources. (Contact person: Sharon Johnson, Homeless Services Administrator, City of San Diego, srjohnson@sandiego.gov.)

- **Joint RFP for Transitional Housing and Permanent Supportive Housing.** The Centre City Development Corporation (CCDC), the City of San Diego, the County of San Diego, the San Diego Housing Commission, and the Corporation for Supportive Housing issued a joint request for proposals to develop and operate transitional and permanent supportive housing for special needs homeless persons. By coordinating the funding and proposal process, the Ad Hoc Committee facilitates the work of potential respondents and leads

them toward integrated services. (Contact person: Dale Royal, Senior Project Manager, Centre City Development Corporation, royal@ccdc.com, 619.533.7108.)

- **Redevelopment Agency Incremental Tax Revenue Funds—CCDC.** A redevelopment agency helps to create new developments and economic activity, generating new tax revenues for the jurisdiction. California law stipulates that the redevelopment authority receive back a share of these additional taxes (called tax increments), and says that the authorities must invest at least 20 percent of the money they get back to increase affordable housing (tax increment financing (TIF)). San Diego's Centre City Development Corporation invests these funds in affordable housing projects, some of which set aside about one-fourth of their units for the special needs homeless population. (Contact person: Donna L. Alm, Vice President, Marketing and Communication, Centre City Development Corporation, alm@ccdc.com, 619.533.7120.)

- **Psychiatric-Family Practice Program Residents at Health Clinic for the Homeless–St. Vincent de Paul Village.** The St. Vincent de Paul Health Clinic substantially strengthens its health services by partnering with the University of California San Diego Medical School to train interns with a dual residency in psychiatry and family practice. Frequently, the interns identify mental health issues when patients arrive with a medical problem. Treatment can normally begin immediately without referrals to other agencies. (Contact person: Margaret McCahill, Director, Clinical Services, St. Vincent De Paul Village, mmccahill@ucsd.edu, 619.233.8500 ext.1526.)

Primary Contact Person

Matthew Doherty, Program Officer
Corporation for Supportive Housing
1901 First Avenue, 2nd Floor
San Diego, CA 92101
Telephone: 619.232.3194
Fax: 619.232.3125
E-mail: matthew.doherty.csh.org

History and Context—How the Current System Evolved

Some significant activities to address chronic street homelessness were already under way in San Diego before the ballpark issue led to a coordinated community-wide response:

- A collaborative called Solutions, led by St. Vincent de Paul, formed in 1994 to provide coordinated services to the city's homeless population. Solutions brought together the primary nonprofit providers as well as a few small public agencies.

- In 1998, homeless advocates felt that the city was not doing enough for homeless people. They staged a camp-out in front of the municipal building, which grew over the course of a few months from a few people to more than 300. When the camp-out grew so large, the

police received an order to remove the campers because they were illegally occupying city property. The police department responded in a unique manner, out of its problem-solving, community-oriented approach. It brought a group of officers to the site and interviewed everyone there, asking who they were and what they needed to get off the street. The officers quickly realized that the issues raised required responses beyond anything the police could muster. Needs included access to public benefits, mental health and other services. Hot was born out of this realization, and the first HOT team launched as a pilot project.

- HOT combines police officers, mental health/substance abuse workers, and cash assistance eligibility technicians in teams that seek out the hardest-to-reach homeless people. Because they combine police and mental health expertise and authority, they are the only outreach teams on the streets that have the ability to remove people either voluntarily or involuntarily, in addition to building rapport and making referrals. By 1999, HOT had just completed a successful pilot, documenting both that people could be helped and that it could save the city and county money being spent on crisis services and law enforcement.

- By 2000 the SIP was also being implemented. SIP is a "drug court" type collaboration of four city and five county agencies, including law enforcement, courts, health care, and homeless agencies. SIP forces chronic homeless inebriates to choose between extended time in jail or treatment and social services.

As the potential displacement of homeless individuals by the planned stadium grew as an issue, Mike Madigan, a private developer who was in charge of the ballpark development, spearheaded a group that came to be known as the Ad Hoc Committee on Downtown Homelessness, made up of individuals from public agencies and the business community. The "think tank" players included Elizabeth Morris, CEO of the San Diego Housing Commission; Donna Alm, Vice President of Centre City Development Corporation (CCDC); Laurie Black, then president of the Downtown San Diego Partnership and an experienced advocate for homeless people with mental illness or co-occurring disorders; and Lynne Heidel, chair of the CCDC Board of Directors. People describe this group's approach as, "Our approach was to sit around the table and ask ourselves what should our approach be." Committee members think their success is due to the many conversations they had and their commitment to seeking information until they felt they knew what they wanted to do and something about how they could do it.

Soon the San Diego City Manager provided resources in the form of Ann Hix, a planner from the City Manager's office. Ann, who estimates she spent half her time for a year on the effort, is described as "the glue that kept it all together." Madigan's and Hix's success in their roles as leaders of the effort is attributed to their neutrality. They started the process knowing nothing about homelessness or homeless programs but were willing to learn and had no preconceived ideas. They went everywhere, asked endless questions, brought fresh perspectives to existing programs, and thought about, "Why couldn't we do X?" rather than, "We've never done it that way." The combination of their politics also helped. One was a liberal public servant, the other a conservative businessman. When both of them agreed on a course of action, they tended to carry the day with audiences across the political spectrum.

Meanwhile, Heidel and Black kept the business community up to date with the Committee's thinking and garnered its support to move forward in a positive way to reduce street homelessness in the downtown area.

By December 1999, the Committee's five-part Special Needs Homeless Initiative had been presented to and approved by the San Diego City Council. Its parts included:

- Creating a centralized intake and referral system and locating a facility;
- Building transitional housing beds for special needs homeless people;
- Building permanent supportive housing units for special needs homeless people;
- Expanding residential alcohol and drug treatment programs for substance dependent and dually diagnosed homeless people; and
- Evaluating and expanding the Police Department's Serial Inebriate Program.

The Initiative's work has been facilitated by taking advantage of opportunities to draw on new resources:

- Under AB 2034, state funding for integrated services for severely mentally ill homeless people became available statewide (after a demonstration year in three counties under AB 34) just as the Ad Hoc Committee was completing its formulation of the types of programs it wanted to develop for this population. San Diego County's Mental Health Services Division applied for a $10.3 million competitive grant, which was awarded in December 2000.
- The Corporation for Supportive Housing's initial efforts to open a San Diego office were then encouraged and supported by Hix and Madigan, so expertise in and resources for developing and operating permanent supportive housing became available.

The committee met (and still meets) monthly. It drew in more and more agencies and resources as it identified needs and invited the participation of agencies that could help meet them. Meetings included self-education, inviting people to make presentations, and learning more about the issues and problems of San Diego's chronic street homeless population, as well as identifying who could bring what resources to the table. In addition, Hix and Madigan spent hours visiting and interviewing providers about what they offered, speaking with homeless people, seeking information on potential models in use elsewhere and visiting some of them. Ultimately the approach selected was a comprehensive one, with plans to include everything from outreach through affordable housing.

In winter 2002, CCDC, the City of San Diego, Corporation for Supportive Housing, County of San Diego, and the San Diego Housing Commission SDHC, the city's public housing authority developed a memorandum of understanding among themselves outlining resource and other commitments, and issued a first-ever joint request for proposals. This Request for Proposal (RFP) "To Develop and Operate Transitional and Permanent Supportive Housing Facilities in the

City of San Diego for Homeless Adults with Serious Mental Illness or Dual Diagnosis" invited qualified housing developers, nonprofit organizations, property owners, and development teams to submit proposals to begin to meet the second and third parts of the Committee's five-part plan. Responses to the RFP got the ball rolling on creating more supportive housing, representing a key strategic initiative for achieving the goals of creating 100 new transitional and 100 new permanent supportive housing units in the next several years. In addition, these agencies and others worked together to secure Assembly Bill (AB) 2034 funding for the Reaching out and Engaging to Achieve Consumer Health (REACH) program, which has gone a long way toward meeting the goal of central or coordinated intake for chronically homeless people with mental illness.

Several circles of influence were essential in bringing the approach from plans to reality. These include:

- **The Ad Hoc Committee.** A small group of key decision makers from essential city and county departments plus the Downtown San Diego Partnership and the Corporation for Supportive Housing.

- **Local elected officials.** Part of the Ad Hoc Committee's success lies in drawing in players from both the city and county, in a spirit of cooperation that was unprecedented in San Diego up to that point. When the Committee was ready, it asked for, and got, an historic, first-time joint meeting of the City Council and County Board of Supervisors. These two bodies committed themselves to the plans offered by the Committee and to working together to make them happen. This public commitment was an important policy success. The City Council and Board of Supervisors created a Joint City-County Homeless Program Committee and appointed two members from each body to serve on it. These members in turn assigned staffers to work on the committee, which held regular meetings at which staff of city and county agencies reported progress toward various goals and discussed ways to reduce any barriers that arose. This Joint Committee became an important avenue through which city and county agencies could talk to each other and develop collaborative plans.

- **The business community.** CCDC works closely with the business community. The portfolio of one staffer, Donna Alm, includes responsibilities to "solve problems" in the downtown area, so homelessness fell into her bailiwick. In addition, the chair of the CCDC Board, Lynne Heidel, became very interested in the issue and provided essential leadership. Laurie Black at the Downtown San Diego Partnership also played a key role in educating the business community and bringing it to the table. Guest speakers educated both Partnership and Ad Hoc Committee members about homelessness, the relation of mental illness and co-occurring disorders to homelessness, and best practices elsewhere in the state and country to address the needs of chronically homeless people.

The next section describes San Diego's approach to ending chronic street homelessness in its downtown area, including documentation of progress to date. Thereafter we give more detail on selected system components, examine funding mechanisms, describe how the current system evolved and where it is going, and describe issues that have arisen with respect to community relations.

Approach to Chronic Street Homelessness

This section briefly describes the network of programs and services focused on reducing or ending chronic street homelessness among single adults. It also examines characteristics of people the system serves, how services are coordinated, and approaches or models in current and anticipated use. Continuum of care components addressing chronic street homelessness are described in more detail in the section entitled "Selected System Components," along with activities and investments related to increasing the stock of affordable housing.

San Diego's approach to ending street homelessness in its downtown area employs four strategies: (1) examining the problem systematically, asking what will resolve it, and inviting "whomever it takes" to help do the job; (2) outreach involving police coupled with appropriate casework and services; (3) using the power of the courts, in an adaptation of the Drug Court model, to address chronic street homelessness among people with addictions; and (4) developing safe havens and Permanent Supportive Housing (PSH) as part of a larger strategy to develop affordable housing.

Program and Service Network

San Diego's efforts to reduce and ultimately end chronic street homelessness crystallized when the Ad Hoc Committee on Downtown Homelessness formed and proceeded to develop the Special Needs Homeless Initiative. We have organized the overview table (Table F.1) showing San Diego's program and service network to highlight the public agencies and business association that are lead partners for the Initiative. The housing and supportive services providers who make up the downtown network follow in alphabetical order.[35] Rows represent different providers; columns represent the types of programs and services offered. An "X" in a cell indicates that the provider offers that program or service. An "F" indicates that a public agency funds a program or service, and an "E" indicates that the provider offers expert advice, technical assistance, or training.

Involvement of Mainstream Agencies

As the rows of Table F.1 for the lead partners in San Diego's Special Needs Homeless Initiative make clear, many public agencies have been actively involved as funders, service providers, and experts offering training and technical assistance. CCDC, the Division of Homeless Services of the Department of Community and Economic Development (DCED), and the San Diego Housing Commission are the chief funders among city agencies. Among them they support every component of the continuum of care, from outreach to affordable housing. CCDC may be of particular interest to other jurisdictions because it is a redevelopment agency. It funds homeless programs within the entire continuum of care using Tax Increment Financing as well as other resources, and also specializes in developing affordable housing in the downtown area with units

[35] Table F.1 does not represent the entire network of homeless assistance programs and services in San Diego. These and other providers may also offer programs and services for single people with brief homeless experiences, as well as homeless families with children and homeless youth.

set aside for PSH. For a redevelopment authority, this is an unusual but exemplary level of involvement in providing solutions to chronic homelessness.

Supportive services, both attached to housing and independent of it, are funded by DCED (employment) and the mental health and substance abuse services units of the county's Health and Human Services Agency. The county's mental health services unit also provides supportive services directly to homeless and formerly homeless people with the goal of helping them achieve stable housing.

The San Diego Police Department is a key actor in the city's approach to ending street homelessness. The Department's long-standing commitment to community-oriented policing, with its emphasis on solving problems rather than just arresting people, (Goldstein, 1990; Kessler and Wartell, 1996) contributes two highly effective programs. HOT—focusing on street people with severe mental illness—began as a pilot in 1998, followed in 2000 by SIP that focused on homeless alcoholics. Their success at helping people leave the streets gave them the evidence needed to expand beyond the pilot phase to their current countywide levels.

Who Is Served?

San Diego's efforts to end street homelessness in the downtown area focus on people with long histories of homelessness plus one or more chronic health problems—primarily those with mental illness, substance abuse, or both. Development of safe havens has made it possible to accommodate people with major mental health problems but who may still be using drugs and/or alcohol. Chronic inebriates receive services through a variety of arrangements, including SIP's case management program.

Coordination Mechanisms

Planning and program development. The Ad Hoc Committee on Downtown Homelessness serves as the major coordination mechanism for planning, assembling resources, and developing programs related to ending street homelessness in downtown San Diego. The Committee meets monthly. It developed its comprehensive approach (from outreach to affordable housing), supported the design of the REACH Program,[36] developed strategies for addressing the housing opportunities necessary so that all REACH program funds could be applied to supportive services, and supported coverage of other parts of the street homeless population through HOT and SIP. Now the Committee is turning its attention to next steps.

[36] Funded through a California state program that supports "Integrated Services for Mentally Ill Homeless People" and is known by its legislative bill number, AB 2034.

Table F.1: City of San Diego: Agencies Involved in Reducing/Ending Chronic Street Homelessness

	Homeless-Related Programs and Services																						
	Prevention	Outreach/Drop-in	Shelter	Safe Havens	Transitional Housing	Permanent Supportive Housing	Other Housing (non-disabled)	Alcohol and Other Drugs	Mental Health	Health	Employment	Corrections	Public Assistance	Child Welfare	Advocacy	Food for Non-Residents	Case Management	Cross-agency Coordination of Service Access & Delivery	Planning	Staff Training	Data/Documentation	PR, Public Acceptance
Nonprofit Programs/ Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People (listed alphabetically)																							
Special Needs Homeless Initiative																							
Lead Partners																							
San Diego City Agencies																							
Centre City Development Corporation (CCDC)				F	F	F	F							X			X	X				X
Police Department (PERT, HOT, SIP)		X						X	X			X					X	X			X	X	X
Department of Community and Economic Development, Division of Homeless Services		F	F		F						F						F	X	X				
Housing Commission			E,F	E,F	E,F	E,F	E,F											X	X, E			X, E	
Attorney's Office, Community Courts												X						X					
Downtown San Diego Partnership (business association)		X,F													X			X	X				X
San Diego County Agencies																							
Mental Health Services		X,F	X,F	F	X, F				X, F								X,F	X	X			X	X
Alcohol and Drug Services		F						F									F	X					
Health and Human Services Agency		X				X, F				F			X				X						
Public Defenders Office (re SIP)								X				X						X					
Sheriff and Jail (re SIP)								X				X						X	X				
Support Services Partners																							
Alpha Project (R)		X	X			X					X						X	X					
Catholic Charities (R)		X	X		X			X	X		X					X	X	X					
Community Research Foundation (R)								X	X	X	X						X	X					
Corporation for Supportive Housing (R)						E, F					E				X			X	E	X, E		X, E	
Episcopal Community Services (R)		X		X	X						X							X					
Family Health Centers of San Diego (R)									X	X								X					
Mental Health Systems, Inc. (SIP, other case management)		X						X	X								X	X					
San Diego Rescue Mission			X	X	X											X	X						
Salvation Army		X	X		X																		
St. Vincent De Paul		X	X	X	X	X	X	X	X	X	X					X	X	X					
Senior Community Centers		X			X	X										X	X	X					
Telecare (R)		X							X									X	X				
Vietnam Vets of San Diego			X		X			X			X							X					
Volunteers of America								X															
Local Elected and Appointed Officials (Mayor, City Manager, City Council, County Board of Supervisors)																		X	X				

X = Provider E = Expert TA Provider F = Funder R = Involved with REACH program

The Ad Hoc Committee includes all the major governmental and business entities involved in addressing street homelessness for downtown San Diego. The committee has no formal existence, which members say is its strength. Its unbureaucratic and unofficial nature allows each participating agency and organization to be frank about its issues and tensions, as well as about its resources and abilities. Attendance by agency heads means that the power is present to make decisions, commit agency resources, and see that plans are carried to completion. Peer-to-peer accountability once commitments have been made keeps things moving forward, and peers can help troubleshoot bottlenecks and barriers and offer their own resources to help regain momentum if things do not work as expected.

Working with chronic street homeless people. Mental Health Services, Inc. (MHS) is the lead agency for the REACH Program, which coordinates services for mentally ill homeless individuals through many partners who together serve the complex needs of its target population. For the REACH Program, MHS contracts for outreach, case management, substance abuse, mental health, physical health, drop-in, and employment and training services. It also contracts for drop-in, safe haven, transitional, and permanent supportive housing, and with the San Diego courts to have a probation officer assigned directly to REACH to help clients with outstanding legal issues.

Several outreach activities coordinate their efforts. HOT, covering the whole City of San Diego, is the first line of approach to disabled people living on the streets. Thanks to AB 2034 funding, HOT has 19 safe haven beds dedicated to people the team brings in, so HOT can get people into a bed as soon as someone says "yes." Teaming with an income maintenance eligibility worker adds another crucial element to the HOT teams' arsenal—the ability to connect street homeless people to public benefits that facilitate their getting off the street.

HOT focuses on people who are more likely to have mental illness as a primary problem and are not likely to get arrested. HOT gets them into safe havens, board and care facilities, and skilled nursing facilities, depending on their level and type of need. When HOT encounters alcoholics it offers rehabilitation and help getting into appropriate care for those who are interested.

SIP comes into play for chronic inebriates who do not seek treatment voluntarily. SIP is a collaboration of four city and five county agencies, including law enforcement, courts, health care, and homeless agencies. SIP works toward assisting chronic homeless inebriates to access treatment and social services. At this time (summer, 2003), an individual arrested by the San Diego Police Department for public intoxication will be taken to the Inebriate Reception Center for evaluation. As generally happens, this individual is identified by the Center as a chronic abuser of services or "Serial Inebriate" and refused admission. Police then take the individual to the county jail and place him into custody pending arraignment. At arraignment, the inebriate is sentenced to the maximum allowed by law (usually 179 days), and also informed that he may speak with a case manager, be assessed, and if approved for treatment, waive jail time to attend a treatment program. If the individual agrees, an assessment interview takes place and is used to determine whether the client is appropriate for treatment services (as a rule individuals with a history of violence, arson, or who are registered sex offenders are excluded). If the individual is considered appropriate for treatment, an order of release is drafted and the individual is released to the custody of the San Diego Police Department, which in turn transports him or her to the designated treatment center for intake. Reasons for denial mainly relate to the judgment that the

person is not truly interested in treatment. As soon as a person is accepted into treatment and agrees to go, the caseworker will help resolve any issue or problem, including mental illness, dual-diagnosis, or corrections-related problems, through linkages within the casework organization attached to SIP. Failure to complete treatment results in issuance of a warrant and a return to custody.

The San Diego City Attorney's office and the San Diego Superior Court work hand-in-hand with SIP. The City Attorney's office is organized by geographical area. It has a special unit of five attorneys plus a supervisor with responsibility for people in the downtown area who are long-term problems, and therefore also for legal problems related to homelessness. The unit gets all the SIP cases that come in for prosecution, which they handle vertically (the same attorney handles the case from beginning to end). Along with the Public Defender and the San Diego Superior Court, the unit has developed a sentencing structure of jail or treatment modeled on drug court. This approach is "something different" for this population, for which the revolving door of arrest and detoxification was not working. The approach is also designed to reduce the impact of public drunkenness on the community.

Pathways to Housing, Approaches and Models

In addition to the traditional pathway of progressing through emergency and transitional housing to PSH, San Diego's street homeless population follow two routes that involve police outreach teams, and one that involves recruitment directly into housing.

- *HOT to safe haven to housing*. The HOT team brings chronically homeless people with a serious mental illness to one of the safe havens, where they can stay until they can be incorporated into REACH or other PSH arrangements. HOT can also put people directly into board and care or skilled nursing facilities, if their condition warrants such placement.

- *SIP to court to substance abuse treatment to regular housing*. Once a person arrested by SIP officers agrees to treatment, he or she usually moves to a transitional housing program and begins attending outpatient substance abuse treatment, or moves to a residential substance abuse treatment program. Twenty-two county-funded providers offer residential or outpatient treatment services and every client choosing to enter treatment has been housed during the treatment period. After completing outpatient treatment, the person may stay in transitional housing or, if employed, may move to his or her own residence.

- *REACH Program (AB 2034) outreach to "housing" to PSH*. REACH Program outreach workers or the HOT team makes initial contact. People who accept "housing" are usually moved to a shelter, hotel room, or safe haven until they can be placed in PSH.

Selected System Components

San Diego's Special Needs Homeless Initiative guides a system for reducing the downtown chronic street homeless population that includes most of the usual CoC components. As Table

F.2 indicates, most of the agencies serving chronic street homeless people offer only a few aspects of a CoC rather than the whole spectrum. Only one, St. Vincent De Paul, comes close to being a mini-continuum within its own walls as it offers many interconnected CoC services.

Several agencies within the system make outstanding contributions. The Police Department's role through HOT and SIP have already been noted. St. Vincent de Paul provides outreach/drop-in, case management, all types of housing (emergency shelter, safe havens, transitional housing, permanent supportive housing and independent living) and support services related to substance abuse, mental health, and health problems.

The Centre City Development Corporation, the downtown redevelopment agency, receives substantial funding from tax increment revenue derived from its redevelopment efforts and devotes a portion to developing housing for the downtown special needs homeless population. CCDC funds transitional and permanent supportive housing. It is also very active in creating affordable housing, which it extends to formerly homeless people by requiring some developers to set aside a significant proportion of units (sometimes as many as 25 percent) to be used as PSH for disabled formerly homeless people. CCDC also plays a strong role in advocacy, cross-agency coordination, planning, and public relations. City and county agencies including SDHC, DCED, and CMH also play critical roles.

Outreach and Drop-in

San Diego's most innovative outreach programs are HOT and SIP, whose coordinative mechanisms have already been described.

While the case management and treatment parts of SIP do not do outreach and receive referrals primarily through the court, the police team end of SIP is active on the streets. A significant proportion of HOT and REACH Program outreach is done through traditional methods of contacting individuals at emergency shelters, day centers, and food lines. When the REACH Program began, it did extensive outreach of this type to fill its treatment slots (250) within the short time allowed by the program. Once the REACH Program had its full contingent of clients, outreach dropped off considerably; many new clients come through HOT and the safe havens. But REACH Program staff still do some outreach through traditional channels, as do St. Vincent de Paul, San Diego Rescue Mission, Alpha Project, and Salvation Army.

Emergency Shelters

According to the Regional Task Force on the Homeless, in April 2002 the city had only 282 emergency shelter beds for singles, but an estimated 4,450 unaccompanied homeless adults in the City of San Diego. San Diego's largest providers of emergency shelter emphasize linking their clients to case managers and transitional services, so turnover in the small number of beds is quite rapid

One innovative emergency shelter service for women grew out of a day center operation. With REACH Program funding, Rachel's Women's Center extended its day services to provide an emergency nighttime drop-in center as well. In a large common area Rachel's accommodates up

to 35 women during the night. It does not have beds or provide meals, but it does provide beverages and large comfortable chairs and sofas on which women can rest during nighttime hours. The room presents a non-threatening atmosphere with nice furnishings including tables, board games, televisions, and a video library. Open from 9:00 in the evening to 6:00 in the morning, Rachel's is known as a place where women can seek shelter at any time.

During winter months, San Diego City funds the operation of a huge shelter tent for emergency shelter. Many street homeless people who avoid the regular emergency shelters do make use of the tent on the coldest nights, and thus become at least minimally known to the system.

Low Demand Transitional Residences

San Diego's Special Needs Homeless Initiative uses safe havens operated by Episcopal Community Services and low demand residences operated by the San Diego Rescue Mission and St. Vincent De Paul. CCDC helped fund the development of this housing, SDHC helps subsidize the housing and CMH helps fund substance abuse, mental health, and health services for the residents.

Transitional Programs

This is the largest category of residential assistance in San Diego's homeless assistance network, with 1,922 beds, although even here the city considers that it has a huge gap and could use two to three times as many transitional slots for singles. The largest providers of transitional housing for singles are St. Vincent de Paul, San Diego Rescue Mission, The Salvation Army, Vietnam Vets, the Alpha Project, Community Resources and Self Help, Inc., and the YWCA. Funding for supportive services in transitional housing programs comes from DCED and CMH, as well as directly from HUD.

Transitional housing plays an important role in the REACH Program because there are not sufficient permanent supportive beds available and some participants need more intensive services that are available in existing permanent supportive housing programs. An increase in permanent supportive housing would reduce the wait for transitional housing by allowing more people to exit that stage.

Permanent Supportive Housing

As of April-2002, San Diego had only 382 permanent supportive housing beds for singles. Rough estimates of the number of chronic street homeless people in downtown San Diego range between 1,000 and 1,500, so even with the innovative programs already in existence or being developed, the city has some way to go to meet the need.

St. Vincent de Paul, Episcopal Community Services, Alpha Project, The Association for Community Housing Solutions, and Pathfinders are the primary providers of permanent supportive housing for the Special Needs Homeless Initiative, although new providers will become involved as the units developed under the Initiative come on line. CCDC helps fund the

development of many the housing units, with SDHC supplying Section 8 vouchers to pay the rents. San Diego County's Mental Health Services, Alcohol and Drug Services, and Health and Human Services Agency help fund the services, which are primarily provided through contracts with nonprofit agencies. Alpha Project also gets money ($1 million over three years) from California's Supportive Housing Initiative Act (SHIA) for supportive services in the housing it operates.

A crucial component in the Special Needs Homeless Initiative's support services is San Diego REACH, a program for mentally ill homeless individuals. MHS is the lead agency for REACH, San Diego's AB 2034 program to bring mentally ill street homeless persons into permanent supportive housing. SDHC, an equal partner in the program, supplies the housing subsidies (Section 8 vouchers). The participation of SDHC allows San Diego to use most of its AB 2034 funding for supportive services and thus serve more people, instead of having to devote some of its state funding to housing as happens in some other California counties.

AB 2034 expanded to new counties a pilot program to integrate services for homeless adults with serious mental illness. The Ad Hoc Committee seized this opportunity to put together and lobby for a joint proposal with city, county, business and nonprofit involvement. The committee sent to Sacramento a intergovernmental delegation of five that literally walked the corridors of California's capitol. The members impressed legislators with their degree of collaboration and fervor for the project, and the project was approved and implemented successfully.

REACH met its enrollment goal of 250 formerly homeless, mentally ill and dually diagnosed individuals ahead of schedule. The REACH Program has many partners who together serve the complex needs of its target population. CMH, the REACH Program's parent agency, contracts with Telecare to perform outreach and provide case management services, and with Community Research Foundation to provide employment, rehabilitation, and recovery services, including substance abuse and mental health services to support REACH Program participants. Family Health Centers of San Diego addresses the physical health needs of REACH clients. Episcopal Community Services provides drop-in and employment services and safe haven housing opportunities. Catholic Charities' Rachel's Women's Center, including the nighttime drop-in center, is part of the REACH network. Alpha Project and TACHS operate housing units where REACH clients live, and TACHS also provides housing development and housing locating services. REACH also contracts with the San Diego County Probation Department to have a probation officer assigned to work directly with the REACH team. This officer is able to help many REACH clients clear up outstanding legal issues (for example, warrants, criminal background checks) in her role as liaison between clients and the courts.

The success and popularity of REACH and 32 other AB 2034 programs funded throughout California is apparent from its continuing legislative support. Despite the state's fiscal crisis, the program continues to be part of the adopted 2003-2004 budget.

To increase permanent supportive housing, the Corporation for Supportive Housing (CSH) facilitates proposals, trains agency staff, coordinates agency efforts, plans projects, advocates for projects and engages in general public relations and education. CSH had begun to implement planning initiatives in San Diego and was then actively encouraged in its efforts to open a San Diego office as a direct outgrowth of the Special Needs Homeless Initiative. Key Ad Hoc

Committee members learned of CSH's purpose and activities and realized that it could offer a great deal of help in meeting the Initiative's goals.

Supportive Services

Two of San Diego's most important programs focused on chronic street homeless people use an interesting approach to delivering supportive services to keep people in housing—they contract with behavioral health companies, one for-profit and one nonprofit. REACH contracts with Telecare Corporation for mental health case management, while Mental Health Systems, Inc. provides assessment, case management, and substance abuse and mental health services for SIP participants. REACH Program participants may also access other providers for a variety of services. These companies are able to deliver appropriate care with workers who often are dual-certified for mental health and substance abuse treatment. They are also sophisticated enough to handle Medicaid (Medi-Cal in California) claims, and are able to finance a significant portion of the services they provide through Medi-Cal billing (after getting clients onto Supplemental Security Income (SSI) and Medi-Cal). The more Medi-Cal pays for the services it will cover, the more program service dollars can be devoted to other service needs.

Other agencies providing support services for people in permanent supportive housing through the Homeless Initiative are MHS (mental health), Catholic Charities (mental health), Family Health Centers of San Diego (health and mental health), Vietnam Vets (substance abuse), and Volunteers of America (substance abuse).

St. Vincent de Paul Village (the Village) offers supportive services to people in its own housing programs and to the general population not living at the Village, whether or not they are or were chronically street homeless. It also offers a very important and otherwise unavailable service to chronic street homeless and other needy persons through its health clinic. Here, people who are not Medi-Cal beneficiaries can receive substance abuse, mental health, and health services—including dentistry and eye care. The clinic is convenient to the residents of the Village's own housing programs; others must come to the Village site for care. The clinic is complete with examination rooms and diagnostic equipment. Patients can receive free dentures, which improve their appearance and self-image, and free glasses, which improve their vision and confidence. The Health Clinic strengthens its program by partnering with the University of California San Diego Medical School to train interns specializing in the treatment of mental illness and substance abuse. It offers the only program in the country where interns and residents can receive dual certification in psychiatric services and "homeless medicine." The Health Clinic also helps clients qualify for SSI, and thus Medi-Cal. Once on the Medi-Cal rolls, clients must transfer to a managed care organization for health care. Ironically, this may lead to a decline in the level of health care received, as St. Vincent's is certainly more attuned to the street homeless population than is the typical Medicaid managed care organization. Combining medical and social work expertise with over 15 years of experience, the Health Clinic has good first time success rates when it helps individuals file SSI eligibility applications. Most agencies in our study reported that SSI eligibility applications are usually bounced back at least once.

Affordable Housing

A lack of affordable housing affects chronic street homelessness just as it affects other homelessness, by creating pressures on households that are barely holding on to housing. SRO units and other inexpensive housing disappear, either through destruction or conversion to other uses, and people are displaced. For instance, at the same time the Ad Hoc Committee has been exerting effort to increase permanent supportive housing units, Federal courthouse expansion in downtown San Diego has "taken" the adjacent property—which was the San Diego Hotel, with 400 Single Room Occupancy units occupied mostly by low-income elderly people. So after several years of effort, San Diego currently has *fewer* affordable efficiency units than it started with, even though it has new units to its credit. As in most communities, affordable housing is a major concern in San Diego. Due to pressures on housing prices, San Diego's homeless population already includes a significant number of elderly people who are eligible to receive permanent supportive housing through the Senior Community Centers' development, which opened in August 2003. This senior housing complex may ease some of the pressure, but the loss of the San Diego Hotel threatens to at least double the current number of homeless seniors. Tens of thousands are assisted through housing programs, but hundreds of thousands are paying a painful proportion of their income for housing. The San Diego Housing Commission serves over 29,000 households each year through rental assistance (Section 8), public housing, rental housing production, rehabilitation, homeownership, and resident services.

SRO housing used to be the affordable housing of choice for single people with very low incomes. In San Diego as in most other cities around the country, SRO units were destroyed or converted to other uses throughout the 1970s and most of the 1980s. In the late 1980s and early 1990s, San Diego experienced some restoration of SRO housing through innovative development and zoning practices, and used some of it to house homeless people. However, rents have been rising steadily, and are often now in the $600+ range for what is essentially less than an efficiency apartment—clearly beyond "affordability" for people living on SSI's $550+ or other public benefit programs or even Social Security. San Diego's stock of SRO units has also been reduced through destruction (loss of the San Diego Hotel to Federal courthouse expansion) or conversion (for example, of the Maryland Hotel to become a "boutique" hotel). SDHC has been working diligently to try to ensure enforcement of an SRO ordinance requiring replacement of any SRO units taken out of service, and also to get a stronger ordinance adopted by City Council, but has faced significant opposition to date.

San Diego has some interesting financial tools for creating affordable housing. Although there is little hope that the growing need can be met in the foreseeable future, some of the housing is targeted for the special needs homeless population. CCDC is the redevelopment agency for downtown San Diego. California's Community Redevelopment Law requires that at least 20 percent of all tax increments generated by a redevelopment project be used to increase affordable housing. Six percent of all new or rehabilitated housing in a redevelopment project area must be for very-low-income households (50 percent of area median income or below). CCDC contributes $6-7 million annually to a low and moderate housing set-aside fund that invests in projects providing affordable housing, including housing for special needs populations. The agency plans to use these funds to secure tax allocation bonds that could generate over $35 million in secured debt financing. Countywide 10,136 units were created from 1992 to 2002, but

a gap of 6,627 units still remains in the very-low income category. The five-year goal is to add 1,200 units to the very-low income inventory.

Documenting Reductions in Chronic Street Homelessness

Movement of Street Homeless into Housing

- REACH[37]—from inception through January 31, 2003, San Diego's REACH program had enrolled 404 unduplicated homeless individuals with severe mental illness. Of these, 253 are still enrolled and 154 had been disenrolled for various reasons (59 percent dropped out of the program and another 17 percent moved out of the REACH program area).

- REACH had the following impacts, annualized to represent the 12 months before compared to the 12 months after enrollment. The 253 clients currently enrolled have had:

  - 73 percent fewer homeless days;
  - 55 percent decrease in incarceration days, and 71 percent decrease in incarceration episodes;
  - 35 percent decrease in hospital days, and 62 percent decrease in hospitalization episodes;
  - 85 percent increase in people receiving cash and other public benefits (usually health insurance, food stamps, SSI, other cash assistance; does *not* include housing subsidies, which most REACH clients have); and
  - 506 days of enrollment, on average, or about 1.4 years, in a program that in January 2003 had only been at full enrollment for about two years; 55 percent had been enrolled at least one year.

- SIP presents a variety of impact data.

  - HOT asked the UCSD Medical Center to track care received by 15 mentally ill chronically homeless individuals well known to the HOT workers. Care received was tracked at Scripps Mercy Hospital, UCSD Medical Center, and the San Diego emergency medical services system during an 18 month period from July 1, 1997 through December 31, 1998. The 18-month cost just for these 15 individuals was just under $1.5 million, which did not include physician fees or care that might have been incurred at other regional hospitals. UCSD physician charges totaled $87,017 for both in- and outpatient care for these same individuals during the study time period. At $69,820 a person a year, HOT did not have to say much more to argue for the cost-

[37] Data supplied by Dave Pilon, director of the statewide outcomes collection and reporting system for AB 2034. Questions about REACH data should be referred directly to Mr. Pilon, at dpilon@mhala.org or (562) 285-1330 Ext. 249. Outcomes are based on 253 current clients; reasons for leaving are based on the 154 clients who disenrolled from REACH as of January 31, 2003. Information about the period before enrollment comes from client self-reports; post-enrollment information comes from REACH case records.

effectiveness of its activities to get chronic street homeless people with multiple disabilities into stable housing situations.

- SIP did a cost analysis showing the very high levels of public resources being absorbed by serial inebriates, compared to the costs of treatment. They calculated a cost of $977 for maintaining one serial inebriate in housing plus outpatient substance abuse treatment for one month, compared to $1,470 for the cost of one police contact with an ambulance visit to the emergency room followed by a day in jail.

- In SIP's 2000 Pilot year, 144 people were arrested an average of 1.9 times. Of these, 72 percent were assessed for treatment (104 people) and almost half (48) were accepted. Twenty-two people completed treatment (46 percent of those accepted, 21 percent of those assessed, and 15 percent of those arrested). The 46 percent completion rate compares well with the of average completion rates for voluntary substance abuse treatment among homeless people of between 20 and 33 percent, with most falling at the lower end (Orwin, et al., 1994). And the SIP participants were all people with very long histories of addiction and street homelessness, and all were treatment resisters.

- In addition, 58 percent of those arrested (72 people) did not have additional police contact or local emergency room use for over one year, whether or not they ever entered or completed treatment. They may have left town or been in jail, or they may have been successful treatment completers.

- In Calendar year 2001 SIP expanded to include Central and Northern Divisions. There were 241 people arrested an average of 2.4 times. Of these, 65 percent were assessed for treatment (157 people) and almost half (71) were accepted. 39 people completed treatment (55 percent of those accepted, 25 percent of those assessed, and 16 percent of those arrested). In Calendar year 2002 SIP expanded to cover the whole City of San Diego and some parts of the county. 249 people arrested an average of 2.03 times (fewer repeat arrests than in 2001). Of these, 76 percent were assessed for treatment (190 people) and about one-third (68) were accepted. Twenty-nine people completed treatment (43 percent of those accepted, 15 percent of those assessed, and 12 percent of those arrested).

Public Funding

The Special Needs Homeless Initiative agencies that fund housing and services draw on local, state and Federal mainstream sources (see Table F.2). In addition, the agencies within the Initiative providing services receive private funding from many individual, corporate, and nonprofit foundation sources. The Housing Commission is the biggest funder of housing, and its monies from Section 8, SHELTER PLUS CARE, and City Public Housing programs are especially important for helping the special needs homeless population get off the street.

CCDC gives the greatest impetus for affordable housing in the downtown area. CCDC efforts are funded by incremental tax revenue raised from its development projects. CCDC targets a portion

Table F.2: Local Agency Investments In Ending Street Homelessness

Agency	Type of Investment		
	Fund Services	Staff Provide Services	Fund Housing
San Diego City Agencies			
Centre City Development Corporation (CCDC): tax increment resources, other local resources			X
Department of Community and Economic Development (DCED), Division of Homeless Services: CDBG; ESG, general revenue	X		X
San Diego Housing Commission (SDHC): Section 8, HOME, Housing Trust, SHELTER PLUS CARE, public housing units			X
San Diego County Agencies			
Health and Human Services Agency			
Mental Health Services: county funding, AB 2034	X	X	X
Alcohol and Drug Services	X	X	X
Housing and Community Development Department (HOPWA)	X		X

of these funds towards residential developments which have a share of their units set aside for the special needs population.

DCED commits funds from CDBG and ESG monies to provide housing and services for the special needs homeless. DCEC's Division of Homeless Services conducts this work.

The County's Mental Health Services and Alcohol and Drug Services also fund some beds for special needs homeless people. However, these agencies' primary role within the Initiative is to provide services. Mental Health Services administers AB 2034 funds for REACH. The outreach, case management and support services from this program are vital parts of the Initiative.

The Initiative's success rests on a coordinated pooling of resources from city, county, and nonprofit agencies. REACH is a good example of this approach, as SDHC provides most of the housing subsidies and funding for all of the case management and support services comes through MHS.

Maintaining and Enhancing the System

Huge gaps still exist in San Diego's arsenal of programs and services to end street homelessness. The Ad Hoc Committee continues to meet, and to pursue resources that will help it continue to meet its goals. For instance, Committee members helped foster and support San Diego's response to the recently issued Federal Chronic Homeless Initiative Notice of Funds Availability. Further, due to the REACH Program's success, MHS was invited to apply for funding to expand the program into northern San Diego County. Those expansion funds were awarded, but then almost immediately rescinded due to state budget issues. The Committee will be working to try to sustain the AB 2034 program statewide in the face of massive state budget cuts, especially since its approved North County application appears to have lost its funding to these cuts. It will be working to educate the newly elected members of the City Council about homeless issues and what remains to be done to address them. It anticipates working with the mayor and city manager to continue to set goals for producing more permanent supportive housing. The same openness, non-defensiveness, and problem-solving orientation that brought it success to date are evident in its approach to its recent applications, and are expected to extend to work in the future.

Community Relations

An important part of community relations for the Special Needs Homeless Initiative was to bring on board the business community and city and county government leaders. Quite deliberately the Ad Hoc Committee built a core of influential members from these sectors as its work progressed. Fortunately, for a number of reasons, the willingness to help homeless people cut across organizations and political ideologies. Downtown businesses facing a concentration of street homeless individuals had self-interest in supporting programs that reduce homelessness in the area. The police department was instituting proactive and resource effective programs, to help treat the special needs homeless population, rather than just recycle them from the streets to jail and back. Furthermore, many people in positions of power in the private and public sectors had been touched by substance abuse and mental illness problems through family members or friends. The key to successful community relations was to make a convincing case that a program could work with the special needs homeless population.

The Initiative houses many participants in large residential developments where they are not a conspicuous presence. This appeals to the participants and reduces neighbors' fears that there will be a negative impact on their area. In higher income neighborhoods, the Initiative has constructed or rehabilitated multi-unit structures in a manner that meets the area's standards. These residential facilities are usually for 20 to 40 individuals and are often functioning unnoticed by most of the public. Some of the program's residential units are in low-income, mixed use, decaying neighborhoods scheduled for redevelopment. These are not the best settings for the participants, but there are fewer NIMBY issues when the program facilities are improving the neighborhood.

San Diego Site Visit Participants

Participants	Organization
Donna Alm	Centre City Development Corporation
Scott Bender	San Diego City, Police Department, Homeless Outreach Team
Adrienne Berlin	San Diego County, HSSA, Adult Mental Health Services
Kate Burns	San Diego Reach / Telecare Corporation
Mary Case	St. Vincent de Paul Village
Hannah Cohen	North County Solutions for Change
Matthew Doherty	Corporation for Supportive Housing
Glenn Duke	P.E.R.T INC.
Loren England	Salvation Army
Debra Fischle-Faulk	City of San Diego, Community and Economic Development
Piedad Garcia	San Diego County, HSSA, Adult Mental Health Services
Larry Graff	Alpha Project
Karen Gurneck	National Alliance for the Mentally Ill, San Diego
Lauri Hess	Community Research Foundation
Anne Hix	San Diego City, Park and Recreation
Kathleen Houck	San Diego Housing Commission
Gary Hubbard	San Diego REACH / Telecare Corporation
Jonathan Hunter	Corporation for Supportive Housing
Sharon Johnson	San Diego City, Community and Economic Development Dept.
Kevin Kmiec	Episcopal Community Services, Friend to Friend Clubhouse
Betsy Knight	Episcopal Community Services, Friend to Friend Clubhouse
Karna Lau	San Diego County, Probation Department, REACH
Deborah Lester	San Diego Regional Task Force on the Homeless
John Liening	San Diego City, Police Department, Serial Inebriate Program
Marry Manaster	San Diego Housing Commission

Margaret McCahill	St. Vincent De Paul Village
Deni McLagan	Mid-Coast Regional Recovery Center
Elizabeth Morris	San Diego Housing Commission
Marcella Ordorica	Office of City Attorney
Jason Ortiz	Telecare Corporation
Mathew Packard	St. Vincent De Paul Village
Debbie Parum	Telecare Corporation
Tony Potter	San Diego County, HSSA, Adult Mental Health Services
Joy Ptashhein	Family Health Center of San Diego
Karol Rhoades	Mid-Coast Regional Recovery Center
Dale Royal	Centre City Development Corporation
Richard Santoni	Telecare Corporation
Richard Schnell	San Diego City, Police Department
Theresa Simms	St. Vincent De Paul Village
Randy Solomon	Alpha Project
Solidad Urbina	The Salvation Army Social Services, San Diego County
Suzy Valenzuela	Episcopal Community Services, City Works Plus
David Vincent	Family Health Centers of San Diego
Gwen Vitkus	Community Research Foundation
Sherry Wilkins	Community Research Foundation
Roy Williams	Mid-Coast Counseling & Recovery Center
Anne Wilson	Community Housing Works
Alex Zazueta	San Diego County, HSSA, Family Resource Bureau
Jeff Zinner	Centre City Development Corporation

San Diego Acronyms

AB	Assembly Bill
CCDC	Centre City Development Corporation
CDBG	Community Development Block Grant
CMH	San Diego County Mental Health Division
CRASH	Community Resources And Self Help
CSH	Corporation for Supportive Housing
DCED	Department of Community and Economic Development
EHAP	Emergency Housing Assistance Program
LIHTC	Low-Income Housing Tax Credits
HOT	Homeless Outreach Team
Medi-Cal	California's Medicaid Program
MHP	Multifamily Housing Program
MHS	Mental Health Services, Inc.
NIAAA	National Institute on Alcohol Abuse and Alcohol
NOFA	Notice of Funds Availability
PHA	Public Housing Authority
REACH	Reaching out and Engaging to Achieve Consumer Health
RFP	Request for Proposal
SDHC	San Diego Housing Commission
SDPD	San Diego Police Department
SHIA	Supportive Housing Investment Act
SIP	Serial Inebriates Program
SRO	Single Room Occupancy
SSI	Social Security Income
TACHS	The Association for Community Housing Solutions
TIF	Tax Increment Financing

APPENDIX G: SEATTLE

Seattle—Brief Description

Seattle, a city with a population of 600,000 in a county of 1.4 million has some economic advantages over the nation on average. Seattle's 2000 median household income was slightly higher than that of the nation ($45,736 and $41,994, respectively) and the poverty rate was slightly lower (6.9 percent for families and 11.8 percent for individuals versus 9.2 for families and 12.4 for individuals).[38] Its 2002 unemployment levels were above the national rate, however, (6.8 percent for Seattle and 5.8 percent nationally). [39]

Like many cities, Seattle faces a housing affordability crisis. Because of the economic boom Seattle experienced during the 1980s and 1990s, the cost of housing has increased substantially. Housing prices have increased 67 percent since 1995 and rental prices have increased 37 percent in the past seven years. A one-bedroom apartment in Seattle costs about $786 per month, or approximately 66 percent of a full-time minimum wage worker's salary.[40] During this same time frame, Section 8 project-based contracts expired and the local government spent millions purchasing the buildings to maintain the Section 8 housing, leaving little money to create new spaces. Also during this time providers developed many supportive housing programs. These supportive housing units were not meant simply to replace affordable housing or project-based Section 8 housing, but that has been the effect in the increasingly out-of-reach rental market. As a result, despite the fact that the number of people homeless at a point in time in Seattle decreased during the 1980s, it began to increase again in the 1990s and the street population continues to experience sharp increases.

Practices of Potential Interest to Other Jurisdictions

Seattle and King County have several practices of potential interest to other jurisdictions:

- **Providing Support Services Matters.** Plymouth Housing Group (PHG) has documented the importance of providing support services to the residents in the population it serves. PHG started the Support Services Division of the agency in 1996. Before the agency provided support services to their residents the average length of stay in housing was 18 months, and since it has provided support services to residents the average length of stay has increased to 36 to 38 months. (Contact person: Tara Connor, Director of Social Services, tconnor@plymouthhousing.org)

- **Housing Tax Levy.** The City of Seattle has a housing tax levy that has been a catalyst for developing permanent supportive housing in Seattle. Four times since 1981, voters have approved legislation that taxes homeowners to raise capital to develop housing. The levy, averaging $49 per homeowner annually, provides initial capital funding for renovation or

[38] Information from Quick Tables, US Census Bureau: http://factfinder.census.gov.
[39] Information for unemployment rates from http://www.bls.gov/cps/home.htm#overview.
[40] Information from Seattle Office of Housing: http://www.cityofseattle.net/housing

new structures and helps nonprofit agencies leverage other funding sources to develop housing. The levy also provides funding for operating costs for housing. (Contact person: Bill Rumpf, Deputy Director, Office of Housing, bill.rumpf@seattle.gov, 206.615.1577.)

- **Special Outreach to Chronic Street Homeless Mentally Ill Persons.** Seattle has two specialized outreach programs that provide workers who interact one-on-one with homeless mentally ill persons until trust is established. These are the Mental Health Chaplaincy and the Downtown Emergency Services Center's, Homeless Outreach, Stabilization, and Transition (HOST) Project. Mental Health Chaplaincy workers walk regular routes through downtown Seattle and at the end of each day visit inpatient mental health units. HOST Project workers initiate engagement processes with mentally ill homeless persons on the street, in emergency shelters and in drop-in centers. (Contact person: Craig Rennebohm, Director, 206.622.2472. Bill Hobson, Executive Director, bhobson@desc.org, 206.464.1570, ext.3015.)

- **Mental Health Information System.** Seattle's providers of mental health services maintain a shared client database. This supports a process to alert mental health providers when their clients unexpectedly enter another component of the system. Once a person is logged into the Mental Health Information System, a countywide agreement assures that local jails and hospitals notify the mental health providers (including those that are homeless service providers) if their client is incarcerated or admitted for services. (Contact person: Diep Nguyen, Information System Coordinator, 206.296.5213.)

- **Multi-agency Teaming for High Utilizers of Public Crisis Services.** At biweekly meetings staff members from several agencies meet to discuss treatment strategies for known high service users of the Crisis Triage Unit and the Sobering Support Center. In some cases, clients and their families participate in the planning. (Contact person: Edward Dwyer-O'Connor, Crisis Triage Unit Program Manager, capeo@u.washington.edu, 206.731.5846.)

- **Section 8 as part of the Continuum of Care.** Seattle Housing Authority and King County Housing Authority have also set up a system whereby people in Shelter Plus Care permanent supportive housing can stay on the waiting list for Section 8 vouchers and access this housing program when they no longer are in need of the level of services Shelter Plus Care requires. (Contact person: Sheila Fries, Shelter Plus Care Program Manager, Plymouth Housing Group, sfries@plymouthhousing.org, 206.267.4707.)

Primary Contact Persons

Bill Hobson, Executive Director
Downtown Emergency Service Center
507 Third Ave.
Seattle, WA 98104-2304
Telephone: 206.464.1570
Fax: 206.624.4196
E-mail: bhobson@desc.org

Alan Painter, Director
Community Services Division, Human Services Department
City of Seattle
618 Second Ave., 7th Floor
Seattle, WA 98104-2232
Telephone: 206.684.0263
Fax: 206.684.0146
TTY/TDDL: 206.684.0274
E-mail: alan.painter@ci.seattle.wa.us

Patrick Vanzo, Administrator
Cross Systems Integration Efforts
King County Department of Community and Human Services
821 Second Ave., Suite 600
Seattle, WA 98104-1598
Telephone: 206.296.0615
Fax: 206.296.5260
TTY/TDDL: 206.296.5242
E-mail: patrick.vanzo@metrokc.gov

David M. Wertheimer, Principal
Kelly Point Partners
600 First Avenue, Suite 305
Seattle, WA 98104
Telephone: 206.914.4475
Fax: 206.903.9579
E-mail: david@kellypointpartners.com

History and Context—How the Current System Evolved

In the late 1970s, the Downtown Human Service Council Group, a private nonprofit policy group that advocated to the Seattle and King County governments, noted increases in street homeless individuals and the increase in mentally ill people who were not getting the services they needed. As a result of these concerns, the mayor's office helped initiate the Downtown Emergency Services Center (DESC). DESC, a non-profit organization opened in 1979, boosted substantially Seattle's services for chronic street homeless individuals. Since its inception its "unofficial" mission has been to reach out to mentally ill and chemically dependent street homeless people using a service structure that would not create barriers to access. Although it was not named so at the time, they essentially called for a low demand approach. In 1980, the state certified DESC as a mental health treatment provider and King County government contracted with it to provide acute case management services. In 1985, Seattle received one of the first Health Care for the Homeless (HCH) grants from the Robert Wood Johnson Foundation (RWJ), making it possible for DESC to have on-site nursing staff, mental health, and drug/alcohol services through Harborview Medical Center's Pioneer Square Clinic. From its beginning, DESC had strong ties

to the city and the county, which are among its funders; and Clark Kimer, Deputy Chief of the Seattle Police Department, chairs the DESC Board of Directors.

During the same time frame, Community Psychiatric Clinic (CPC) began to develop housing for its patients. CPC was originally formed in 1953 to provide affordable traditional mental health services for those who could not access such services. Over the years, however, CPC staff realized that a large proportion of their clients were homeless, including a portion who were chronically homeless, and that they could not effectively serve clients who did not have stable housing. So, in 1983 CPC partnered with the Seattle Housing Authority to develop its first housing program and residential treatment program. Over the years CPC has continued to develop housing units of residential treatment (including a save haven housing program and an emergency respite care program), supported living, and independent living with supportive services (including Shelter Plus Care units).

In the early 1990s, DESC also began to develop housing programs for its clients in addition to emergency shelter already provided. It now operates emergency shelter, save haven housing, and permanent supportive housing. Like CPC and DESC, a number of other mental health agencies began to develop housing, but have since stopped this practice. Mental health agencies are being forced to deal with cutbacks and new Medicaid eligibility rules that make it difficult for them to even provide outpatient care, their primary service function. Consequently, CPC and DESC are currently the only mental health treatment programs in Seattle that have continued to develop new housing programs for homeless and chronically homeless clients. Other agencies still operate projects they developed previously, although a number of those projects and hundreds of beds have been lost to the system since the mid 1990s probably contributing to rising street counts

Plymouth Housing Group organized in the early 1980s to provide stable, safe, affordable housing for homeless and very low-income individuals. Support services were introduced in PHG housing in 1996/1997. Before this time, the average stay at PHG was 18 months, but since supportive services have been introduced the average stay has increased to 36-38 months. PHG does not require that individuals be clean and sober but they must be able to follow associated housing rules. PHG staff link tenants with relevant community resources. PHG also administers the Shelter Plus Care program for the King County Department of Community and Human Services.

A Federal funding opportunity had an important impact on Seattle's programs for the chronically street homeless population. In 1993, King County applied for and became a site in the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration's Access to Community Care and Effective Services and Support (ACCESS) demonstration project. The Seattle sub-sites for the project were CPC and DESC. This five-year project was a significant event in Seattle's development of outreach and engagement services for chronic street homeless individuals. The project undertook assertive outreach, found new pockets of homelessness, and helped chronic street homeless persons through the eligibility process for health and human services. It helped spark system innovations in Seattle and King County services, such as the merger of the mental health and chemical dependency divisions of county government and adding a housing specialist to this staff (now called the Mental Health, Chemical Abuse, and Dependency Services Division, King County Department of Community

and Human Services). The demonstration persuaded the county government that programs such as those operated through ACCESS were saving money that would have been spent on back-end services such as jail and hospital costs. As a result of the success of the ACCESS project, King County continues to pay for outreach and engagement services through DESC in the form of the HOST Project, described below.

The Continuum of Care Plan

To ensure that services funded by the McKinney-Vento Homeless Assistance Act were not leaving gaps, HUD in the 1990s began requiring communities to submit comprehensive applications for competitive funds, rather than individual programs submitting applications. In response Seattle, King County, service providers, clients, business associations, and community organizations worked together for two years on the Seattle-King County Continuum of Care Plan adopted in the spring of 1996. These community components already interacted on numerous homelessness issues. However, the new McKinney-Vento requirements structured more comprehensive planning. The CoC process did not focus specifically on the chronically street homeless population. However, the agencies providing such services were already being funded and continue to be part of the application. The City of Seattle Human Services Department and King County Department of Community and Human Services continue to jointly share the responsibility of developing and submitting the consolidated application for McKinney assistance.

Approach to Chronic Street Homelessness

Although Seattle does not have one authority responsible for addressing chronic homelessness, over time the region has developed an approach to this population as homeless service providers, low income housing providers, and other agencies involved with this population have cultivated working relationships and have capitalized on Federal and local funding opportunities to expand programming. There is no city wide coordinated entity that controls and manages the full spectrum of resources and services targeting chronic homelessness. Instead, individual nonprofit service providers and government agencies have taken it upon themselves to tackle the problem of chronic street homelessness through specialized service offerings. Some of these agencies work together to meet the needs of their clients while others operate service structures representing the full continuum of care under their own umbrella. Local government leaders—primarily from Seattle and King County—have sponsored various coalitions and task forces over the years that have brought these agencies together to analyze needs, establish priorities, and plan for specific projects and system improvements. Seattle has also responded to Federal funding guidelines concerning programming strategy and initiatives to reduce chronic street homelessness.

On our visit to Seattle on March 18-21, 2003, we interviewed 44 people. They represented city and county agencies; nonprofit service agencies operating outreach, drop-in, shelter, and housing programs; agencies serving homeless people through case management, mental health and substance abuse treatment, and health care; and advocacy organizations. People who had experienced chronic street homelessness were included in a separate focus group. A full listing

of persons interviewed, other than focus group participants, may be found in at the end of this appendix. In addition to the site visit meetings, we gathered information from phone interviews before and after the visit, written material from the programs, newspaper articles, agency websites and the Seattle/King County Continuum of Care (CoC) application.

Agency Interactions at the City and County Level

As already noted, Seattle does not have a regional, systematic coordinating body to manage resources and orchestrate a service approach specifically for the chronically street homeless population or to create a pipeline for expanding permanent supportive housing. Instead, Seattle has several interagency planning groups and organizing bodies, only one of which has an important focus on chronic street homeless persons. These include:

- The Chronic Populations Action Council (CPAC) (previously the Systems Integration Advisory Committee and originally called the Systems Design Work Group) was formed originally as part of Seattle's Federally funded, five-year ACCESS demonstration project to focus on system issues related to homeless mentally ill people. At the same time, a Chronic Public Inebriates workgroup was developed at the request of the county executive to address concerns around this subset of the homeless population, and developed and action plan to create appropriate services and housing. When the mental health and chemical dependency divisions of county government merged in 1998, the two groups also merged. In late 2002, the group was renamed CPAC. The original two groups and, now the united group, pushed with ultimate success to develop a number of specialized services for the chronically street homeless population. These include the Harborview Medical Center Crisis Triage Unit, the Mental Health Court, the Dutch Shisler Sobering Center, the REACH Project, the mental health detoxification enhancement project, the Emergency Service Patrol, and consumer-choice housing projects such as the Archdiocesan Housing Authority's Wintonia project and the DESC's 1811 project (described below). The Council meets monthly to exchange information among government and private service providers, homeless persons advocacy groups, and business representatives. The Council continues to work toward goals laid out in the plan created by the original ACCESS Systems Design Work Group and the Chronic Public Inebriates workgroup as well as other projects. Although not exclusively focused on street homeless issues, the Council, and its previous iterations, has clearly increased services and promoted systems integration for this population and continues to have a major focus on this issue.

- The Downtown Seattle Association, a local business association focused on downtown business community concerns including social service policy, provides leadership in the area of chronic street homelessness. This group helps garner support from neighbors and improve community relations for projects serving this population. Specifically, it supports DESC's work and has been instrumental in the development of the new consumer choice housing project being designed by DESC.

- The Seattle/King County Coalition for the Homeless, which addresses issues concerning all types of homeless persons, also meets monthly and has subcommittees that meet as

needed, often weekly. Founded in 1974 in partnership with the City of Seattle and King County, the Coalition is the community's oldest and strongest organizing force on homelessness issues. It is part of the Washington State Coalition for the Homeless that meets quarterly and has two representatives on the King County Committee to End Homelessness (CEH). Despite its considerable work on homelessness issues, it does not have a specific focus on chronic street homelessness.

- The McKinney Steering Committee includes representatives of service providers, local government, and the United Way, and since 1997 has provided policy guidance on Continuum of Care planning and application processes. It seeks broader community input through broad-based meetings of stakeholders known as the Seattle-King County Advisory Committee on Homelessness (ACH). The ACH grew out of an earlier homelessness advisory group that developed a Continuum of Care plan in 1998. The City of Seattle and King County jointly convene and staff these groups.

- HCH Network Planning Council, housed in the Department of Public Health, is an 18-member community-based advisory group that conducts planning and program development for homeless health services countywide. About 65 percent of program resources are targeted to single adults, and it oversees REACH case management project, a Medical Respite program targeting chronically homeless, and the provision of shelter-based nursing and mental health staff in downtown Seattle shelters.

- HIV/AIDS Planning Council (not exclusively focused on homeless, but has been instrumental in launching housing and services for chronically homeless people with AIDS (e.g., the Lyon Building)

Of note is the high degree of cross-membership among these groups; many of the same individuals and organizations are represented across these and related coordination groups, essentially forming an informal communication and coordination network among the City of Seattle, King County MHCADS, Public Health, housing organizations, and service providers.

Agency Interaction at the Case Level

Seattle agencies face a challenge in moving interagency awareness, coordination, and collaboration from the level of systems coordination and general program activities to case management and services. The broadest programs are umbrella agencies offering mini-continuums that can and do provide care for clients without involving other agencies. Clients can benefit by having "one stop shopping" and simpler interactions with providers that help to avoid gaps in service. This vertical approach, however, may lead to inefficient duplication of services and needless competition. For example, other than the data provided within the Mental Health Information System and the HCH Network database, currently no central integrated case management database exists through which one agency can tell whether a client also receives case management services from another agency. When agency staff members discover overlapping case management, they often reconnect clients to the original service provider. But currently no central database lets staff members look up the services that someone is receiving across agencies in different systems.

Some instances of coordination and collaboration do exist at the case level. Seattle uses a tiered system for mental health services that is coded into a Mental Health Information System—the county mental health database. Individuals have a record in the shared database and get a rating, or tier, for their service needs. A person must first be on or eligible for Medicaid then the agency serving the client will apply for a tier for the client based on medical necessity and treatment intensity. The county will review the tier request and grant or deny the tier. Once tiered, the person can begin to receive ongoing publicly funded treatment. The database also logs the agencies that provide care within the mental health system; two agencies cannot serve the same individual and both receive reimbursement for their care. As a result, this database prevents mental health service duplication and encourages some service coordination. If, for example, the DESC's HOST team begins to provide outreach and engagement services to an individual who already gets services from another agency, the HOST staff will reconnect the person to the original agency to continue services. Or if the person seems to need the specific services HOST has to offer, HOST staff will contact the other agency and ask them to stop providing services to the individual so HOST can provide services.

The Mental Health Information System also provides opportunity for coordinating services with local hospitals and jails. Once a person is logged in the database, a countywide agreement assures that local jails and hospitals notify the mental health provider if its client becomes incarcerated or is admitted for services. Then the mental health provider is encouraged to contact the client to re-establish or refine service linkages. Some mental health workers reported that they wait a day or so, depending on the circumstances, before visiting a client in jail or the hospital so the person has some time drug-free along with regular food and sleep. Waiting makes it easier for providers to engage clients in services.

Another collaborative effort at the case level is multi-agency teaming to address the needs of homeless people who use a lot of crises services. The REACH Project and Crisis Triage Unit organize case teaming of relevant service providers to develop a case plan designed to stabilize housing and other issues for these people who use extensive public resources. Agencies attending the meetings commit to carrying out their part of the case plan, and follow-up assures that the promised services actually happen. These approaches are described further below.

Selected System Components

Seattle's service system for the chronically street homeless population includes most of the usual CoC components. The programs reside within individual agencies, some of which offer only a single aspect of the CoC while others offer many interconnected services under the auspices of one agency. We refer to the later arrangement as a vertical approach or a mini-continuum. Table G.1 presents an overview of the agencies involved, showing the type of programs and services each agency offers the chronically street homeless population.[41] Rows represent different providers; columns represent the types of programs and services offered. An "X" in a cell indicates that the provider offers that program or service. An "F" indicates that a public agency

[41] Table G.1 does not represent the entire network of homeless assistance programs and services in Seattle. These and other providers may also offer programs and services for other single adults who are homeless (but not chronically so), homeless families with children, and homeless youth.

funds a program or service, and an "E" indicates that the provider offers expert advice, technical assistance, or training. Seattle's approach to chronic street homelessness is described below by service type. The programs either have an exclusive focus on chronically street homeless individuals or some portions of their services address the needs of such individuals.

DESC and CPC, both private non-profit organizations, are the two providers with the most comprehensive services for the chronic street homeless population. They each have a wide range of housing resources that enables them to shelter individuals as they move from street homelessness to permanent housing. DESC and CPC both provide substance abuse and mental health services through their licensed programs and operate save havens, and DESC provides health services. They both provide case management and help their clients work with mainstream agencies. Although CPC does not operate emergency shelter, it does provide emergency housing options. Both programs work around gaps in the system and keep their clients as they move between levels of care.

Other broad range housing developers and service providers are AIDS Housing of Washington (AHW), the Archdiocesan Housing Authority (AHA), and Plymouth Housing Group. These agencies manage a wide range of housing and help their clients receive other supportive services through mainstream agencies. Of the mini-continuum agencies, DESC is the only one that has an exclusive focus on chronic street homeless people.

Prevention

Providing housing alternatives to living on the street is an essential part of preventing homelessness. Seattle is creating more housing for persons who are homeless or at risk of becoming homeless, but not enough and not fast enough to keep up with the demand. We discuss these efforts below under Affordable Housing.

Outreach and Drop-in

The four outreach and drop-in programs in Seattle significantly focused on chronically street homeless are the Mental Health Chaplaincy, REACH Project, HOST Project and Angeline's Day Center. Other outreach and drop-in programs are Operation Night Watch, the Women's Referral Center, the Chief Seattle Club, Lazarus Day Center, and the Compass Center.

Mental Health Chaplaincy. The Mental Health Chaplaincy is an outreach and engagement program for the most difficult and most vulnerable mentally ill street homeless people. Its outreach strategy involves long-term engagement with clients until they receive benefits and are comfortable moving into services and/or housing. Because the system can be fragmented and clients often are involved with numerous agencies, people can fall out of the system. The Chaplaincy's approach is meant to be a source of consistency for homeless people until they are stabilized. Also, Chaplaincy staff members provide training to other agencies in the community and maintain particularly strong ties to faith-based communities and organizations.

Table G.1: City of Seattle: Agencies Involved in Reducing/Ending Chronic Street Homelessness

	Homeless-Related Programs and Services																					
	Prevention	Outreach/Drop-in	Shelter	Safe Havens	Transitional Housing	Permanent Supportive Housing	Other Housing (non-disabled)	Alcohol and Other Drugs	Mental Health	Health	Employment	Corrections	Public Assistance	Child Welfare	Advocacy	Food	Case Management	Cross-agency Coordination of Service Access and Delivery	Planning	Staff Training	Data/Documentation	PR, Public Acceptance
Nonprofit Program/ Services/ Agencies Serving Currently or Formerly Chronic Street Homeless People (listed alphabetically)																						
AIDS Housing of Washington					X	X	X								X		X			TA		
Archdiocesan Housing Authority		X	X		X	X	X	X		X					X		X	X			X	X
Wintonia Housing						X	X	X							X		X	X				X
Westlake Housing						X	X	X		X					X		X	X				X
Lazarus Day Center		X																				
Noel House			X																			
Josephinum House						X											X					
Dorothey Day House						X											X					
Women's Referral Center		X																				
Chief Seattle Club		X																				
City of Seattle																						
Human Services Department	F	F	F	F	F	F	F	F	F	F	F							X	X			
Office of Housing					F	F	F												X			
Community Psychiatric Clinic		X		X	X	X		X	X		X	X		X	X		X	X	X	X	X	X
Residential Treatment					X				X								X					
Harbor House				X				X	X								X					
Emergency Respite					X			X	X								X					
Publicly Funded Mental Health					X			X	X								X					
Supported Living						X		X	X								X					
Independent Living						X		X	X								X					
Compass Center			X		X																	
Downtown Emergency Service Center		X	X	X		X	X	X	X	X		X			X			X		X		X

Table G.1: (Continued)

	Prevention	Outreach/Drop-in	Shelter	Safe Havens	Transitional Housing	Permanent Supportive Housing	Other Housing (non-disabled)	Alcohol and Other Drugs	Mental Health	Health	Employment	Corrections	Public Assistance	Child Welfare	Advocacy	Food	Case Management	Cross-agency Coordination or Service Access and Delivery	Planning	Staff Training	Data/Documentation	PR, Public Acceptance
HOST Project		X						X	X								X					
Drop-in Center		X														X						
Emergency Shelter		X			X					X												
Kerner Scott House				X				X	X								X					
Morrison Building						X		X	X								X					
Lyon Building						X		X	X								X					
Union Hotel						X		X	X								X					
Dutch Shisler Sobering Center		X						X														
Evergreen Treatment Services - REACH Project		X						X						X				X			X	
Harborview Medical Center Crisis Triage Unit								X	X	X				X				X			X	
Harborview Mental Health								X	X	X	X	X		X				X		X		
Healthcare for the Homeless Network - Department of Public Health / Seattle and King County		X, F						X, F	X, F	X, F				X		F		X	X	X	X	
King County Department of Community and Human Services																						
Community and Human Services Division	F	F	F	F	F	F	F	F	F	F	F								X			
Mental Health, Chemical Abuse, and Dependency Services Division								X, F	F										X			
Emergency Service Patrol		X						X														
Mental Health Chaplaincy	X	X							X						X					TA		X
Operation Night Watch		X																				
Plymouth Housing						X	X				X				X			X	X	X	X	X
Coming Home Program						X											X					
Veterans Affairs - Healthcare for the Homeless										X					X							
William Booth Center			X		X																	
YWCA - Angeline's Day Center	X	X	X			X	X			X	X			X	X					X	X	X

X = Provider TA = Expert TA Provider F = Funder

The Chaplaincy program helped to develop and uses the Relational Outreach and Engagement Model currently promulgated by the National Health Care for the Homeless Council.[42] This model has four phases to working with homeless individuals: approach, companionship, partnership, and mutuality, which revolve around building and shaping a relationship with the client. The focus is to build trust with a person and become that person's companion before pushing him or her into services and programs. The process helps people evolve until they are ready to access services on their own terms. This type of connection may be missing in other service contacts and it may be the hook that helps move people to services, assists them in trusting the service providers, and gets them off the streets. In practice, the outreach workers spend time with homeless people on the street, becoming part of their everyday experience, becoming familiar, and offering companionship. The Mental Health Chaplaincy typically works with Harborview Mental Health, local emergency rooms, DESC, and the HCH Network.

REACH Project. The REACH Project is an outreach and long-term engagement strategy for chronically homeless public inebriates using a harm reduction model. REACH is a project of the Department of Public Health's HCH Network, and involves two agencies. Project leadership and case management staff members are provided by Evergreen Treatment Services. A full-time registered nurse is also part of the team, contracted through Pike Market Medical Clinic. All REACH staff members, both the case managers and the nurse, are sited at the Dutch Shisler Sobering Support Center. REACH case managers work with clients to develop relationships and address basic health and housing needs. They have direct access to and control of Shelter Plus Care housing vouchers.

This Sobering Center is managed overall by the King County Department of Community and Human Services, which partners with part of the Recovery Centers of King County to operate sobering services as well as outpatient centers and county detoxification programs. Working with staff from a number of county and city departments, the King County Executive's Office conceived of and helped develop the Sobering Center.

HOST Project. DESC runs the HOST Project. Outreach and Engagement Specialists work within specific geographic regions or in other targeted programs or facilities such as drop-in centers for women, local hospitals, and jails to find chronically street homeless people. Sometimes they approach potential clients directly and other times they develop an engagement plan with staff members from other agencies who have had interactions with the person. HOST staff members receive referrals from concerned citizens, jail, the Department of Social and Health Services (DSHS), the mental health court, hospitals, the Harborview Medical Center Crisis Triage Unit, the Seattle Public Library, family members, and other mental health professionals, shelters, and drop-in centers.

HOST also connects to people through other DESC services. DESC shelter staff members refer clients and provide information based on the large amount of time spent with shelter users. DESC also runs a drop-in center on weekday mornings offering hygiene and storage facilities and a place to relax, eat, play games, read, watch television, and/or use computers. HOST staff members often see the same individuals many times in a given day or week. Drop-in center visits

[42] The curriculum can be found at: http://www.nhchc.org/Curriculum/index.htm.

are another opportunity for staff members to engage vulnerable individuals. Whether based on a referral or directly approaching someone, HOST workers target the very vulnerable people who have not been successful in other service settings.

HOST staff members use a number of engagement strategies with individuals when they approach them directly on the street. Although staff members do not deny their agency connection when asked, they do not introduce themselves as mental health or outreach workers. They try first to engage people in "small talk." The workers try to meet people where they are comfortable. One strategy is to know where a particular person spends most of her/his time and then to also spend time in that area. It is helpful when a homeless person recognizes the HOST worker as a familiar face in the neighborhood. Homeless persons seem to be less threatened when the staff person is part of their world.

A second strategy is to offer people on the street tangible items such as coffee, clothes, or sleeping bags as an immediate way to make a connection. Once tangible items are accepted, the staff members also offer their time to help the homeless person get benefits, medical care, or other needed services, including attending appointments with clients. Disabled homeless individuals may not have the patience to wait for an appointment, but if someone is with them they are more inclined to stay until they receive the attention they need.

A third strategy is to offer the services of the drop-in center, including its storage space. Staff members reported that storage is a big draw to the drop-in center. Homeless individuals are always asked to move along on the street and it is difficult to move with their belongings. The storage space allows people to know their belongings are secured. A fourth strategy used once a person is engaged in some services is to start working on housing options. Outreach staff may make a referral to the safe haven program run by DESC long before the homeless person is ready to accept that offer, so a part of the waiting period has passed when the person is ready to go.

Outreach and engagement staff members report that individuals vary widely in the time it takes before they are receptive to help. While most homeless persons come in off the street in a matter of weeks or months, for some the outreach process requires years. Each staff member typically sees five or six people very regularly and others on their caseload one time per month.

Angeline's Day Center. In 1986, the Seattle YWCA opened Angeline's Day Center for chronically street homeless women. The center's mission is to provide women with basic survival services and a safe place to be. The center is a low-barrier, harm reduction environment that women can frequent as long as they are not violent or abusive. It is designed for 78 women per day but actually serves 150-250 women daily and served a total of 1,371 different women in 2002. The YWCA does not actively do outreach because most women find Angeline's through word-of-mouth on the street or through referrals from the police, hospitals, and the crisis line. Despite not having strategic outreach activities, the YWCA estimates it reaches about 90 percent of chronically street homeless women in Seattle through the center's services.

The center meets basic needs such as hygiene, three meals a day, and information and referral to other agencies as well as having mental health specialists and nursing staff on site as part of the HCH Network. It hosts Alcoholics Anonymous meetings on site and brings in other substance abuse treatment agencies for services and referral. Additionally, a housing resource group helps

women fill out applications for housing if they are appropriate for particular settings. Angeline's staff members connect with case managers from numerous programs so they know who to contact if problems arise. If a woman does not have a case manager from any service provider, the staff will connect them to a program that meets their specific barriers and cultural needs.

Emergency Shelters Focused on the Chronic Street Homeless Population

As shown in Table G.1, Seattle has several agencies providing emergency shelter for the chronic street homeless population. However, three are especially significant for giving their clients a broad range of services: DESC's 24-Hour Emergency Shelter, Harborview Medical Center Crisis Triage Unit, and Angeline's Day Center.

DESC's 24-Hour Emergency Shelter. Among its programs, DESC operates a 24-hour emergency shelter that serves about 8,000 people annually. An on-site nurse—funded by the HCH Network and provided by Harborview Medical Center's Pioneer Square Clinic—provides medical services and a HOST staff member works in the shelter to provide engagement and case management services.

Harborview Medical Center Crisis Triage Unit. The Harborview Medical Center Crisis Triage Unit was created to divert people from law enforcement interventions and psychiatric hospitalizations, and although it maintains a "no refusal" admissions policy, has developed specialized services for people who are too drunk for detoxification and too violent for jail. The unit provides crisis stabilization services and medical care for a maximum of 24 hours. It provides a single point of entry to many service systems and screens for and links clients to mental health, substance abuse, and disability services.

The unit has 13 beds—8 single rooms and 5 beds in an observation room in the emergency department of the Harborview Medical Center. The unit receives referrals from a number of sources: equal proportions are walk-ins, from law enforcement, and referred by family and other community members. The unit handled 8,000 visits in 2002 and expects to see more in 2003. Twenty-eight percent of the people served are homeless.

Each client works with a nurse, a medical assistant, a psychiatric nurse, and a liaison social worker. The social worker provides information and referral to other community agencies and resources. Although the triage unit functions in part as a diversion strategy, because of the acuity of so many of the individuals referred to the triage, about one-third of its clients end up hospitalized (about half voluntarily). Other clients are referred and formally linked to other mental health and chemical dependency services such as Harborview Mental Health and DESC. "Back door" staff members, including certified mental health and chemical dependency specialists, are utilized to follow up on referrals and promote effective service connections for individuals leaving triage. These staff members are critical to the diversion process, and help to reduce Crisis Triage Unit recidivism.

Changes in financial resources (King County is reducing the unit's funding by about $800,000) are forcing changes in the service model from an integrated to a more medically oriented model. This will allow them to bill Medicaid/Medicare and will bring a psychiatric physician into the unit 24 hours a day.

Angeline's Day Center. The YWCA's Angeline's Day Center allows 30 women a night to sleep in the center. These women are referred from the AHA women's shelter, where AHA and YWCA staff members work together to identify women that AHA cannot serve for the night and send them over to Angeline's.

The Seattle YWCA has a major focus on services for women who are homeless. Thirty-eight percent of their $19 million budget is devoted to such services. This year they implemented a capital campaign and raised $43 million to expand the Angeline's Day Center to create Opportunity Place. It will include all the current services at Angeline's described above, but will also co-locate 14 other agencies for mental and physical health services, employment and education services, and other resources. Additionally, 145 low-income Section 8 housing units will be built on the upper floors of the building.

The Medical Respite Program provides short-term nursing and recuperative care for chronically homeless clients with an acute medical diagnosis. Respite staff use the opportunity provided by daily contact with clients in a safe and structured setting to provide psychosocial assessments and case management services to link clients with housing, on-going primary medical care, substance abuse and mental health treatment and other needed services. The program has the following objectives: 1) resolve presenting medical problems; 2) provide psychosocial evaluation as needed and appropriate referrals in the area of housing status, entitlements, physical health, mental health and substance abuse; and 3) initiate the process of housing stabilization.

The Respite Program is a collaborative project between HCH Network and Pioneer Square Clinic (a satellite clinic of Harborview Medical Center). HCH contracts with two local shelters to provide shelter, case management, food, and laundry services. Seventeen beds for men are located in the William Booth Center (Salvation Army shelter) and five women's beds are located at the YWCA. Respite services are offered 7 days a week. The shelters provide non-clinical staff 24 hours per day. Both shelters provide emergency and transitional housing available to appropriate clients after discharge from the respite program.

From July 1997 through December 2002, Medical Respite served 1,717 unduplicated clients. The program averages 400 admissions per year; all are homeless single adults. The clients have long histories of homelessness, and 75 percent have mental illness and/or substance abuse problems. Of note is that 40 percent lived on the street prior to on Respite, making this a program that works with a particularly high number of street homeless. The time spent is Respite in a window of opportunity to work with this highly disabled street population in order to promote housing stabilization.

Safe Havens and Low Demand Residences

Seattle has two programs providing safe haven or very low demand type residences–Harbor House and Kerner Scott House.

Harbor House. CPC, runs Harbor House a transitional housing program using a safe haven model. CPC partnered with Federal, state, county, and city governments to build the facility in which both Harbor House and the Dutch Shisler Sobering Support Center are located.

Kerner Scott House. DESC runs the Kerner Scott House, a 40-bed program using a safe haven approach. DESC workers reported that a number of clients need a safe haven/low demand environment rather than emergency housing as their first step off the street. Shelters are often crowded and noisy, and the homeless person may not feel comfortable and safe in that environment. The Kerner Scott House employs a low demand harm reduction model. DESC staff members have found that people are better able to address their problems when they are in stable housing. There are no requirements to be eligible for residency and the staff is very flexible in allowing clients to do what they need. For example, a woman was not comfortable going to her room so the staff allowed her to sit in a chair in the hall for months until she was ready to move to her room. If a person is still using heroin, the staff treat it as a clinical issue rather than a criminal justice issue as long as the person is not using inside the facility. A person may remain in Kerner Scott as long as necessary until permanent housing is available. Program data show that nearly half (48 percent) of residents of Kerner Scott remain in the program for 12 months and 23 percent remain for 24 months.

Case Management

Seattle has three case management approaches that are especially noteworthy—a multi-agency team for high users of crisis public services; the Dutch Shisler Sobering Support Center; and HOST Intensive Case Management.

Multi-agency Teaming for High Users of Crisis Public Services. An important component of the Crisis Triage Unit program is an effort coordinated with other service providers to address the needs of the most vulnerable clients. Every two weeks staff members from the Triage Unit, REACH, the emergency room, the Sobering Center, the detoxification center, the Emergency Service Patrol and other relevant service providers meet to discuss high service users. These are people who have used the Triage Unit four times in three months; 52 percent are homeless. Together the agencies create plans for clients that each provider commits to following. This system allows service providers to think together creatively about client needs and the types of services that would be helpful to particular individuals. Clients sign information releases so agencies can coordinate in this way. At times the Triage Unit may also involve the client, family, friends, or police representatives. Together with the health and social service agencies, they decide what is missing to stabilize the person and come up with a plan that everyone commits to implementing.

Dutch Shisler Sobering Support Center. The Sobering Support Center was built and is owned by CPC and co-locates three connected programs collaborating to provide services for chronic public inebriates–the Sobering Support Center itself, the Emergency Service Patrol, and the REACH Project. The Sobering Support Center, part of the Recovery Centers of King County, cares for people as they sober up. Clients arrive at the Sobering Support Center either by referral from concerned citizens or through the Emergency Service Patrol. Clients are able to sleep off their binge at the Sobering Support Center as well as store their belongings in available storage

space. Staff members check vital signs every few hours and a nurse case manager provides medical services. Sobering Support Center staff members refer clients to REACH for case management.

The Emergency Service Patrol, a King County program, is a van service that picks vulnerable homeless people up from the streets and brings them to the Sobering Support Center or to other service providers as needed.

REACH Project staff members receive referrals from the Sobering Center or conduct outreach in the Center or on the street. Clients must use the sobering center to be eligible for REACH's intensive case management. REACH staff members target the most vulnerable and difficult to serve, who are likely to make heavy use of the Sobering Center. Services target client-defined goals, focusing clients on engaging and building relationships. Most of the clients want survival services, most of which are provided on the street. REACH has eight case managers each with a caseload of about 20 people.

Early contacts involve screening clients to be sure they are not using other service providers or to determine whether other service providers would better suit their needs. Because REACH focuses on alcohol abuse, workers try to refer homeless people with other issues as their primary problem to appropriate services. If the person is appropriate for REACH services, staff members complete a second assessment and sent it to the HCH information system. From that point staff members connect their clients to many types of service as needed. Case managers spend an enormous amount of time with clients because they help make appointments and also accompany clients to ensure receipt of services.

REACH has a positive relationship with the DSHS. It assists clients to apply to the state for Alcohol Drug Abuse Treatment and Support Act money, eligibility for which opens the door to all chemical dependency services in Seattle. This fund provides cash assistance to people who are disabled due to addiction as long as they are in treatment and have a payee. Establishing eligibility for these payments is extremely challenging because it requires four appointments—three screenings by different people and a fourth meeting for an assessment. About four weeks pass between initial screening and assessment, after which eligible clients are placed on a waiting list for services. Then clients must contact the program every day between 9:00 a.m. and noon to see if a bed is ready for them. REACH staff members report it is incredibly challenging to motivate an addicted homeless person to go through all the appointments and call every day once qualified. Also, the DSHS program has an employment focus, so individuals who will never be able to work regardless of sobriety may not get treatment.

The REACH Project has positive relationships with housing providers, some of whom are more willing to take clients from REACH's case management rolls than other sources because the project is well respected. REACH staff members believe in harm reduction models because not everyone they serve is ready to accept treatment though they might accept housing. However, once clients are in housing and can value having that stability, they can begin to deal with the consequences of their drinking and other addictions. REACH controls 24 Shelter Plus Care beds, so its case managers can decide who goes into those slots. All other housing is accessed through other programs including the Wintonia (the Archdiocesan Housing Authority's consumer choice housing program), DESC, and others. The Wintonia is currently the only explicitly consumer-

choice housing in the Seattle area. However, DESC is currently trying to construct a new facility for the same purpose (the 1811 project). There are also abstinence-encouraged housing projects, such as Scott Kerner, which accept residents who drink but do not permit drinking on the premises. Usually abstinence-encouraged projects enforce this restriction only when a resident presents a problem by drinking in the building's common areas.

The goal of the combined services of these three Sobering Support Center programs is to reduce homeless persons' reliance on more expensive community services such as emergency rooms, detoxification, and the Crisis Triage Unit.

HOST Intensive Case Management. DESC clients move from HOST outreach and engagement specialists to HOST intensive case managers when there is a natural transition point in the relationship. Sometimes this happens soon after the specialist develops a relationship with the client and other times it could take months or even years to make the transition to intensive case management. Intensive case managers carry a caseload of about 12 to 15 people. The specialists try to match the type of client they have for transition to particular intensive case managers based on specific strengths and skills of the manager. Intensive case management should be temporary—a year or so—but in actuality it can operate for years depending on the needs of the clients. The goal is to move clients from intensive case management to long-term mental health and chemical dependency services either with DESC staff or other agencies in the community.

The HOST team also offers clients a unique service—applying for benefits—through a contract with DSHS. Homeless clients may not want to go to the welfare agency but may want benefits. The HOST staff is able to complete the paperwork for them by contacting a specific person at DSHS assigned to this task. However, if HOST staffers try to use other eligibility workers, the process seems to fall through. In addition, a HOST staff person is out-stationed at the DSHS agency one day a week so eligibility workers can refer clients directly to HOST if necessary.

Focus group participants reported that having a case manager was critical to their ability to get off the streets and get the help they needed. They saw the case manager as the starting point to identifying resources they were not aware existed in the community.

Permanent Supportive Housing

Seattle has four substantial permanent supportive housing programs run by DESC, CPC, AHA, and PHG.

Downtown Emergency Services Center. DESC maintains 321 units of permanent supportive housing in the Union Hotel, the Lyon Building, and the Morrison Building. All have 24-hour on-site clinical staff. DESC tries to create a seamless integration between the property management function in the buildings and the supportive services division, as staff members believe this approach yields a better connection between clients and workers and long-term success. The staff members, who usually have a social work background, are trained to handle both property management issues and supportive services. The philosophy is that it is easier to teach a social worker property management skills than the other way around.

DESC's permanent supportive housing embraces a harm reduction approach. This does not mean that problems and issues do not arise or that anything goes in DESC housing. Rather DESC staff has been trained to respond to issues differently than in the past to work out the resident's problems instead of using eviction as a response. Residents are still held accountable for their actions (often by fellow residents) and DESC staff members work with the resident to address their problems.

A particularly important project is the Lyon Building, which was developed and is owned by AHW but operated by DESC. This building is specifically for HIV/AIDS individuals who also suffer from mental illness, substance abuse, or both. It is designed to assist multi-problem persons and is intended to be their permanent residence. DESC is currently trying to develop permanent supportive consumer choice housing for chronic public inebriates and individuals with multiple barriers through its "1811 Project" named after the site address. DESC has an agreement to set aside beds for persons dealing with both AIDS and addictions as part of the project and a Special Projects of National Significance (SPNS) grant from HUD/HOPWA has been awarded to DESC to support outreach and engagement efforts targeting this population.

Community Psychiatric Clinic. CPC has developed a mini-continuum of housing and services for homeless mentally ill clients. It maintains 276 24-hour supervised beds, 86 supported living beds, 132 independent living beds, 79 Shelter Plus Care beds, and 152 Section 8 beds. Historically a private nonprofit comprehensive behavioral health treatment center for people with severe mental illness and chemical dependency, CPC has remained largely independent in developing housing. The housing tax levy funds (discussed in the funding section below) have been essential to the development of CPC's units and help leverage other funds when projects begin. CPC has also worked with six churches in the area to develop housing. The churches purchase the housing and contract with CPC to manage it. The rent subsidies from clients cover a portion of the mortgage costs. Of the three costs of operating supportive housing—capital costs to build or rehabilitate, operating costs, and service costs—capital is the easiest money to raise in Seattle and the service dollars are the most difficult to obtain. Typically, CPC receives no city, Federal, or state funds for services when developing housing projects. Some homeless mentally ill persons can quality for Medicaid and county mental health services.

CPC housing clients usually come into services through its general intake department. In 2002, CPC served 5,100 clients, 700 of whom were new (about that number leave its services each year). CPC has staff co-located at the county hospital (Harborview), the community hospital, and the jail to screen people for mental illness and then offer services to qualified individuals. CPC also receives referrals from hospitals, family members, and self-referrals.

Client housing needs are addressed once they enter the CPC system. In 2002 CPC provided a total of 206,501 bed days of which 121,456 were for persons who were homeless when they entered services. The remaining bed days were for persons who moved from a different level of care within the CPC continuum of services. They too may have been homeless at one time.

CPC employs a harm reduction model in all its residential programs but does not explicitly operate consumer choice housing. CPC is a licensed chemical dependency treatment provider in addition to its mental health services. Three CPC houses are reserved specifically for recovering clients. If clients begin experiencing problems, CPC moves them into different housing within

CPC, rather than releasing them to the streets. Although CPC does not technically "require" clients to use services (with the exception of the clients in the Shelter Plus Care beds), all of its clients receive Medicaid and have some sort of service strategy. CPC has United Way funding and raises private funding for the few clients who are not Medicaid beneficiaries.

CPC's supported housing programs have specialized case managers on site. A client's case is transferred from the treatment program to the housing department for additional services. Staff members specially trained to provide housing supports and skills in daily living have lower caseloads.

Archdiocesan Housing Authority. AHA has 650 units of permanent housing in downtown Seattle, in which residents have access to on-site services that use a variety of models of care to suit varying client needs. Although all AHA programs serve the homeless and low-income population, the ones that target the chronically street homeless population are the Wintonia and the Westlake. Not all the AHA programs require residents to be actively involved in services, but the Wintonia and Westlake do. Regardless of whether services are required, all the programs use a community-based approach, building a sense of community among residents to give people a feeling of connection to other residents and that the building is their home.

The Wintonia includes 92 units of housing for chronically homeless individuals, 45 of which are reserved for people disabled by chronic alcoholism. It is currently the only explicitly consumer choice housing in Seattle. In this case, consumer choice housing means residents can use alcohol on site in their units but they cannot have guests while they are using or be intoxicated in the common areas of the building. (DESC's proposed 1811 project will have the same consumer choice housing rules.) Wintonia residents assigned to beds set aside for chronic inebriates must participate in chemical dependency services that DESC staff members deliver on site. An on-site resource coordinator works with residents in a case management capacity to help them access the services they need.

The Wintonia receives referrals from the REACH Project, DESC, and substance abuse treatment facilities. The average length of stay at the Wintonia is three years, with two years as a critical point for self-sufficiency. If residents stay for 2 to 3 years they likely move on to more independent living situations (such as the AHA's Josephinum House). If they leave before the two-year mark they are likely to be having problems and also have difficulty remaining in other housing.

The Westlake has 53 units for men aged 55 and older who have been homeless at least one year, although many have been homeless much longer. As at the Wintonia, the Westlake has an on-site resource coordinator. Although the housing is not explicitly for chronic public inebriates, many of the residents struggle with this problem, so house rules regarding using alcohol are the same as those at the Wintonia. The Westlake receives referrals from REACH, DESC, the Plymouth Housing Group, its own day center, and the Compass day center. The average length of stay at the Westlake is 5.5 years. Some residents move to independent living and others move into nursing care because of their age and health status.

Other AHA permanent housing programs may not be intended for chronically homeless individuals specifically, but this population may end up in the housing. For example, the women

in the Dorothy Day House tend to be chronically homeless and the Josephinum House has 30 Shelter Plus Care units.

Plymouth Housing Group. PHG's mission is to provide stable, safe, affordable housing for homeless and very low-income individuals. PHG operates 11 buildings with 730 tenants. Although many of the tenants in PHG properties were chronically homeless and are disabled by mental illness and/or chemical dependence, this is not a requirement for PHG housing. PHG operates a rental office and homeless resource center in downtown Seattle at which homeless and low-income people can apply for "one stop" housing. Through this rental office, PHG does pre-application screening for its own housing, AHA's housing, and the Low Income Housing Institute (LIHI). Applicants can learn immediately which housing programs they qualify for.

PHG workers link tenants with relevant community resources. PHG has documented the importance of providing support services to the residents in the population it serves. PHG started the Support Services Division of the agency in 1996. Before the agency provided support services to their residents the average length of stay in housing was 18 months. Since the agency began providing support services to residents the average length of stay has increased to 36 to 38 months.

PHG has a specific focus on the chronically street homeless population through its Coming Home program. PHG's Coming Home program involves six months of intensive services to formerly street homeless individuals who are moving into permanent housing. Tenants receive one-on-one support from housing stabilization workers to help them learn life skills, many of which they may never have learned before. Coming Home serves approximately 140-170 single individuals at a time, primarily between the ages of 31 and 50. Thirty percent of the participants have a mental illness and 25 percent are dealing with substance abuse issues. Although it is not clear how long the participants were homeless before starting the program, 19 percent were on the street the week before starting, 49 percent were in emergency shelter, 16 percent were in transitional housing, 12 percent lived with relatives or friends, 2 percent were in rental housing, 1 percent were in psychiatric facilities, and 1 percent were in substance abuse treatment facilities. Almost all of the participants completed the intensive services and "graduated" from the program into permanent housing.

PHG operates from a harm reduction/abstinence encouraged model; tenants have no requirement to be in treatment or working toward recovery. The aim is for people to feel safe and secure in their own apartment. Staff members are equipped to assist a tenant in receiving treatment if the tenant is motivated to do so.

PHG also administers the Shelter Plus Care program for the King County Department of Community and Human Services. Seattle has 512 Shelter Plus Care housing units operated through partnerships with 14 service agencies in the city. Each agency has a housing point person who works with PHG to fill the Shelter Plus Care units. Waiting time to obtain a unit ranges from 3 to 18 months depending on the agency. Shelter Plus Care in Seattle supports persons in several PSH venues from SROs to private market apartments. The program offers subsidized housing in private markets, low income housing properties, or group home settings as well as case management, employment, mental health, and chemical dependency services. Services are provided with a harm reduction approach. Four of the agencies operating Shelter

Plus Care units (the Sobering Center, DESC, the REACH Project, and Harborview Mental Health Services) have a particular focus on the chronic street homeless population, which they define as having been homeless for two years or more during which they spent substantial time on the street and are challenged by disabilities. Other agencies in the Shelter Plus Care program provide permanent housing for homeless individuals with disabilities (such as mental illness, chronic substance abuse and/or HIV/AIDS) and these individuals may or may not have been chronically homeless on the street.

Shelter Plus Care tenants must participate in intensive case management services as a Federal requirement attached to the housing subsidy. In addition to regular meetings, case managers conduct at least four home visits in the first year of client participation and more as necessary. The case managers connect clients to whatever community resources they need and have the ability to move people to more independent housing or more intensive housing as the need arises. After the first year, clients are expected to have at least two contacts with their case managers annually. The program experiences about a 20 percent turnover every year, among which 10 percent did not succeed in the program and another 10 percent moved on to independent living (no supportive services) with or without a housing subsidy.

A Shelter Plus Care Coordinating Committee guides the Shelter Plus Care program; the Committee includes representatives from PHG and the 14 partner agencies, the King County Mental Health, Chemical Abuse, and Dependency Services Division, and King County Housing and Community Development Program. The committee members represent a broad range of homeless services to allow for flexibility in programming.

Supportive Services

Seattle-King County Health Care for the Homeless Network. The Seattle-King County HCH Network is part of the Department of Public Health, Seattle and King County, Community Health Services Division. The network was one of the original HCH grantees funded by the Robert Wood Johnson Foundation. It contracts with various agencies and service providers to offer a comprehensive health service approach to meet the varying needs of chronic street homeless people as well as other homeless populations. The four primary contract agencies serving the chronic street homeless people are the Pioneer Square Clinic (owned and operated by Harborview Medical Center), Evergreen Treatment Services, Pike Market Medical Clinic, and the Seattle Indian Health Board.

Pioneer Square Clinic's main service site is its outpatient clinic on Third Avenue, a few blocks from DESC in the south end of downtown. Pioneer Square Clinic also operates a small clinic site co-located with the Public Health Needle Exchange program (known as Second Avenue Clinic), targeting chronically homeless intravenous drug users. Pioneer Square Clinic offers nursing services, mental health, and substance abuse services at a number of downtown shelter locations (such as DESC and Angeline's Day Center). Pioneer Square Clinic's HCH –funded mental health/substance abuse staff form a "Downtown Mental Health Team" which also takes referrals from a range of shelters and programs (such as Mental Health Court), and serves those clients that entities like DESC and CPC cannot serve because the clients are not eligible for Medicaid. HCH's Mental Health Team coordinates closely with the community-based mental health

agencies, referring clients to them who appear to be eligible for the publicly funded mental health system. As the mental health system tightens its eligibility requirements, HCH staff members find it more difficult to transition clients to the community-based system of mental health care.

Evergreen Treatment Services also provides nursing care management to the REACH populations of chronic public inebriates through Registered Nurse services purchased from Pike Market Medical Clinic. Both services work through the Dutch Shisler Sobering Support Center. The Seattle Indian Health Board conducts outreach at the Chief Seattle Club and plays a major role in providing care to the Thunderbird Treatment Center.

Community Clinics. The major community clinics working with the street population are Pioneer Square Clinic, Pike Market Medical Clinic, and Seattle Indian Health Board. Of these, Pioneer Square Clinic has a particularly strong focus on the serving homeless people and the chronically homeless. The clinic uses an "open access"-scheduling scheduling model to make it easy for clients to get same-day clinical services, and providers have a high level of expertise in working with the downtown homeless population who have acute and chronic conditions.

Harborview Medical Center – provides urgent care, ambulatory clinics, Madison Clinic (for people with HIV/AIDS), dental clinic, and others. As the public hospital located a few blocks from downtown Seattle, Harborview Medical Center and its programs play a significant role in providing health services for the chronically homeless.

Public Health. Seattle and King County provide an array of special health services that, while not designed uniquely for homeless people, play a key role in addressing major health issues and disabling conditions. These include coordination of an HIV/AIDS prevention and care system (including a Needle Exchange program), a Tuberculosis Clinic, and sexually transmitted disease clinic. A 2002 outbreak of tuberculosis among chronically homeless people in downtown Seattle has strengthened the ties among the Tuberculosis Clinic, HCH Network, and the major homeless shelters, day centers, and housing programs serving this population. For example, the network has set up a system by which individuals are housed in motels until they are no longer contagious and then DESC and PHG have set aside seven units that these clients can use.

Affordable Housing

Seattle is taking a number of measures to develop affordable housing plus a continuum of housing for homeless individuals. The City of Seattle Consolidated Housing and Community Development Plan serves as the application for four HUD programs–CDBG, HOME, ESG, and HOPWA.[43] Its purpose is to identify needs related to housing, cost burdens, housing conditions, special populations, homelessness, and health and human development, and to describe the city's priorities to address these issues through specific activities funded by these Federal sources and other local funds.

[43] City of Seattle website – www.ci.seattle.wa.us

In addition, Seattle has a long history of voter-approved tax measures for low income housing and housing for homeless people. Voters approved housing levies in 1981, 1986, 1995, and 2002. The 2002 housing levy totals $86 million over seven years with the cost to the average homeowner of $49 per year.[44] The program includes five major initiatives plus administrative costs: rental preservation and production (provides housing to people with disabilities, elderly, homeless, and working families and resources for rehabilitation, new construction, or redevelopment of units); home ownership for low-income working families; neighborhood housing opportunity program with a mixed income, mixed use emphasis; rental assistance to prevent homelessness; and operating and maintenance (for rental units for extremely low-income individuals and people with disabilities).

Resources in Seattle that supportive housing developers may be able to use include:

- The Seattle housing levy with $6 million per year for 7 years devoted to housing affordable to households at 30 percent of median income housing – including capital and operating subsidy prioritizing those needing supportive services.

- The Sound Families Initiative (funded by the Gates Foundation) for $40 million over five years to provide PSH to homeless families, some of whom may be chronically homeless families.

- A combination of other Federal, state, and local funding sources such as HOPWA, CDBG, City of Seattle General Fund, Document Recording Fee Funds, ARCH, the Department of Corrections' "Going Home" program, Housing Innovations for Persons with Developmental Disabilities, Mental Health Housing Funds, and others.

There is now a conscious strategy to have nonprofit agencies provide supportive housing with a back door to public housing and Section 8 subsidized private and non-profit housing. The approach to housing development in Seattle seems to be successful through public/private partnerships. Nonprofit agencies are capable of using the capital and operating funds available to develop housing and to create supportive programs that assist the populations of interest.

However, funding for services remains more ad hoc than funding for capital and operating budgets. Service funds require separate applications and annual renewals. State and local budget cuts have created a relatively unstable funding environment. Funders are beginning to collaborate formally around these issues with city and county agencies expressing interest in creating a Housing Funders Group to formalize the approach.

The seven public housing authorities in the Seattle region have organized to create project-based Section 8 vouchers. Project-based Section 8 provides operations and some service funds through enhanced allowance for property management. For example, $500 per month per unit goes to owners (with the resident paying some). If the property management and maintenance costs are $300 then there is some flexibility to use the rest of the money for operations such as enhanced

[44] Seattle Office of Housing website – www.cityofseattle.net/housing

property management and services and it frees up Shelter Plus Care resource for others who need them.

Seattle Housing Authority and King County Housing Authority have also set up a system whereby people in Shelter Plus Care permanent supportive housing can stay on the waiting list for Section 8 vouchers and access this program when they are no longer in need of the level of services Shelter Plus Care requires. Although the person is considered permanently housed when in Shelter Plus Care, the housing authorities understand moving to Section 8 housing is yet another step on the continuum of care for homeless individuals, and it frees up Shelter Plus Care resources for others who need them.

The YWCA also provides low-income housing units in downtown Seattle. Approximately 10 percent of the women in its housing experienced chronic street homelessness and the vast majority would be homeless if they did not have this setting. No clinical services are provided in the permanent housing units.

Documenting Reductions to Chronic Street Homelessness

The Seattle/King County Coalition for the Homeless oversees an annual one night street count and survey of homeless shelters and transitional programs that have been conducted for 24 years (Seattle/King County Coalition for the Homeless, 2003). The survey of shelters and transitional programs is conducted the same night as the street count and produces unduplicated numbers of people using homeless services at the time of the count. The coalition returns annually to the same areas of the city and county to count street homeless individuals and also adds new neighborhoods to the count periodically. When comparing numbers of street homeless year after year, however, the coalition does some analyses that use a constant geographic area to avoid increases in numbers being attributable to the increase in area. From 1999 to 2002 the One Night Count of street homeless individuals went up 81 percent in "traditional count areas" from 983 to 1,779. From 2001 to 2002 the total count of street homeless individuals went up 40 percent from 1,454 to 2,040, but a substantial portion of that was from adding three new areas to the count. From 2001 to 2002, restricting the analysis to the 2001 geographic area, the number of street homeless individuals increased 23 percent in one year. From 1998 to 1999, during better economic times, a same geographic area count of street homeless individuals still went up 16 percent in one year.

During the 1999 to 2002 period, these increases in street homelessness occurred despite a 21 percent increase (from 4,917 to 5,940) in the survey count of the number of homeless individuals in shelter or transitional shelters. The community is losing ground while making improvements in resources for homeless individuals. One explanation is that homeless individuals are drawn to or sent to Seattle from surrounding communities. Our focus group of homeless individuals indicated that Seattle was known to be a relatively "good" place to be homeless. In the October 2002 One Night Count survey of shelters and transitional housing, 46 percent of the respondents indicated that their last permanent address was outside Seattle. In the late 1990s there were skyrocketing housing prices in Seattle and some tearing down of single room occupancy buildings, and these economic pressures probably pushed more people on to the streets because they could not afford the available housing. More recently the job market has soured, and our

interviewees reported that rising unemployment is also creating economic factors that result in more people being on the street. Even if people laid off do not become homeless, some may move to low rent quarters, making the affordable housing market tighter. Finally, substance abuse treatment has been cut back.

Of those using services in Seattle in 2002, 60 percent were single adults in shelter or transitional housing. Less than 1 percent used a safe haven. Forty-one percent of the homeless people using services were female and 38 percent were white (compared to 80 percent of the general population), 37 percent were African American (compared to 5 percent of the general population), 10 percent were Hispanic (compared to 3 percent of the general population), 5 percent were Native American (compared to 1 percent of the general population), and 4 percent were Asian/Pacific Islander (compared to 10 percent of the general population). The most frequently cited disabilities among homeless people using services were mental illness and chemical dependency.

The increase in Seattle's homeless population in general and street homeless population in particular can be attributed to many challenges overwhelming the efforts of programs to tackle the issue of chronic street homelessness. Seattle has seen an economic downturn at the same time affordable housing has decreased. Indeed, individual program data from DESC, CPC, and AHA indicate these programs are successful in assisting chronically street homeless individuals into permanent supportive housing.

Data in April 2003 from the Lyon Building, the Morrison Building,[45] and Union Building show that of the residents ever served between 70 and 78 percent have been in the housing for at least 12 months and between 39 and 58 percent have been in the housing for at least 24 months. Looking at the data from April 2002 without residents who enrolled in the building during the past year, 92 percent of clients remained in the Lyon Building for at least 12 months and 68 percent stayed at least 24 months. For the Union Building, 75 percent remained at least 12 months and 54 percent remained for 24 months. As further evidence of housing stability, looking at data from April 2001 without residents who enrolled in the building during the past two years, 75 percent of residents in the Lyon Building remained for at least 24 months and 58 percent of residents in the Union Building did the same.

An independent evaluation of the Lyon Building found that over 90 percent of the residents had been homeless at some time and 46 percent had been homeless for one-fourth of their adult lives (Northwest Resource Associates, 2002). Despite the high past incidence of homelessness among the Lyon Building's residents, 65 percent of them had lived there for more than three years (Northwest Resource Associates, 2002).

The AHA's Wintonia and Westlake programs also appear successful at keeping clients in housing. The average length of stay at the Wintonia is 3 years. If residents stay for 2 to 3 years they likely move on to more independent living situations (such as the AHA's Josephinum house). If they leave before the 2-year mark they are likely having difficulty remaining in

[45] In October 2001, DESC acquired the Morrison Building, formerly operated by the Seattle Housing Authority.

housing. The average length of stay at the Westlake is 5.5 years. Some residents transition to independent living and others transition into nursing care because of their age.

In four years, the CPC's Harbor House, a 20-bed save haven program for people with severe mental illness, moved 151 formerly chronically homeless individuals (50 percent of clients ever served) to permanent supportive housing.

Data from AHA's Wintonia and Westlake programs and DESC's Lyon and Union Buildings document that a substantial proportion of clients remain in housing for years. Although actual data about length of time on the street has not been gathered for these programs with the exception of the clients in the Lyon Building, both of these agencies are confident that they serve a chronically homeless group of people who have spent many years on the street outside of housing or service programs.

The Crisis Triage Unit analyzed the effects of the case review process for 32 people, comparing their circumstances six months before the case review and six months after it. Results showed a 62 percent reduction in using the unit's services during the six months after the case review compared to the six months before. A year later the same people still used the unit 60 percent less than before intervention.

Of the 120 clients the REACH Project served in 2002, 65 percent had improved or maintained their housing in either transitional or permanent supportive housing settings. Sixty-six percent had obtained substance abuse treatment. Seventy-three percent obtained income support and 53 percent secured a protective payee. Eighty percent of the clients obtained non-urgent health care. In addition, in the past three years 60 REACH clients maintained housing for longer than one year and more than 25 percent of these maintained their housing for over three years.

REACH staff members report that if homeless clients did not have intensive case managers working with them they likely would not sustain efforts to get housing or follow through on other issues such as medical concerns.

Public Funding

Funding sources for Seattle's many programs for homeless individuals are very diverse, and usually we cannot identify funding specifically for reducing chronic street homelessness. The following is an overview extracted from the Seattle/King County Continuum of Care Proposal:

- In the 2002 fiscal year, the city committed $10.0 million and the County $3.2 million out of their general funds to combat homelessness, and they also provided staffing commitments representing 18 Full Time Equivalents.

- The Seattle Housing Levy is another important source of local government funding—in September 2002 Seattle voters renewed the housing levy, costing homeowners an average of $49 per year, that will generate $86 million over the next 7 years to provide low income and subsidized housing.

- King County uses CDBG funding to acquire and rehabilitate rental units for homeless persons. Seattle uses CDBG funding to support the operations of emergency shelter, transitional housings, and day/hygiene centers.

- Seattle and King County Public Housing Authorities assign Housing Choice Vouchers to homeless households, and both have designated public housing units for homeless households.

- Seattle uses Mental Health Block Grant funds to administer involuntary treatment; the clients have included an unknown number of homeless individuals. In 2003 the funds will be used to fund HOST and the Crisis Triage Center.

- King County uses Substance Abuse Block Grant funds to support county services, including the Emergency Services Patrol, to homeless individuals.

- King County has a Regional Social Services Block Grant that supports services, primarily for DCFS staffing, for an unknown number of homeless individuals.

- King County uses TANF funds to assist homeless families and individuals.

- State programs, including the Washington State Housing Trust Fund and the Washington State Housing Finance Commission (tax credits for construction transitional housing), provide funding support for emergency shelter, transitional housing, acquisition, rehab and construction.

- Private and foundation funding supports programs providing food, emergency shelter, transitional housing, outreach and case management.

- Agencies use Federal funding from PATH and HCH to provide outreach and services. Seattle and King County also dedicate funds to HCH services.

Community Relations and Advocacy

Housing programs in Seattle sometimes face resistance from community members during development. Some believe the presence of housing for homeless and/or disabled individuals has many impacts on the community, some of which are adverse. Interviewees reported that responsible service providers should listen to the concerns of these neighbors and, to the extent possible, address them. At the same time however, the service providers should not change their approaches so dramatically that they can no longer achieve the agency's mission.

Table G.2: Local Agency Investments In Ending Street Homelessness

Agency	Type of Investment		
	Fund Services	Staff Provide Services	Fund Housing
CDBG	X		X
City of Seattle General Funds	X		X
DSHS - PACE (employment services)		X	
ESAP	X		X
ESG	X		X
FEMA	X		X
Federal Home Loan Bank			X
HCH - HRSA 330 (h)	X		
HOME	X		
HOPWA (SPNS)	X		X
King Co. General and Criminal Justice Funds	X		X
Local Foundations (Allen, Medina, Seattle)	X		X
Mental Health Block Grant	X		
PATH	X		
Regional Social Services Block Grant		X	
Seattle Housing Levy			X
Seattle and King County Public Housing Authorities			X
Shelter Plus Care (McKinney)			X
Substance Abuse Block Grant	X	X	X
Supportive Housing Program (McKinney)	X		X
TANF	X		
United Way	X		X
VA Healthcare for Homeless Vets		X	
VA Per Diem	X		X
Washington State Emergency Shelter Assistance Program	X		X
Washington State Housing Trust Fund			X
Washington State Housing Finance Commission (tax credits)			X
Washington State Medicaid Match	X		
Washington State Mental Health Funds	X		

Currently Seattle is embroiled in a community relations battle over development of DESC's 1811 project—a housing program for chronic alcoholics. The program is intended to be a consumer choice housing facility using a housing first and harm reduction model. The Downtown Seattle Association, an influential business association, strongly supports the 1811 project. Nevertheless, a wealthy business and a commercial development corporation in the area are opposing it. The corporation filed an appeal once DESC's master use permit was approved. The local decision ruled in favor of DESC and the corporation appealed to the county superior court. Again the decision ruled in favor of DESC. Currently the corporation plans to appeal to the State level.

In the meantime, DESC has spent $90,000 on legal fees during the appeal process and has been forced to return its tax credit to the State because of the time lost on the project. DESC will have to reapply for funding, extending development by two years. DESC has experienced resistance to other projects in the past, but not to this extent and each time it effectively won community's support.

Often in Seattle the projects that begin with this type of opposition eventually become well liked in the neighborhood. For example, when AIDS Housing of Washington developed its Bailey-Boushay House, a housing program designed for people living with AIDS, it faced extreme resistance from the community. Now, however, both the program and the building are an important and well-respected part of the community, which gives $1 million annually in private money to the program.

In a similar vein, AHA experienced a high degree of community resistance when it established the Wintonia building, but now Wintonia is so integrated into the area that it hosts the neighborhood council meetings. The local school objected when the Wintonia first opened, but now students from the same school put on shows every year for the Wintonia residents. Community residents see a positive impact on the street as public inebriation has declined with the Wintonia's presence. The people struggling with alcohol issues are drinking in a controlled environment. As part of the media coverage on the DESC 1811 project, the Seattle Times published a feature article on the Wintonia entitled "*Wintonia Has Proved a Good Neighbor"* (November 25, 2002). Local residents and retailers from the Wintonia neighborhood have testified on behalf of the 1811 project.

A number of agencies in Seattle have faced community resistance and many employ similar tactics to improve their relations with their neighbors. Some practical and successful strategies reported by service providers include:

- To the extent possible, agencies should seek sites that cannot be legally challenged and are not vulnerable to reversals of permits.

- Agencies should go into the development process knowing they must inform the community of their intentions.

- Agencies should act throughout the process with the attitude that people will ultimately do what is right.

- Agencies should include community members as early in the process as possible. The community should be notified of the project early on and should be updated often about its progress.

- Agencies should leaflet and/or make personal contact with the immediate neighbors in the area.

- Agency representatives should attend neighborhood/community boards or councils to explain the program as soon as they have site control. When convening these meetings, identify and mobilize your supporters within that community to attend the meeting. In

addition, ask supporters from other neighborhoods where similar housing has been accepted to come speak on behalf of the agency or the residents of such housing programs.

- A staff person should serve on the neighborhood/community board or council as long as the housing is open.

- Agencies should have open meetings with community members so concerns can be expressed and then addressed by staff.

- Agencies should not hide information from the public about the nature of the population intended for the housing or the services that will be provided.

- Agencies should create opportunities for community members to get involved through clothing drives, fix-up days and other activities that engage neighbors and help improve their understanding of the residents. They also become sympathetic and supportive of the program.

- Once in the community, program participants should maintain the grounds, participate in cleanups, report suspicious activity and generally be good neighbors.

Agencies in Seattle have often found that those most staunchly opposed to a program in the beginning are the same people who become the most supportive. Once they support the program, they can become references when it comes time to develop another housing program.

The Future—Maintaining and Enhancing the System

As noted above DESC is currently trying to move their 1811 project through litigation. This project will set up permanent supportive consumer choice housing for chronic public inebriates and individuals with multiple barriers.

CPC is working with King County Mental Health, Chemical Abuse and Dependency Division to create a plan for developing a significant new housing stock for persons with mental illness. CPC has two new construction projects currently underway. One project, a partnership with the University of Washington, will provide transitional housing to homeless, mentally ill, and chemically dependent pregnant and postpartum women and their children in order to research the impact of fetal alcohol births. CPC is also working with East King County officials and advocates to develop new and needed housing opportunities for the east county's underserved homeless mentally ill population. A new cluster housing project is currently in development in the east county and a unique "accessory dwelling unit" pilot project is in the planning stages.

Seattle and King County are developing an HMIS called Safe Harbors for their CoC. At this time they are completing their assessment of existing agency information systems and delineating the specifications for the system. Some agencies are reluctant to support the HMIS because they fear it could be used to deny clients services because of information about their past.

The Committee to End Homelessness (CEH) is a new group with an emerging "senior role" for planning around ending homelessness in King County. The CEH meets monthly and has two representatives nominated by each of the eight founding organizations (City of Seattle, King County, King County Judicial Drug Court, United Way, Coalition for the Homeless, and the Human Service Organizations of North King County, South King County, and East King County). These organizations have also committed resources and senior staff members. The CEH is being expanded to 30 members by adding at-large members. Like the coalition, this group does not have a specific focus on chronic street homelessness. Chronic homelessness will be a priority area for the CEH to work on.

Seattle Site Visit Participants

Participants	Organization
Walt Adam	Mental Health, Chemical Abuse, and Dependency Services Division, King County Department of Community and Human Services
Graydon Andrus	Downtown Emergency Service Center
Mary Burki	Housing and Community Development Program, Community Services Division, King County Department of Community and Human Services
Paul Carlson	Sound Families Initiative, Homeless and Supportive Housing Specialist, Office of Housing, City of Seattle
Donald Chamberlain	AIDS Housing of Washington
Christina Clayton	Homeless, Outreach, Stabilization, and Transition Project, Downtown Emergency Service Center
Don Clayton	Homeless, Outreach, Stabilization, and Transition Project, Downtown Emergency Service Center
Nancy Cole	Plymouth Housing Group
Tara Connor	Plymouth Housing Group
Georgia Conti	Community Services Division, Human Services Department, City of Seattle
Kelley Craig	Reach Project, Evergreen Treatment Services
Edward Dwyer-O'Connor	Harborview Medical Center
Michael Elsner	Mental Health, Chemical Abuse, and Dependency Services Division, King County Department of Community and Human Services
Trudi Fajans	Health Care for the Homeless Network, Department of Public Health, Seattle and King County
Sheila Fries	Shelter Plus Care Program, Plymouth Housing Group
Chloe Gale	Reach Project, Evergreen Treatment Services
Bill Hallerman	Archdiocesan Housing Authority
Shirley Havenga	Community Psychiatric Clinic
William Hobson	Downtown Emergency Service Center
Ron Jackson	Evergreen Treatment Services
Ken Kraybill	National Health Care for the Homeless Council
Betsy Lieberman	AIDS Housing of Washington

Richard Liranzo	Plymouth Housing Group
Daniel Malone	Downtown Emergency Service Center
Emily Meyer	Homeless, Outreach, Stabilization, and Transition Project, Downtown Emergency Service Center
Mike Nielsen	Community Psychiatric Clinic
Glenette Olvera	Harborview Community Mental Health Center
Alan Painter	Community Services Division, Human Services Department, City of Seattle
Wendy Pompey	Dutch Shisler Sobering Center, Mental Health, Chemical Abuse, and Dependency Services Division, King County Department of Community and Human Services
Diana Powers	YWCA of Seattle—King County & Snohomish County
Ashley Proto	Homeless, Outreach, Stabilization, and Transition Project, Downtown Emergency Service Center
Craig Rennebaum	Mental Health Chaplincy
Jim Rhodes	Homeless, Outreach, Stabilization, and Transition Project, Downtown Emergency Service Center
Lisa Cunningham Roberts	Health Care for the Homeless Network, Department of Public Health, Seattle and King County
Bill Rumpf	Office of Housing, City of Seattle
Rita Ryder	YWCA of Seattle—King County & Snohomish County
Sue Sherbrooke	YWCA of Seattle—King County & Snohomish County
Marian Shugrue	The Westlake, Archdiocesan Housing Authority
Kate Speltz	Housing and Community Development Program, Community Services Division, King County Department of Community and Human Services
Joe Thompson	Archdiocesan Housing Authority
Patrick Vanzo	Cross Systems Integration Efforts, King County Department of Community and Human Services
Linda Weedman	YWCA of Seattle—King County & Snohomish County
David Wertheimer	Kelly Point Partners
Janna Wilson	Health Care for the Homeless Network, Department of Public Health, Seattle and King County

Seattle Acronyms

ACCESS	Access to Community Care and Effective Services and Support
ACH	Seattle-King County Advisory Committee on Homelessness
AHA	Archdiocesan Housing Authority
AHW	AIDS Housing of Washington
CEH	Committee to End Homelessness
CPAC	Chronic Populations Action Council
CPC	Community Psychiatric Clinic
DCFS	Department of Children and Family Services
DESC	Downtown Emergency Service Center
DSHS	Department of Social and Health Services
FTE	Full Time Equivalent
HCH	Health Care for the Homeless Network
HMC	Harborview Medical Center
HOST	Homeless, Outreach, Stabilization, and Transition (Outreach and case management project through the Downtown Emergency Service Center)
LIHI	Low Income Housing Institute
MHCA	Mental Health, Chemical Abuse and Dependency Services Division
PATH	Projects for Assistance in Transition from Homelessness
PHG	Plymouth Housing Group
REACH	Reaching out and Engaging to Achieve Consumer Health
RWJ	Robert Wood Johnson
SPNS	Special Projects of National Significance
SHB	State House Bill

APPENDIX H: GLOBAL ACRONYMS

AACP	American Association of Community Psychiatrists
ACCESS	Access to Community Care and Effective Services and Support
ACLU	American Civil Liberties Union
AHP	Affordable Housing Program
AMI	Area Median Income
BLS	Bureau of Labor Statistics
CDBG	Community Development Block Grant
CMHC	Community Mental Health Center
CoC	Continuum of Care
CPS	Current Population Survey
DHHS	Department of Health and Human Services
DMH	Department of Mental Health
DOL	Department of Labor
ES	Emergency Shelter
ESG	Emergency Shelter Grant
FEMA	Federal Emergency Management Act
FHLBank	Federal Home Loan Bank
FMR	Fair Market Rate
HAP	Housing Assistance Plan
HMIS	Homeless Management Information System
HOME	Federal block grant to create affordable housing
HOPE VI	Homeownership and Opportunities for People Everywhere
HOPWA	Housing Opportunities for Persons with AIDS
HUD	Department of Housing and Urban Development
LIHTC	Low Income Housing Tax Credit
Medi-Cal	California's Medicaid program
MHBG	Mental Health Block Grants
MSA	Metropolitan Statistical Area
NIDA	National Institute on Drug Abuse
NIMBY	Not In My Backyard (meaning, don't put that program in my neighborhood)
NLIHC	National Low Income Housing Coalition
NOFA	Notice of Funds Availability
PATH	Projects for Assistance in Transition from Homelessness
PSH	Permanent Supportive Housing
RMU	Rent, Mortgage and Utility payments
S+C	Shelter Plus Care
SHIA	Supportive Housing Initiative Act
SABG	Substance Abuse Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SHP	Supportive Housing Program
SHU	Supportive Housing Unit
SMI	Seriously Mentally Ill
SPA	Service Planning Areas

SRO	Single Room Occupancy
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
VA	U.S. Department of Veterans Affairs
WIA	Workforce Investment Act
YMCA	Young Men's Christian Association
YWCA	Young Women's Christian Association

APPENDIX I: METHODS

The methods involved in this study were very simple, consisting of site selection and site visits.

Site Selection

We followed a two-stage process for identifying "exemplary" models or approaches to ending chronic street homelessness, during which we were looking for sites that:

- Had a plan, and had gone some distance toward implementing it, such that the relevant programs and services to reduce chronic street homelessness were functioning for at least one and preferably 2-3 years;
- Involved a systematic, coordinated effort of many programs, not just a single program;
- Had one or more ways to document the effectiveness of their approaches, ideally a time series of street counts.

In addition, we were looking for a judicious blend of communities to represent variations on some important characteristics, such as:

- Whether the whole spectrum of chronically street homeless adults are assisted, or whether assistance focuses on particular subgroups (e.g., those with severe mental illness, or veterans);
- The degree to which mainstream agencies are involved, and which ones. Strategies involving mental health, substance abuse, corrections, and veterans affairs agencies might be quite different, and informative to observe;
- Clear organizational and administrative structures; and
- Ongoing funding streams.

We also focused on finding communities where the homeless population is mostly "home-grown," as the problem of ending street homelessness is far more difficult in locations that serve as magnets for homeless singles.

To begin the process of finding sites to visit, the Urban Institute (UI) emailed experts describing the study and requesting their advice on communities with exemplary practices. We received a tremendous response to the email request for information, and Walter R. McDonald & Associates, Inc. (WRMA) staff requested copies of relevant studies identified by the respondents. The senior project team members developed a discussion guide for calls to community/ program directors and/or Continuum of Care conveners to confirm that the recommended sites met our criteria. The guide is reproduced at the end of this appendix. We used the first three pages only for the first wave of screening calls, and the rest of the guide for the follow-up calls.

Dr. Burt, from the Urban Institute, conducted a project team conference call training session on how to do the screening calls. Following the training, the project team gathered screening information through calls to community/program directors. During this process, some additional programs were identified that looked promising. Following HUD review and reactions to the first wave of screening calls, we again contacted the sites/communities of most interest with more detailed follow-up calls using the last part of the screening protocol.

In addition to programs that we identified as most promising, we also made follow-up calls to other programs or parts of systems in which those sites were embedded. To facilitate comparisons of community-wide systems, site information obtained from calls, emails, and documents were organized into a community site report form so that all reports would be in the same format. Each community site report included information about the individual programs we contacted that are part of the community-wide system. In some cases, if the program was not part of the community-wide system, it was so large as to provide systemic housing and services to a particular population within the community.

First Screening Round

To arrive at the initial list of 25 sites, we began with over 120 programs, including:

- A list of approximately 70 safe haven programs from the Corporation for Supportive Housing;
- 34 communities involved in California's Integrated Services for Homeless Adults with Serious Mental Illness program (known after the bill number by which it was introduced into the California Assembly, AB 2034, which began with three pilot sites and then was expanded by the legislature);
- Several programs recommended by the Corporation for Supportive Housing in California;
- Several Veterans Affairs Comprehensive Homeless Centers;
- 7 downtown business partnerships;
- 2 Ohio programs identified during the Continuum of Care Evaluation;
- 9 sites already heavily evaluated for the Connecticut Supportive Housing Demonstration Program;
- The heavily evaluated Pathways programs in New York City and Westchester County;
- 4 projects funded by the National Institute on Drug Abuse (NIDA);
- A project that transitioned from an Access to Community Care and Effective Services and Supports (ACCESS) project; and

- 2 self-referred programs in Seattle.

Clearly we had to winnow these 120 programs down to the most promising 25, which would be further narrowed after final screening calls to 10 to 15 programs. We did that winnowing in several ways.

Safe Havens

We received a list of close to 70 safe haven programs from the Corporation for Supportive Housing. Safe havens, by their nature, help street homeless people with disabilities take the first step off the street, which may be to a low barrier emergency shelter or indefinite stay transitional housing program. The list we received did not indicate whether any were part of systematic efforts in their community to reduce chronic street homelessness, and specifically whether they were linked with programs that either did outreach to bring people into the safe haven or to permanent supportive housing (PSH) to help them leave homelessness. Nor did it indicate whether any of them could document their impact in reducing chronic street homelessness.

Because we needed to narrow the list considerably, we contacted Vanessa Bernard of the Office of Special Needs Assistance Programs (SNAPS) within HUD's Community Planning and Development Division, and Ann O'Hara of the Technical Assistance Collaborative, Inc. in Boston to ask which ones we should pursue. Vanessa Bernard identified three—Pathfinders in Lowell, Massachusetts, Project H.O.M.E. in Philadelphia, and Harbor House in Seattle. Project H.O.M.E. is included in our list of 25, as is Harbor House in Seattle. We called the Lowell program and found that it is small and not linked in a systematic way to other programs, so we did not include it in the initial list of 25 communities/programs recommended for site visits.

Ann O'Hara identified two programs for further exploration—Hawaii and Atlanta. We interviewed both. The Hawaii program was identified as a HUD model for the nation in 1997. However, it lost much of its support from mainstream agencies, and it is questionable whether it is a model any more, so we dropped it from our list of promising sites. We could not ascertain whether the Atlanta program had sufficient data on the proportion of the people served who were chronically street homeless and how many became stably housed and experienced other impacts. While that safe haven program has become integrated into a larger effort and the model appears likely to be having an impact were the program able to document impact, because our original list of 25 had so many other promising sites, HUD did not select Atlanta for a second round of screening calls.

Veterans Affairs Homeless Programs

The Department of Veterans Affairs (VA) has five Comprehensive Homeless Centers (in Dallas, Little Rock, Cleveland, Los Angeles, and New York City) and a host of other programs serving homeless veterans in many places. All have good data on reductions in homelessness thanks to the evaluation system maintained by Dr. Robert Rosenheck at the VA's Northeast Program Evaluation Center. Dr. Rosenheck's data indicate that on average about 20 percent of people seen at VA homeless programs have current spells of homelessness of 12 months or more. But the VA does not have data on lifetime homelessness, or number of episodes. The odds are that

somewhere between 35 and 50 percent have had previous episodes that would qualify them as chronic.

To narrow the field, we asked Dr. Rosenheck which of the comprehensive centers he thought were best/most exemplary, and also whether there were other VA programs that we should consider as best practices. He identified two of the comprehensive centers: Los Angeles because it is massive, multi-faceted, and has strong links with local providers; and Dallas because, while it does not have a significant housing component connected to it, does concentrate on employment and seems to have some success with getting people jobs. So we called those two. In addition, we checked out the VA program in New Haven/West Haven, because Dr. Rosenheck said it was very good and had strong linkages to housing. It is also in the same place as some of the Connecticut Supportive Housing program's local sites, and we wanted to see the connections among them. All three were included in the list of 25, but other VA sites were never called.

BID-Sponsored Programs

We obtained a copy of *Addressing Homelessness: Successful Downtown Partnerships*, a study of programs sponsored by Business Improvement Districts (BIDs) that address homelessness, published by the International Downtown Association (2000). It covered BID projects in 18 cities. We could tell just from the report that many would not be relevant to this study, but we did check out BID projects in Philadelphia; San Diego; Washington, DC; and Times Square, New York City. The BID project in Philadelphia is part of the community system that we studied during the site visit to that city. While the Times Square BID continues to support the Consortium on the Homeless that it helped establish, it no longer provides any funding and the Consortium appears to be quite independent of the BID. The Consortium runs a very small respite center that has beds for seven men (and one emergency cot) and appears to have little systematic impact information. The Washington, DC project has many good aspects but connection to housing is not one of them. Hence those two were not on the list of the initial 25 sites that we recommended. The San Diego business partnership is not actually a BID, but is involved in San Diego's comprehensive effort that is on the list. It is interesting in its own right as an example of significant business involvement in homeless issues.

NIDA Demonstration Programs

We received information about several demonstration programs for substance-abusing homeless people, funded by NIDA. Most of these programs focused on reducing substance abuse, but not necessarily on ending homelessness. They did not have a strong connection to housing, and had very high treatment dropout rates (around 80 percent), so we did not pursue them. One, the Birmingham, Alabama project, did appear to have that connection, and it turned out to be true. So we included it in the initial list of 25 recommended sites. We also were able to contact a NIDA project in New York City, but it was very limited in scope and had no impact data.

California's Integrated Services for Homeless Adults with Serious Mental Illness

California's Department of Mental Health (DMH) funds counties under Assembly Bill 2034 (and before that, Assembly Bill 34) to provide integrated services to homeless people with mental illness, including the services needed to leave homelessness. The program as a whole has a strong evaluation system, which shows considerable reduction in homelessness for the people in the program. The program only reaches about 10 percent of potentially eligible individuals, due to a lack of resources to serve the others. Three pilot counties were funded in the program's first year (1999); there now are (or are about to be) programs in 34 of the state's 54 counties. We checked out seven sites that the state program administrator said were the strongest, including the three pilot sites. Four of these were included in the list of 25 recommendations. Three that we contacted (Madera, Humboldt, and Fresno) were judged to be too small to add to the list, given that we had other examples of these AB 2034 programs in cities where we could also check out other connected programs and strategies.

New York City Programs

In addition to Pathways, which was included on the initial list of 25 potential sites, we contacted Housing Works and the Times Square BID/Consortium on the Homeless. The latter appears to have fallen apart, or at least its links to housing are no longer strong. Housing Works (a program focusing on people with HIV/AIDS, many of whom are or were homeless) has no data. So neither program made the initial list of 25.

Other Programs

We interviewed two other programs to which people had referred us: an outreach program in New Haven, Connecticut that had been an ACCESS program; and Mercy Housing in San Francisco. Neither was judged appropriate for this project. In addition, HUD asked us about specific cities, which we checked out and found that:

- Memphis has good standards, a good data system (both street counts and unduplicated residential program data), but does not have a systematic service structure to reduce chronic street homelessness. It also has significantly less than optimal mainstream involvement, especially for housing resources. Based on the Continuum of Care (CoC) site visit, it also has hardly any PSH beds.
- St. Louis has a data system that is basically a system of intake and referral-to-the-nearest-empty-bed. It does not have a systematic approach to reducing any type of homelessness. It does have a longitudinal research project that has followed hundreds of homeless people for several years according to David Pollio, the researcher on the longitudinal project.
- Kansas City has the same sort of data system (intake and referral) as St. Louis. It does not have a systematic outreach-to-housing service structure or a systematic approach to ending street homelessness.

- An informant from Miami was among the people we contacted for recommendations about potential sites. She is, in fact, the Corporation for Supportive Housing's main contact for Florida, and might be expected to know if Miami offered any opportunities for our study. She referred us to the assessment of the BID efforts to reduce homelessness, but did not say anything about Miami as a relevant site. We therefore did not pursue it.
- Chicago did not appear to have any programs reputed to meet our criteria.
- Portland was included in the initial list of 25.

Second Round Screening

Based on information obtained from emails, evaluation reports, telephone interviews, websites, studies identified by experts, and other documents, the project team identified sites that have promising practices, meet our criteria, and appear appropriate for more in-depth study through site visits. The follow-up interviews confirmed that the sites we identified as most promising in our first deliverable would be appropriate for site visits.

During the second screening round, we tried to capture the community-wide model or approach, including all the programs or agencies involved with chronic street homeless people from initial contact through permanent housing. We also tried to determine whether community-wide efforts provide the variety of programs necessary so homeless individuals may immediately access services and some type of housing even if individual programs have rules that would make it more difficult to engage homeless individuals.

When inquiring about the target population, we again tried to determine whether the program or approach targeted chronic street homeless individuals, but we were still not always able to make this determination. Most programs and systemwide efforts told us they were targeting homeless individuals or homeless individuals with specific types of problems. While it was clear that some individuals with these problems had been on the street for long periods, few programs could document the proportion who were chronic street homeless individuals. After talking to more people within each community for the second screening round, we were able to determine that most communities we were considering could document levels of street homelessness through (at least) annual street counts.

We had similar continuing difficulties with identifying the scale/scope of the program or community effort. Some people with whom we spoke about community-wide efforts were unable to tell us the size of the community's homeless population and certainly not the size of the chronically homeless or street populations. Almost all programs/community efforts were able to identify the agencies with which they work.

The extent to which programs could document their impact on the chronic street homeless population was difficult to assess in the first round of screening and continued to be a problem in the second round. Programs that could not provide any documentation in response to our first screening round were not included in the 25 programs that emerged from that round. In the second round of screening, we attempted to identify not only individual program data that might

be available, but also whether the community conducted street counts, participated in an HMIS, or had some other type of community-wide data.

Based on second round screening, the project team verified the preliminary assessment of sites from the first round. We determined that some cities had several program sites that were fairly well coordinated *as citywide efforts*, and recommended that we combine these sites and spend more time in those communities. We could thus visit more *programs* than initially anticipated (but fewer *cities)* and focus on understanding the ways in which they are coordinated, how government and private sector agencies participate, and what evidence they have that the number of street homelessness have been reduced.

The communities of Boston, Columbus (OH), Los Angeles, Philadelphia, San Diego, and Seattle include 14 of the programs originally recommended for further study through a site visit, in addition to other programs. In addition, Birmingham, the location of the NIDA research project, was found to have a community-wide system that brings people in from the street and provides a variety of programs and types of housing until they achieve stable housing. Thus Birmingham also has several programs that would be worth visiting.

Site Visits

We visited seven cities, spending four days in Philadelphia, Los Angeles, and Seattle; three days in San Diego; and two days in Columbus, Boston, and Birmingham. During site visits we interviewed representatives of each community's overall planning and program development process, and representatives of selected programs that were part of the service structure addressing chronic street homelessness. We also held at least one focus group per city with 5 to 10 homeless and formerly homeless program clients who had been chronically homeless on the streets. Appendix C of this report gives the names and affiliations of everyone interviewed, with the exception of those who participated in focus groups. The master discussion guide for interviews with program and agency representatives and the focus group guide are attached to this appendix following the screening discussion guide.

DISCUSSION GUIDE FOR USE WITH CANDIDATE SITES[46]

HUD REDUCING CHRONIC STREET HOMELESSNESS PROJECT

Community (City/State):

Name of Program/Collaboration/Agency:

Name/Title/Contact Information of Person Interviewed:

Role of Person Interviewed (convener, data person, program director, etc.):

Interview Date:

Interviewer:

Introduction

If calling back to someone you've already interviewed:

This is _____, again, with (WRMA or UI). I (or _____ if it wasn't you) spoke to you a while ago about your program/initiative to **reduce chronic street homelessness**. We're calling back because we're potentially interested in coming to _____ to learn more about how your community is doing this.

If calling someone for the first time:

Hello, my name is _____, and I am with (WRMA or UI). I am working on a project for HUD to learn about successful approaches to reducing or ending chronic street homelessness. I have already spoken with _____, who said that you/your agency is actively involved in this effort in _____ (name of community). Is that correct? Are you the person I should be talking to, or is there someone else?

> *Get to the right person, and find out what the connections are between this agency and the ones we know about. If the connection is not there and the original people said it was, try to find out what's going on.*

---

[46] We have condensed this discussion guide by eliminating the spaces left for writing respondent answers, in the interest of report brevity.

Overview of Community/Understanding of System

> *<u>Definitely</u> ask these questions for San Diego (downtown area), Philadelphia, Boston (Area A), Seattle, and Columbus. Try it also for Birmingham.*

We're trying to understand the extent to which your community has a *coordinated system* designed to find street homeless people, bring them into services, and eventually help them move out of homelessness permanently. We understand that something like this exists in _____.

Is that true? If yes, how long has it been operating?

If just a plan, when do you expect it will begin to operate?

Could you describe it to me, and where your program/agency fits into the system? Get overall description – what agencies and programs are involved, what are their roles? Get full contact information for each.

Who developed this system? Who is the best person to describe it to us? Get full contact information.

Who runs/orchestrates/coordinates this system? Get full contact information. What exactly do they *do* as part of that coordination?

If talking with someone with an overview for the whole community: Over the course of this system's existence in its current form, about how many chronically homeless single adults have been helped to leave homelessness permanently in _____?

How do you know they have left permanently? What data do you have to show that?

Use the next section if you are talking to someone who actually runs a service program. It is not appropriate for a convener, data person, etc.

The next section asks about your own program and who you serve. Then we'll return to the issue of how your program gets its clients and how it connects to other programs and agencies in _____.

Characteristics and Numbers of People Served

Does your program focus on any specific problems or sub-populations of chronically homeless street people—i.e., does a person have to have the condition/problem to be eligible for the program *(probes: alcohol, drug or mental health problems, HIV/AIDS, veterans, etc.)*?

In addition to any conditions/problems that are a criterion for eligibility to your program, what other problems affect significant proportions of the chronically homeless single adults you serve (whether or not your program/initiative focuses on these problems)— e.g., alcohol, drug, mental illness, HIV/AIDS, etc.?

Other than the criteria of condition/problem you just described, do people have to meet specific criteria to participate in your program/initiative? What are they?

About how many on-the-street chronically homeless single adults do you serve over a given month or year? About what share of all such people in your community is this? If your clients are not coming to you directly from the street, how many had spent significant time on the streets before starting the chain of connections that led them to you?

Over the course of your program/initiative's existence in its current form, about how many chronically homeless single adults have you helped to leave homelessness permanently?

How do you know they have left permanently? Data?

End of questions asked during the first screening round. Begin second round questions.

How Your Program Works with Other Agencies or Programs

As part of its work to end chronic homelessness, does your program/initiative coordinate with other agencies or programs?

If we know of/are planning to go to other programs in the community, list them here and ask about them first (I'm supplying 4 chances to insert programs we know about. If that's not enough, add more):

Do you work with _____ (repeat for all types of agencies)?

In what ways?

Other programs/agencies you work with:
Which **government** agencies do you work with to help reduce chronic street homelessness?
Public housing authority? No _____ Yes _____ ------→ Does that agency:
_____ Bring chronically homeless people into the system initially
_____ Move people through or within homeless-specific programs and services
_____ Move people out of homelessness
_____ Pay for housing/paying for supportive services
_____ Develop/manage housing
_____ Provide supportive services
_____ Develop and maintain public support
_____ Other
For every activity checked, please describe the role of this agency and your program's relation to it in some detail
Same set of questions asked about the following agencies: mental health, substance abuse, Veterans Affairs, community development, welfare, child welfare/foster care, corrections/police agencies.
What **nongovernmental** agencies/programs do you coordinate with and how does each of these contribute to ending chronic street homelessness?

What agencies or programs are involved in **bringing chronically homeless people into the system initially**? How do they work? How do they connect to your program?
What agencies are involved in **moving people through or within homeless-specific programs and services**? How do they work? How do they connect to your program?
What agencies or programs are involved in **moving people out of homelessness?** How do they work? How do they connect to your program?
What agencies or programs are involved in **paying for housing/paying for supportive services?** How do they work? How do they connect to your program?
What agencies or programs are involved in **developing/managing housing?** How do they work? How do they connect to your program?
What agencies or programs are involved in **providing supportive services**? How do they work? How do they connect to your program?
What agencies or programs are involved in **developing and maintaining public support**? How do they work? How do they connect to your program?
What agencies or programs are involved in **developing and maintaining data to document services delivered and accomplishments of the system**? How do they work? How do they connect to your program?

Note to us: we may be able to combine the government and other program sections, just asking the questions for the other programs, and then determining whether they are governmental, homeless-specific, or other nonprofit.

Are there any additional sources of financial or in-kind support (including private sector or philanthropic) or interagency cooperation that make your program/initiative work? What are they and why are they essential?

Measuring Impact

Are there any data or other ways of measuring the impact of this program/initiative on chronic street homelessness? E.g., fewer homeless people visible on the streets, fewer days homeless during a specified period than before program involvement.

If yes, get details …what kinds of data/measures, how collected, when (one-time or ongoing), and by whom. Also, if we don't already have them, get copies of data collection forms, sample data sheets, summaries of most recent data, evaluation reports, etc. Ask specifically about measures that can show reductions in chronic homelessness.

Has your community conducted counts (or developed estimates) of its chronic street homeless population? *(if yes, **get the data**. Also get details …who, how, where, when, etc., contact person for additional information.)* Do these counts document changes (reductions) in the numbers of chronic (or street) homeless?

Do you think your program/initiative could be easily replicated in other communities interested in reducing chronic street homelessness? Why (or why not)? Have there been any issues highly unique to your community that might affect another community's ability to replicate this program/initiative *(probes: historical, political, demographic, or fiscal issues).*

Thank you for speaking to me about this program/initiative. We will probably be speaking with you again, as it is likely that we will be coming to _____ for this project. Please feel free to call us with any follow-up questions or to provide us with any additional information.

Interviewer: Please be sure to give them our e-mail address, phone number, and mailing address, and remind them to send us any materials that might helpful (e.g., evaluation findings, community action plans, etc.)

NOTE HERE – all materials they have promised to send (and come back and check off when you get them)

History/Overview/Context Discussion Guide

1. Describe the community's approach for ending/preventing chronic street homelessness.
   1.1. What are the **homeless-specific** components?
      1.1.1. Street outreach/drop-in
      1.1.2. ES
      1.1.3. TH
      1.1.4. PSH/SHELTER PLUS CARE
      1.1.5. Other housing
      1.1.6. Other agencies involved (e.g., empl and training, HCH)?
   1.2 What **mainstream** agencies are involved?
      1.2.1 What is the role of each?
      1.2.2 How does each fit in with each of the others?
   1.3 Be sure you have a **Who Does What (Exhibit 1)** chart that several people have reviewed, corrected, and approved.
   1.4 Can you **draw a pathway or several pathways** that show these interconnections, as a chronic street homeless person would experience them? How many **common, regular** ways are there for a chronic street homeless person to get from the streets into stable housing, with or without supports?
2. Who/what **coordinates and administers** the system? Whose responsibility is it to assure that all the pieces are working together?
   2.1. How does this happen (e.g., weekly meetings of key staff/providers, case tracking or other data feedback on a regular basis)?
   2.2. How does the actual coordination work?
   2.3. How many levels of coordination are there? E.g.,
      2.3.1. Agency heads for policy decisions,
      2.3.2. Mid-level managers for agency-to-agency bottlenecks
      2.3.3. Caseworkers for integrated case management
3. So far, what has it **cost to develop and coordinate the system** (not including costs for the actual homeless-related programs)?
4. **What needs** of which chronic street homeless people does the system address?
   4.1. Are there special focuses or specialization? (e.g., for SMI, substance abusers, PWAs, veterans)
   4.2. Do some subgroups get more attention/resources than others?

5. If the system is also **structured to prevent** people with histories of chronic street homelessness from becoming homeless again:

   5.1. How does it do this?

   5.2. For all chronic street homeless, or, if for particular subgroups, which ones?

   5.3. How are these people "credited" to the system since they may not actually become homeless again?

6. If you feel your system uses a **particular model of models of care** (e.g., housing first, stages in a continuum, clean and sober vs. not, voluntary vs. mandatory service participation), could you describe it/them and why you have chosen these approaches?

7. **History.** Nothing springs full-blown; it is important for us to understand how your approach has developed to date, and what you are planning for the future.

   7.1 What were the **stages/phases/steps** you went through to get to the system you have today?

   7.2 What were the **success points, turning points**?

      7.2.1 How was the cooperation/active participation of critical components achieved?

      7.2.2 Were there critical incidents or events or plans that changed your approach (e.g., new stadium, new loitering ordinance, desire to develop riverfront)?

      7.2.3 What were the issues/tensions, and what pushed things forward? What were the obstacles and how were they handled?

   7.3 How long has it taken so far?

   7.4 Assuming that you are not finished, what are the next stages you hope to accomplish? What are the **gaps** or problems with the current system, and what are you planning as ways to fill them?

8. **Who** made it happen? Describe the **leadership**, to begin with, along the way, and now. Is anyone so critical that if s/he left, the system would be in jeopardy?

9. How were/are **community relations** handled?

   9.1. What were the attitudes and roles of the police, business owners, transit authorities, others with a particular interest/problem with street homeless? Were these negative or positive?

   9.2. Did they change, and if yes, how and to what?

   9.3. How do you avoid the NIMBY response?

10. Did you have **providers who were willing and able** to take on chronic street homeless people, with all of their problems?

    10.1 If yes, please describe.

    10.2 If no, or not enough, what have you done to try to increase their willingness, or ability, or both? What have been the issues, what issues are still "hot," and how were/are these issues being handled?

11 How is the approach funded?

11.1 What funding streams are being used?

11.2 Who controls which funding streams, both originally and through any centralized mechanism if the community has one?

11.3 How do providers gain access to funding, and to the different funding streams if they are not combined?

11.4 What are the issues and problems for providers in getting appropriate funding, with respect to eligibility, willingness (to serve the relevant populations, accept particular funding streams, etc.), capability (to write proposals and also to do the work), knowledge of funds availability, timing and complexity of application process, etc.?

11.5 If multiple funding sources are mingled, how did this come about?

11.6 Do requirements of the funding sources create any barriers or promote any successes?

11.7 If the current funding reality took a while to develop, how did it happen and what did it look like when you started working to end chronic street homelessness (what funding was available, from whom, how hard to get, etc.)?

11.8 How vulnerable are the various funding streams you use to reduction or elimination? Are any likely to increase?

11.9 We all know there is never enough money. Where are the gaps and weak points in your system? If the community had more money, where would it go, realistically, considering politics and community pressures? Would it be used to reduce/end chronic street homelessness, or are the priorities elsewhere? If yes, where?

Outreach-Caseworker Discussion Guide

Use when interviewing outreach workers and caseworkers, as individuals or in groups.

Introduction

Introduce yourselves and WRMA/UI, describe study – best practices in ending chronic street homelessness, funded by HUD. Pass around project description if people want it.

Ask people to fill in the sign-up sheet

Describe how information will be used:

We will be naming cities and programs

We will be listing people we interviewed by name and program affiliation at the end of the report.

We will NOT be quoting outreach workers and case workers by name

We are very glad to have this chance to speak with you, the outreach/caseworkers who have the most direct contact with homeless people themselves and do the most to connect them to programs and services. We'll also be talking to the directors of the programs you work for, and to some of the clients who have gone through the system. But we are particularly interested in getting your views on your work, because you have the most down-to-earth experience of how easy or hard it is to link people up with the things they need.

1. **Who** do you outreach to/who comes to your drop-in program/who do you do case management with?
   - 1.1. (OR/drop-in only) Do you only approach/work with individuals, or do you also interact with street homeless in groups, as in encampments?
   - 1.2. If both, what is similar and what is different about your approach? If not both, why not?
2. Please describe **how** you do your work
   - 2.1. Where?
     - 2.1.1. On the streets, walking
     - 2.1.2. From cars or vans
     - 2.1.3. In shelters or feeding programs
     - 2.1.4. Do you go to jails, hospitals, or other such settings?
     - 2.1.5. At their residential program
     - 2.1.6. In my office or elsewhere that is inside but not where clients live
   - 2.2 When? What times of day or night?

2.3 Alone or in teams? If in team, with someone else from your program, or from another program?

2.4 Backup – are there people, or services you can call if you run into particular issues or problems? Which issues/problems, and where do you call?

2.5 Sharing information – ever?

2.5.1 If yes, with whom – your teammate, other teams or workers from your own agency, workers from any other agency?

2.5.2 If yes, what are the purposes of this information sharing? (e.g., facilitating service delivery, not tripping over each other's feet, putting all info into a single system, turning one of your "people" over to someone else for a next step in the system)

3. **What services/connections** do you have to offer the people you contact? Food, health care, cash benefits, housing, other?

3.1. What works to "bring people in" from the streets?

3.1.1. What do you offer that they want?

3.1.2. How do you build relationships/trust with the people you work with on the street/in this program?

3.1.3. How long does it take, usually?

3.1.4. Do you have one or more strategies that seem to work well (e.g., getting them tangible benefits while still on the street such as SSI or food stamps; approaching them at critical moments such as when they have been arrested, to see if you can get them to accept services/housing when they come out, other)

3.1.5. What is your relationship with police, storekeepers, other members of the public on your "beat?" If you act as a go-between in relation to street homeless people, about what, how do you do it, give examples? Do they help or hinder your outreach/casework efforts?

4. Is success (convincing someone to come in off the streets) contingent on personal relations, having something to offer, what?

5. **How are you able to connect your clients/residents to the other pieces of the system** including

5.1. How do your clients connect to services?

5.2. How do they get housing? How many steps does it take from the streets (e.g., ES, TH, the PSH, or directly into housing)?

5.3. How does your staff interact with other programs/agencies to assure that clients get what they need?

5.4. What are the specific linkages? How, literally, does it work?

5.5. If relevant, how does your program support formerly street homeless people in housing once you get them in it?

6. Please describe what you think of as the **typical route, or routes,** by which chronic street homeless people in this city are able to leave the streets and achieve stable housing, whether supported or not?

   6.1. Where do your own activities fit in?

7. Thinking about connections, to other homeless services and to mainstream programs and agencies, do you think there is a good ***system*** in this community for helping chronic street homeless people leave homelessness permanently?

   7.1. If yes,

      7.1.1. What are its essential parts?

      7.1.2. How does the system work (how do clients flow through it)?

      7.1.3. What keeps this system going?

   7.2. If no, or not a good one,

      7.2.1. What is missing?

      7.2.2. Where do things break down?

      7.2.3. Or is there just no structure at all for helping chronic street homeless people transition out of homelessness?

Data Issues Discussion Guide

Can the community document its success in reducing chronic street homelessness?

1. Does the community do **street counts**?
   1.1 Since when?
   1.2 What is the geographic coverage, frequency, who does it, other descriptive
   1.3 If yes, get the documentation.
2. Does an **HMIS** exist?
   2.1 If yes, is it capable of providing data for the last several (at least 2) years?
   2.2 If yes, have the data been used to measure the effectiveness of the approach?
      2.2.1 What do the results show? **Get the HMIS evidence** of reductions in chronic street homelessness?
   2.3 If no, what is the status of HMIS development?
3. Have any **state or local evaluations** of the community approach to reducing/ending chronic street homelessness been conducted?
   3.1 What do these studies find with respect to ending chronic street homelessness in your city?
   3.2 If anything available, get the results/documentation.
4. How does the community **use its data**, other than to document success?
   4.1 Daily for case management?
   4.2 Weekly or monthly for system feedback about glitches, bottlenecks in service delivery?
   4.3 To identify gaps and plan for additional programs/services?
   4.4 Reports to funders?
   4.5 To lobby for additional funding based on arguments of efficiency and effectiveness?
   4.6 Other?
5. **Collect community documentation** of as many of the following as possible with respect to people who experienced chronic street homelessness, from whatever sources can provide them:
   5.1 Decreases in numbers of homeless people who chronically spend nights in places not meant for habitation;
   5.2 Increase in numbers now stably housed in permanent supportive housing (stable = at least 1 year, also look for average length of stay of 12 months or more);
   5.3 Increases in numbers in regular affordable housing without supports (also stable, by above definition);

5.4 Increases in numbers receiving appropriate services from mainstream agencies (including mental health, substance abuse, cash benefits, health, health insurance, and so on), and keeping/ maintaining them for at least 1 year;

5.5 Increases in numbers employed in jobs that they have held for at least 6 months (doesn't have to be full time);

5.6 Increases in numbers/proportions being discharged from institutions (including correctional facilities and VA facilities) with appropriate housing resources and maintaining them for at least 1 year.

Program-Specific Discussion Guide

Use when interviewing program directors, also subset (marked with **) for caseworkers.

1. Describe **your program's mission or goals** related to chronic street homeless people.

   1.1 How long has it been serving chronic street homeless people?

   1.2 Was this part of the program's original mission?

      1.2.1. If no, how did the mission enlarge to serve this population? What issues were involved? How were they addressed?

      1.2.2. Are these still issues? How is your program addressing them?

   1.3 Are there other issues in serving this population? What are they? How is your program addressing them?

2. If you feel your program uses a **particular model(s) of care** (e.g., housing first, stages in a continuum, clean and sober vs. not, voluntary vs. mandatory service participation), could you describe it/them and why you have chosen these approaches?

3. **How do (formerly) chronic street homeless people **get into** your program?

   3.1 How easy, regular, routine are these routes to services for chronic street homeless people?

4. If your program does outreach/has drop-in –

   4.1 To whom, where, etc.?

   4.2. Why? What is the rationale for doing outreach/having drop-in?

   4.3. What services/connections do you have to offer the people you contact?

   4.4. What works to "bring people in?" What do you offer that they want?

   4.5. Is success contingent on personal relations, having something to offer, what?

5. If your program doesn't do outreach, or not much –

   5.1 Why not?

   5.2. What then serves as the entry point to your program for chronic street homeless people?

6. ****What does your program offer** (formerly) chronic street homeless people?

6.1 How does your program **move them on** to some subsequent stage or directly into permanent housing? or

6.2. How does your program support them in housing once you get them in it?

6.3. How easy, regular, routine are these routes to services and housing?

7. **How are housing and services linked in your program?

7.1 Voluntary or mandatory participation in services?

7.1.1. Right to housing even if do not participate in services?

7.1.2. If voluntary, please describe the approaches you use to induce people to participate in services and supports?

7.2. How do people taper off of supports, if they do?

7.2.1. Do they ever go completely independent?

7.2.2. Can they fluctuate in their use of supports, as needed?

7.2.3. Begin receiving again once they have become (mostly) independent?

7.3. How are **client funds** handled?

7.3.1. Must clients yield control to a representative payee?

7.3.2. Is rep payee available but voluntary?

7.3.3. Other arrangements for handling funds and assuring rent payment?

8. **How does your program **connect (how are you able to connect your clients/residents) to the other pieces of the system** including

8.1. How do your clients connect to services?

8.2. How does your staff interact with other programs/agencies to assure that clients get what they need?

9. **Please describe what you think of as the **typical route, or routes,** by which chronic street homeless people in this city are able to leave the streets and achieve stable housing, whether supported or not?

9.1. Where does your program fit in?

10. **Thinking about connections, to other homeless services and to mainstream programs and agencies, do you think there is a good ***system*** in this community for helping chronic street homeless people leave homelessness permanently?

10.1. If yes,

10.1.1. What are its essential parts?

10.1.2. How does the system work (how do clients flow through it)?

10.1.3. What keeps this system going?

10.2. If no, or not a good one,

10.2.1. What is missing?

10.2.2. Where do things break down?

10.2.3. Or is there just no structure at all for helping chronic street homeless people transition out of homelessness?

11. How does your program handle **relations with its neighbors**?

11.1As part of early siting and development?

11.2 At move-in?

11.3 Now?

12. How is your program **funded**?

12.1 How stable is the funding?

12.2 How hard is it to put together the funding package you have? How many applications, etc?

12.3 Issues/difficulties with maintaining funding package? Recent (or future) threats to funding?

12.4 What would happen if you lost significant funding?

13. What **data** do you collect on your own clients:

13.1 While they are with the program

13.2 How you learn about client experiences with other programs

13.3 How you connect your data with data from other programs or an overall data system such as an HMIS

13.4 How you learn about long-term (1 year +) client outcomes, and for what proportion of clients.

14. We all know there is never enough money.

    14.1 Where are the **gaps and weak points** in the system of programs and services in your community to serve (formerly) chronic street homeless adults?

    14.2 If the community had more money, where would you want it to go?

    14.3 Where *would* it go? Would it be used to reduce/end chronic street homelessness, or are the priorities elsewhere? If yes, where?

Focus Group Discussion Guide

For Participants of Programs to End Chronic Street Homelessness

Thank you for meeting with us today. My name is "XXX" and this is "YYY" and we are here as part of a study to understand how programs like *[name of program/s used to recruit]* can help people who have been living on the streets for a long time find a place to live and stay off the streets. You were invited because you have had these experiences. For this study, we are also talking with the people who plan, run, and pay for programs like this. We are also visiting other communities across the country to understand what they are doing to help people in need.

We would like to learn about your experiences in "getting off the streets" of *[name of this community]* and your ideas about what programs or services are working well and what can be done better. There are no "right" or "wrong" answers. We hope you will feel free to share your point of view even if it differs from what others have said. Often, we're just as interested in comments about difficulties as in comments about successes. At times, learning about difficulties is the most helpful. We are really just interested in understanding how well programs like those here in *[name of this community]* work from the perspective of people who have experiences like yours.

You've probably noticed the microphone. We're tape recording the session because we don't want to miss any of your comments. People often say very helpful things in these discussions and we can't write fast enough to get them all down. We will be on a first name basis tonight, and we won't use any names in our reports. You may be assured of complete confidentiality.

Well, let's begin. We've placed name cards on the table in front of you to help us remember each other's names. Let's find out some more about each other by going around the table. Tell us your name and where you live.

Note to facilitators:

Pay close attention to the many themes of interest in this study and allow the participants to raise them before you bring them up explicitly, they include:

- *ease of flow between multiple programs;*
- *availability of needed services;*
- *voluntary versus mandatory nature of program services, experiences with each;*
- *appropriateness of services/approach for various sub-groups of chronic homeless;*
- *preferences for types of services connected to housing, and **how** they are connected (required or voluntary);*
- *etc. ADD HERE…*

"Getting Off the Streets" for the First Time

I'd like to begin our discussion by asking everyone how and when you first came in off the streets (not just in for a meal or some time in a drop-in center)?

Probes to help the discussion along:

- What made you decide to "come in"? (word on the street, another homeless person, specific service provider…?)
- What program or person first helped you? *[we want to know what type of program this is/was so try to get exact name/s and confirm type/s later]*
- There must have been many times before you decided to "come in" that you thought about it, or that people asked if you wanted to "come in." What was different about this time? Were you just 'ready?" Did *[program/person]* offer you something or some service in particular that made it okay for you to leave the streets?
- What did you know about this program/person *before* you came in? How did you know this?
- Were the program and the help you received what you expected? Any "surprises"?
- Did you get everything you needed when you first came in? Was there anything that you didn't need/want but had to do?
- Was there anything that should have been done differently or better?
- How well would the program or services that helped you "come in" work for other people you know who are still living on the streets? What do they need? How could they be helped off the streets for the first time?

"Next Steps" After Getting Off the Streets

Now I'd like to talk about what happened after you first got off the streets. Did you return to the streets? Did you stay with the first program that helped you off the streets, or did you move onto another program or location?

Probes for those who went back to the streets:

- Why did you return to the streets?

- Was it because of something the program did or didn't do? What
- Was there anything that could have been done differently to stop you from returning to the streets?
- How many times did you go back to living on the streets before staying off this time?
- What would work best to stop people who have come off the streets for the first time from returning again?

Probes for those who stayed off the streets (and for staying off this time):

- How did you move from one program or location to another?
- Were the program and the help you received what you expected? Any "surprises"?
- Did you get everything you needed? Was there anything that you didn't need/want but had to do?
- Did you have to wait a long time for anything? If yes, how long, and for what?
- Was there anything that should have been done differently or better?
- How would you feel about having someone be a representative payee for you—that is, receiving your money every month and paying your rent and other bills, and then giving you what is left over? If a program required you to turn your money over to a staff person to manage, how would you feel about it?
- Would what helped you also work for other people you know who are still living on the streets? Who would it work for and why? Who would it NOT work for and why?

Staying Off the Streets

The last topic I'd like to cover with you is what it takes to keep people who have lived on the streets for a long time from ever going back. What types of services and supports are important to helping people stay housed for a long time (forever)? What do you need, now that you have been off the streets for a while? What will you need in the future? What have your experiences been, both good and bad?

Probes:

- What do you know about permanent housing programs *(like this one?)* in this community? Do they work? All of them, or only some? If only some, which ones and why those? How

good are they? Do they provide you with everything you need (or help you get what you need from other programs/places)?

- What are the most important things that will help you stay off the streets? Is there anything offered by permanent housing programs that you don't really need?

- In thinking about how the community can help formerly homeless people stay housed forever, is there anything that *[name of community]* should be doing differently or better?

- What do you think people who are living on the street right now need in order to leave the streets and come to programs such as this one? Would this program work for all of them, or just some types of people who are now living on the streets?

Are there any other experiences or ideas you would like to share with us before we end our meeting? Does anyone have any questions for us?

Thank you all so much for your time and help. When we are finished visiting all the places we are studying, we will write a report with our findings. We hope that other communities will read this report and learn about what they can do to help other people like you. What you have shared with us today will help these communities as they develop programs like this. Thanks again.

Distribute payments in envelopes and have them sign receipts for project accounting.

APPENDIX J: REFERENCES

Andersen, A., LLP; Center for Mental Health Policy and Services Research, University of Pennsylvania; K. E. Sherwood; and TWP Consulting. 2000. *Connecticut Supportive Housing Demonstration Program: Final Program Evaluation Report*, New Haven, CT: Corporation for Supportive Housing.

Boston Foundation. 2002. *Boston Indicators Report 2002.* Boston, MA: Author.

Burt, M. R., D. Pollack, A. Sosland, K. S. Mikelson, E. Drapa, K. Greenwalt, and P. Sharkey, 2002. *Evaluation of Continuums of Care for Homeless People: Final Report.* Prepared for U.S. Department of Housing and Urban Development. Washington, D.C.: U.S. Government Printing Office.

Campbell, M. 2001. "Lack of Affordable Housing a Detriment to City," *Birmingham Business Journal*, 30 April.

City of Boston. 2000. *Leading the Way: A Report on Boston's Housing Strategy FY 2001-2003.* Boston, MA: Author.

City of Philadelphia. 1996. Five Year Financial Plan: Fiscal Year 1997-Fiscal Year 2001. Philadelphia, PA: Author.

Coalition on Homelessness and Housing in Ohio. 1999. "Homelessness a 'Major Community Issue' for Central Ohioans," *Breaking Ground*, December: 1-6.

Community Research Partners. 2001. *How We are Doing in Central Ohio: Areas of Progress and Areas of Concern.* Columbus, OH: Author.

Community Shelter Board. 2003. *Moving Forward, March 2003, Rebuilding Lives:Breaking the Cycle of Homelessness.* Columbus, OH: Author.

——. 2003. "Executive Summary, Stakeholder's Input to FY 2003 Allocation Recommendations and Application Process: Report to the Board of Trustees, January 30, 2003," Columbus, OH.: Author.

——. 2002. *Preventing Homelessness: Discharge Planning from Corrections Facilities.* Columbus, OH: Author.

——. 2001. "Ending Homelessness in Columbus," Briefing for Members of the U.S. House of Representatives, Financial Services Committee, and the U.S. Department of Housing and Urban Development, November. Columbus, OH: Author.

——. 1999. *Good Neighbor and Shelter Certification: Draft for Public Comment*, 30 November. Columbus, OH: Author.

Corporation for Supportive Housing. 2001. *California Supportive Housing Resource Guide: FY 2001/2002.* Oakland, CA: Author.

Culhane, D. P., E. F. Dejowski, J. Ibanez, E. Needham, and I. Macchia. 1994. "Public Shelter Admission Rates in Philadelphia and New York City: Implications for Sheltered Population Counts," *Housing Policy Debate, 5*(2): 107-163.

Culhane, D. P. and R. Kuhn. 1998. "Patterns and Determinants of Public Shelter Utilization Among Homeless Adults in New York City and Philadelphia" *Journal of Policy Analysis and Management,* 17(1): 23-43.

Culhane, D. P., S. Metraux, and T. Hadley. 2002. "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing," *Housing Policy Debate,* 13(1): 107-163.

Davis, G., G. Johnson, and S.W. Mayberg. 2003. *Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness:* A *Report to the Legislature as Required by Division 5, Section 5814, of California Welfare and Institutions Code*. Sacramento, CA: California Department of Mental Health.

——— 2002. *Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness:* A *Report to the Legislature as Required by Division 5, Section 5814, of California Welfare and Institutions Code*. Sacramento, CA: California Department of Mental Health.

Emergency Shelter Commission. 2002. *Homelessness in the City of Boston Winter 2002-2003: Annual Census Report.* Boston, MA: Author.

Goldstein, H. 1990. *Problem-Oriented Policing.* New York, NY: McGraw-Hill.

Grieff, D., T. Proscio, and C. Wilkins. 2003. *Laying a New Foundation: Changing the Systems that Create and Sustain Supportive Housing.* New York, NY: Corporation for Supportive Housing.

Greater Philadelphia Urban Affairs Coalition, 1998. *Our Way Home: A Blueprint to End Homelessness in Philadelphia.* Philadelphia, PA: Author.

Hiller, A. and D. Culhane. 2003. *Closing the Gap: Housing (un)Affordability in Philadelphia.* Philadelphia, PA: Cartographic Modeling Laboratory, University of Pennsylvania.

Hunter, I., A. Sheff, B. Roth, and A. Dinova. 2002. *Welcome to…AB34/AB 2034: Comprehensive, Community-based Treatment Services for the Homeless, Forensic Mentally Ill*. San Fernando Valley, CA: San Fernando Valley Community Mental Health Center, Inc.

International Downtown Association. 2000. *Addressing Homelessness: Successful Downtown Partnerships.* Washington, D.C.: Author.

Kasprow, W. J., R. Rosenheck, D. DiLella, and L. Cavallaro. 2002. *Health Care for Homeless Veterans Programs: Fifteenth Annual Report.* West Haven, CT: Northeast Program Evaluation Center.

Kessler, K. and J. Wartell. 1996. "Community Law Enforcement: The Success of San Diego's Volunteer Policing Program." Los Angeles, CA: Los Angeles Reason Public Policy Institute.

Konrad, E. L. 1996. "A Multidimensional Framework for Conceptualizing Human Services for Integration Initiatives," *New Directions for Evaluation,* 69: 5-19.

Kromer, J. 2001. *Neighborhood Recovery: Reinvestment Policy for the New Hometown.* New Brunswick, NJ: Rutgers University Press.

Lamp Community. 2002. *The Philosophical Framework of the Community Model: An Approach to Providing Comprehensive Housing and Services to Homeless Individuals with Chronic Mental Illness.* Los Angeles, CA: Author.

Martinez, T. and M. R. Burt. 2003. *Changes in Service Use Patterns for Chronically Homeless People Placed in Permanent Supportive Housing.* Oakland, CA: Corporation for Supportive Housing.

McGuire, J., S. Berman, W. Daniels, A. N. Tran, and A. Mares. 2001. *Creating VA-Community Partnerships for Housing Homeless Veterans: The VA West Los Angeles Healthcare Center Experience.* Los Angeles, CA: Department of Veterans Affairs Greater Los Angeles Healthcare System.

Menino, T. M. 2002. *Leading the Way: A Midpoint Progress Report on Boston's Housing Strategy FY 2001-2003.* Boston, MA: City of Boston.

———. 2000. *Leading the Way: A Report on Boston's Housing Strategy FY 2001-2003.* Boston, MA: City of Boston.

Melaville, A. L. and M. J. Blank. 1991. *What It Takes: Structuring Interagency Partnerships to Connect Children and Families with Comprehensive Services.* Washington, D.C.: Education and Human Services Consortium.

National Alliance to End Homeless. 2000. *A Plan, Not A Dream: How to End Homelessness in Ten Years.* Washington, D.C.: Author.

Northwest Resource Associates. 2002. *Evaluation of the Lyon Building Supported Housing Program.* Seattle, WA: Northwest Resource Associates.

Office of Emergency Shelter and Services. 1997. *Fact Sheet.* Philadelphia, PA: City of Philadelphia.

——. 1996. *Year End Report.* Philadelphia, PA: City of Philadelphia.

O'Hara, A. and E. Cooper. 2003. *Priced Out in 2002.* Boston, MA: Technical Assistance Collaborative.

Orwin, R. G., H. H. Goldman, L.J. Sonnefeld, M. S. Ridgely, N. G. Smith, R. Garrison-Mogren, E. O'Neill and A. Sherman. 1994. "Alcohol And Drug Abuse Treatment of Homeless Persons: Results from the NIAAA Community Demonstration Program," *Journal of Health Care for the Poor and Underserved,* 5 (4): 326-352.

Proscio, Tony. 2000. *Supportive Housing and Its Impact on the Public Health Crisis of Homelessness,* New York, NY: Corporation for Supportive Housing.

Rosenheck, Robert, W. Kasprow, L. Frisman, and W. Liu-Mares. 2003. "Cost-effectiveness of Supportive Housing for Homeless Persons with Mental Illness," *Archives of General Psychiatry,* 60 (September): 940-951.

Rosenheck, R., W. Kasprow, L. Frisman, and L. Wen. (n.d.) *An Experimental Study of Supported Housing for Homeless Persons with Mental Illness.* West Haven, CT: Northeast Program Evaluation Center.

Seattle/King County Coalition for the Homeless. 2003. *The 24th Annual One Night Count of People Who Are Homeless in King County, Washington.* Seattle, WA: Author.

Shern, D.L., C. J. Felton, R. L. Hough, A. F. Lehman, S. M. Goldfinger, E. Valencia, D. Dennis, R. Straw and P. A. Wood. 1997. "Housing Outcomes for Homeless Adults with Mental Illness: Results from the Second-Round McKinney Program," *Psychiatric Services,* 48 (2): 239–241.

Strategic Homeless Planning Group. 2000. *Boston Strategic Homeless Planning Group: Summary Report.* Boston, Massachusetts: Author.

Tsemberis, S. and R. F. Eisenberg. 2000. "Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities," *Psychiatric Services,* 51 (4): 487-493.

Urban Land Institute. *2002 Downtown Birmingham, Alabama: A Master-Planning Process for Downtown,* Washington, D.C.: Author.

U.S. Department of Housing and Urban Development. 2002. "Fair Market Rents for the Housing Choice Voucher Program and Moderate Rehabilitation Single Room Occupancy Program Fiscal Year 2003," *Federal Register Part II,* 30 September: 4.

———. 1995. *National Evaluation of the Supportive Housing Demonstration Program.* Washington, D.C.: U.S. Government Printing Office.

U.S. Department of Housing and Urban Development
HUD USER
P.O. Box 23268
Washington, DC 20026-3268

Official Business
Penalty for Private Use $300
Return Service Requested

FIRST-CLASS MAIL
POSTAGE & FEES PAID
HUD
PERMIT NO. G-795

January 2004