A Partnership of the City of Raleigh, Wake County,
Wake Continuum of Care and Triangle United Way

Research and Review

Preliminary Report on Local, State and National Efforts to Prevent and End Homelessness

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INTRODUCTION

Efforts to prevent and end homelessness in Raleigh/Wake County must be informed by similar efforts around the country, innovative programs and services, research on evidence-based practices, and a thoughtful analysis of system priorities and gaps in the city and county. Specific resources reviewed for this report include the following:

- 10-year plans to end homelessness from Chicago; Indianapolis; Columbus/Franklin County, OH; Montgomery County, MD; Maricopa County, AZ; Memphis/Shelby County, TN; Philadelphia (Philadelphia Committee to End Homelessness); Philadelphia (Greater Philadelphia Urban Affairs Coalition); and Atlanta.

- Programs and services around the country that have innovative and successful approaches to outreach, housing, income/employment, services, subgroups, prevention, community buy-in/public awareness, and homeless management information systems.

- State-of-the-art federal, national, state, and local research on evidence-based practices to serve homeless individuals and families. A complete set of references is included in each section of the report.

- Information on Raleigh and Wake County from the following sources:

    - Wake Continuum of Care
    - City of Raleigh Five-Year Consolidated Plan 2000-2005
    - City of Raleigh One Year Action Plan FY 2004-2005
    - Wake County Consolidated Plan 2000-2005
    - 2003 Wake County Action Plan (the 2004 Action Plan was received when this document was largely complete)
    - The Triangle Alliance to Resolve Chronic Homelessness Comprehensive Plan

Using This Report

This report is organized into eight sections that represent key topic areas related to preventing and ending homelessness (see below). In the first seven sections, the material is divided into an introduction, what the research/literature says, what other cities are proposing (a look at existing 10-year plans), what other cities are doing (program examples and contact information for innovative services), and what Raleigh is doing/could do. The final section on homelessness management information systems features a list of key resources to guide planning and implementation of an HMIS.

Highlights from each of the substantive sections follow.

- **Outreach**—Effective outreach meets homeless people where they are, engages them in trusting relationships, and connects or reconnects them to needed mental health, substance abuse, health, housing, and social services. Some cities recognize the need to coordinate outreach efforts to make the system of services seamless to the individual or

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family. In the New York City Pathways to Housing program, outreach includes an offer of housing, independent of the need for any mental health or substance abuse treatment.

- **Housing—**Lack of affordable housing is one of the primary barriers to preventing and ending homelessness. Research shows that housing subsidies, with or without supportive services, can help prevent homelessness for at-risk families. However, housing alone is not sufficient. Many individuals and families need some type of services and supports to help them remain housed. Permanent supportive housing links housing to a range of flexible and voluntary services and supports designed to meet residents' needs and preferences. "Housing first," a type of supportive housing, helps individuals obtain housing without having to commit first to substance abuse or mental health treatment. Many communities are moving to a housing first approach to help stem the tide of chronic homelessness.

- **Income/Employment—**Individuals who are homeless need places to live and income to support them in their new homes. Though most homeless people are eligible for public benefits, few receive them, in part because of the complexity of the application process. Programs designed to help homeless people find and retain jobs must offer a comprehensive set of services that include housing, health care, mental health and substance abuse treatment, transportation, child care, etc. Some programs designed for people with disabilities, such as supported employment, show promise for people who are homeless. One of the latest trends, supported by a federal demonstration program, is to connect housing and employment opportunities for homeless people.

- **Services—**Supportive services can help homeless individuals and families achieve residential stability, psychiatric stability, and sobriety. Several of these services—such as Assertive Community Treatment (ACT) teams and integrated treatment for co-occurring serious mental illnesses and substance use disorders—are considered to be evidence-based practices. Services and systems that serve homeless people must be comprehensive and integrated, so that an individual can walk into any agency, be assessed, and be referred to or provided with needed services (the "no wrong door" approach). However, the homeless services system alone cannot prevent and end homelessness. Many cities propose to integrate their service systems, and they include mainstream providers in these efforts.

- **Subgroups—**The homeless population is heterogeneous, and any efforts designed to prevent and end homelessness must take into account the needs of various subgroups within the larger population. These include children, youth, parents, racial and ethnic minorities, and women who are victims of domestic violence, among other groups. Chronically homeless people are a relatively small percentage of the total homeless population, but they consume a significant amount of resources, so housing and services designed to meet their needs must be an integral part of any city's plan to end homelessness. Less intensive services may be appropriate for homeless families displaced by a job loss or health crisis. Two of the plans reviewed make specific proposals to attend to the educational needs of young children.

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- **Prevention**—Preventing homelessness is more cost-effective and humane than allowing people to become homeless in the first place. Prevention efforts must be designed to *reduce risk factors* that make individuals and families more susceptible to becoming homeless and *enhance protective factors* that mitigate against homelessness for people at risk. Specific strategies can range from emergency rental assistance, to comprehensive discharge planning policies, to rapid re-housing for individuals who become homeless. Prevention efforts geared to at-risk communities may be successful; several 10-year plans recommend neighborhood-based prevention and early intervention strategies.

- **Community Buy-in/Public Awareness**—Key stakeholders must be aware of and lend support to a community's efforts to prevent and end homelessness. These include elected officials, provider organizations, the business community, faith-based providers, the general public, and homeless and formerly homeless citizens. Cognizant of the need to engage these constituencies, several cities propose social marketing campaigns and other communications efforts, as well as regular report cards that keep the community apprised of progress toward selected goals.

- **Homeless Management Information Systems**—All communities that receive McKinney-Vento Act funds from the U.S. Department of Housing and Urban Development (HUD) are complying with HUD requirements to have a homeless management information system (HMIS) in place for the 2004 fiscal year (beginning October 1, 2004). The obligation to create an unduplicated count of homeless people is mandated by Congress. To help communities develop an HMIS, HUD has prepared a number of documents that outline planning and implementation strategies, review software packages, and highlight city and state HMIS efforts. Critical concerns such as client confidentiality and staff training are highlighted. These reports are available from HUD at www.hud.gov/offices/cpd/homeless/hmis/.

Raleigh and Wake County have an impressive array of services designed to prevent and end homelessness and a community that is actively engaged in the process. Recommendations are made throughout this report for ways in which such services could be better coordinated, with specific examples provided. The single biggest gap, as is true in most communities, is the lack of permanent, affordable housing for individuals and families living in poverty. Surely, the Partnership dedicated to creating the Raleigh/Wake County plan will address this and other significant needs as it selects strategies to form the backbone of its 10-year plan.

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OUTREACH

Once believed to be a nontraditional service, outreach is now considered the first and most important step in connecting or reconnecting homeless individuals to needed mental health, substance abuse, and social services and to housing (SAMHSA, 2003). Indeed, outreach has become the mainstay of working with homeless people who have serious mental illnesses and/or substance use disorders, who may have had previous negative experiences with traditional providers and who may have difficulty forming trusting relationships. Outreach focuses on meeting an individual's immediate needs for food, income, and shelter and must proceed at the client's pace and on the client's own terms. Outreach is the most common service offered by providers who receive SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) funds.

What the research/literature says: Outreach, whether in shelters or in the streets, is effective (SAMHSA, 2003). A study of individuals enrolled in the SAMHSA Access to Community Care and Effective Services and Supports (ACCESS) demonstration program revealed that even individuals with the most severe disorders, who are the most reluctant to accept treatment, will enroll in services and show improved outcomes when served by an outreach team (Lam and Rosenheck, 1999). Successful outreach is marked by adopting a nonthreatening approach; being flexible in the number and type of services offered, as well as the manner in which they are provided; and making numerous contacts over extended periods of time (Interagency Council on the Homeless, 1991; McMurray-Avila, 1997). People who have been homeless can be particularly effective at reaching their peers who are reluctant to seek help (SAMHSA, 2003).

What other cities are proposing: Outreach to people living on the streets has become a fairly well-established practice in the homeless services community, and most cities' 10-year plans make mention of their outreach efforts. Maricopa County, AZ, notes that outreach teams must be a fundamental component of multidisciplinary teams needed for an integrated services approach (see the services section of this report for further discussion of integrated services and systems). The Maricopa plan also suggests that volunteers—including members of faith communities, students, businesses, and neighborhood organizations—be recruited and trained by skilled outreach teams to help with this effort.

One thread that runs through the reports is the need to coordinate existing and new outreach efforts. Indianapolis calls for the need to appoint entities to coordinate street outreach that emphasizes moving people off the street and linking them with housing and an array of support services. Memphis proposes the development of a comprehensive, coordinated outreach program, and Maricopa County, AZ, addresses the need to coordinate outreach efforts to those individuals who are chronically homeless.

Among the plans, Chicago is perhaps the most forward thinking in that it ties street outreach to its housing first approach. In this case, the purpose of street outreach to people not requesting services will be to provide assessment and linkage to what the city terms "engagement housing," such as Safe Havens and other harm reduction approaches, and to permanent supportive housing.

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This follows the Pathways to Housing model of connecting people from the streets directly to permanent housing (see below).

What other cities/programs are doing:

Outreach coordination

Philadelphia's Outreach Coordination Center (OCC), run by Project H.O.M.E., 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. Representatives of all teams meet monthly to review activities and needs. The OCC maintains a database of all people contacted by the participating outreach teams, averaging about 2,000 unduplicated individuals annually. This database can be linked to the Office of Emergency Shelter and Services database, which means outreach workers can see if any of their clients have used shelter and, if so, how much. *Contact*: Genny O'Donnell, Director, Outreach Coordination Center, gennyodonnell@projecthome.org.

Outreach directly to housing

Pathways to Housing in New York City offers scattered-site, independent housing to individuals with serious mental illnesses, including those with co-occurring substance use disorders, when it contacts them through street outreach. Housing first contrasts with the "housing ready" or continuum of care approach in which an individuals moves from outreach to shelter to transitional housing to permanent housing (more information about housing first will be included in the housing section of this report). This approach to outreach acknowledges that the person's first and most pressing need is for someplace to live. It shortens the more traditional work of outreach to the period between first contact and when the individual is housed (several weeks in the Pathways to Housing program). Outreach workers are members of Assertive Community Treatment (ACT) teams that conduct what might be termed "in-reach" to people in housing to connect them to further services, based on their needs and desires. *Contact*: Sam Tsemberis, Ph.D., Founder and Executive Director, Pathways to Housing, Pathman101@aol.com or 212-289-0000.

Outreach as part of health care

Boston's Health Care for the Homeless Program provides outreach, assessment, and health care services to homeless individuals in shelters and on the streets seven days a week. In addition, the Boston program has outreach vans and street outreach teams that provide food, emergency care, medical assistance, referrals, and transportation to shelters, service providers, and hospitals. *Contact*: Jim O'Connell, M.D., Director, joconnell@bhchp.org.

Involving police in street outreach

Both **Philadelphia** and **San Diego** have police homeless outreach teams. In Philadelphia, the police Homeless Outreach Team (HOT) responds to street emergencies and coordinates its work with the Outreach Coordinating Center. San Diego's Homeless Outreach Team (HOT) combines

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uniformed officers, a mental health worker, and a benefits eligibility worker who reach out to homeless people who have mental illnesses, assess their needs, qualify them for services, and connect them to safe havens or other appropriate settings. *Contact*: Scott Bender, Sergeant, San Diego Police Department, sebender@pd.sandiego.gov or 619-692-4800.

San Diego also has a Serial Inebriates Program (SIP) that follows a drug court model, with officers who give chronic public inebriates living on the streets a choice between custody and an alcohol treatment program. *Contact*: Rich Schnell, Sergeant of Western Division and Police, San Diego Police Department, rschnell@pd.sandiego.gov or 619-692-4800.

What Raleigh is doing/could do:

Based on numerous documents, including the Wake Continuum of Care and Raleigh and Wake Consolidated Plans and associated Action Plans, it appears there are a number of groups in Raleigh that conduct street outreach. These include, but may not be limited to, Adult Community Treatment Teams, the McKinney Team, PATH, Community Outreach Teams, PACT, the Crisis Outreach Team, and the Inner City Mental Health Clinic (some of these groups may be the same but are called by different names in different documents). Additional groups conduct outreach to homeless youth.

Each of these teams may have a well-defined population, geographic area, or target group, but it is also likely their work overlaps. Raleigh may want to consider having one of these agencies serve as a coordinating center, much like the Philadelphia model. This could improve efficiency of response, avoid duplication of services, and give the city a better sense of who it is serving through street outreach. Each of these outcomes serves the ultimate goal of ending homelessness.

We understand that Alice McGee (Church in the Woods) is conducting outreach to homeless people who live in area woods. Does one of the current outreach teams serve this group, or could it? It may not be necessary to add additional outreach capacity if current efforts are better coordinated. In addition, outreach efforts will mesh well with a housing first approach, if the city decides to adopt this strategy. (Shortage of available housing is a significant concern and will be discussed further in the housing section of this report.)

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HOUSING

It goes without saying that people are homeless because they have no place to live. But the early 1990s mantra of many advocates that "housing, housing, housing" was the answer to the crisis of homelessness has given way to the understanding that many individuals and families, especially those with mental illnesses and/or substance use disorders, need supportive services to help them remain in housing. In the 1980s, independent, subsidized rental housing in sites scattered throughout the community—with access to supportive services—emerged as an alternative to residential treatment for people with mental illnesses. This type of housing developed in response to the failure of the residential continuum model—popular in the late 1970s and early 1980s—that was designed to move people with serious mental illnesses through a series of progressively more independent residential treatment settings until they achieved independent living. In this model, housing was contingent on receipt of services, and individuals had to be "housing ready," which typically meant they had to achieve psychiatric stability and sobriety and be willing to comply with treatment plans.

"Housing first" approaches have emerged as an alternative to housing readiness models as a way to engage individuals who have been unable or unwilling to accept treatment. Housing first models typically take a harm reduction approach—i.e., individuals with behavioral health problems can obtain housing without having to commit to substance abuse or mental health treatment. Services are voluntary, and housing choice is a key component (National Health Care for the Homeless Council, 2003). Tenants must abide by their lease requirements, and some housing first programs require participation in a money management program (generally a representative payee arrangement).

Both housing ready and housing first approaches fall under the general rubric of "supportive housing," which the Technical Assistance Collaborative (TAC) in Boston defines as follows:

> Permanent supportive housing is decent, safe, and affordable community-based housing that provides residents with the rights of tenancy under state/local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet residents' needs and preferences (O'Hara, 2003).

Permanent supportive housing can be in scattered-site apartments or in such congregate settings as singe-room occupancy (SRO) buildings. Some congregate settings focus on individuals with particular conditions, such as serious mental illnesses, while others serve a mix of groups that may include low-income individuals as well as formerly homeless individuals and families. Supportive services vary, depending on individual or family needs, but at minimum must include case management to provide or link individuals with the full range of services needed to remain housed. These include primary health care, mental health services, substance abuse treatment, money management, benefits assistance, job training, transportation, day care, etc.

Paying for housing. To date, the McKinney-Vento Act Homeless Assistance programs have been the major source of housing subsidies for supportive housing (O'Hara, 2003). Other federal resources used for affordable housing for people with very low incomes include the Community

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Development Block Grant (CDBG), HOME, and Housing Opportunities for Persons with AIDS (HOPWA) programs, governed by the U.S. Department of Housing and Urban Development's (HUD) Consolidated Plan. The Department of the Treasury provides low-income housing tax credits through the Internal Revenue Services. Public housing authorities control the use of public housing and the Section 8 Housing Choice Voucher program. State and local housing finance agencies and housing trust funds are additional sources of revenue for affordable housing.

Paying for services. Though some McKinney-Vento Homeless Assistance programs, including the Supportive Housing Program, provide funds for supportive services in addition to housing subsidies, HUD has made clear its intentions to focus more resources in the coming decade on housing development (Johnston, 2003). Among federal resources that are currently available to pay for supportive services in housing are those administered by the U.S. Department of Health and Human Services. These resources include targeted programs—such as Health Care for the Homeless (HCH) and Projects for Assistance in Transition from Homelessness (PATH)—and such mainstream programs as Medicaid and block grants to states that support the provision of mental health services, substance abuse treatment, and social services.

What the research/literature says: Once in housing with supports, the majority of individuals and families—regardless of their disabilities and other needs—stay housed, are less likely to become homeless, and are less likely to be hospitalized or spend time in jails or prisons (Rog, 1997; Lipton, 2000). A recent federally funded study that compared clients of New York City's Pathways to Housing program (a housing first program for people with serious mental illnesses and co-occurring substance use disorders) to a similar group served by the local residential continuum found that the Pathways housing first model achieved an 80 percent housing retention rate compared to 23 percent for the continuum group. The Pathways model also reduced hospitalizations more successfully and at a lower cost than the continuum programs (Gulcur et al., 2003).

There is some evidence that housing subsidies, with or without supportive services, can help prevent homelessness for families (Shinn and Baumohl, 1999). Subsidies are especially critical for those whose only source of income is Supplemental Security Income (SSI). On average, people with disabilities living on SSI needed to pay 105 percent of their monthly income to rent a one-bedroom apartment price at the HUD Fair Market Rent in 2002 (O'Hara and Cooper, 2003). In addition to subsidies, consumer choice in housing is associated with residential stability (SAMHSA, 2003). There is still a need to identify particular aspects of supportive housing that result in positive outcomes for clients (National Health Care for the Homeless Council, 2003).

Research also suggests that supportive housing may be cost-effective. In a study of homeless people with psychiatric disabilities in New York City (Culhane et al., 2002), those who moved to permanent supportive housing experienced marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated, resulting in a significant reduction in the cost of public services ($16,282 per person per year). Based on a cost of $17,277 per unit per year for permanent supportive housing, the net cost to housing providers in New York City was $995 per year (Culhane et al., 2002). A Corporation for Supportive Housing study in

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Connecticut found that Medicaid costs for individuals who moved to permanent supportive housing decreased for both mental health and substance abuse treatment ($760 per service user) and for in-patient and nursing home services ($10,900) (O'Hara, 2003).

What other cities are proposing: The general trend in other cities' 10-year plans is away from emergency shelter and transitional housing to permanent supportive housing. Chicago, for example, is in the process of transitioning its approach to addressing homelessness from a shelter-based strategy to a housing-based strategy. The city is developing an interim housing model in which short-term housing is provided for the minimum time needed to access permanent housing. Permanent housing will be based on a housing first model with homeless people playing a key role in the type of housing they choose and the level of services they desire.

Interestingly, though many of the plans call for a housing first approach, definitions of housing first differ slightly. The National Alliance to End Homelessness 10-Year Plan, which serves as the blueprint for many city and state plans, calls for housing first for families and permanent supportive housing for individuals with disabilities, using housing first to mean rapid entry into permanent housing for those who primarily need a roof over their head and limited services. Likewise, Indianapolis proposes a housing first approach that emphasizes placing homeless people in affordable housing. For people who need more intensive services, the city calls for a "housing plus" approach that "links housing units affordable to the poorest of the poor with support services" (Indianapolis Housing Task Force, 2002).

Montgomery County, MD, uses the term "housing first" to refer to both types of approaches:

> "Housing first" means permanent supportive housing (housing with services) for the chronically homeless. For less disabled people and families, "housing first" means moving them into permanent housing with links to services very quickly (Montgomery County Coalition for the Homeless, 2002).

The distinction between housing first as housing with limited services for families and housing with intensive services for individuals with disabilities is not as important as the overall approach, which emphasizes housing as the primary need of all homeless people. (It is important to note that although most housing first approaches take a harm reduction approach to substance abuse, projects that receive HUD funding cannot permit use of illegal substances on the premises [Burt et al., 2004].)

Many of the plans that call for a housing first approach note the significant change this model represents. The Chicago plan acknowledges that the proposed system change is a major challenge, which will require "agency and program-level reorganization, Board and staff training, and deliberate system-level change management" (Chicago Continuum of Care, 2002). The city also recognizes the need for an incremental approach to moving from a shelter-based system to permanent housing, proposing a dual-operating system that will evolve to the new system over several years. The 10-year plan prepared by the Philadelphia Committee to End Homelessness (2000) noted, "The concept of 'Housing First' is a change in Philadelphia thinking."

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The need for affordable housing: Of course, the move from shelter to permanent supportive housing for homeless people requires an increase in the availability and accessibility of affordable housing, which is in short supply in many communities. Many of the 10-year plans call for an increase in affordable housing without specific plans to make this happen. The City of Indianapolis is a notable exception. Its 10-year plan calls for making 1,700 additional rental units affordable over the next five years and linking these units to support services. An additional 400 families already living in affordable housing would receive support services to keep them from falling into homelessness. The plan includes a breakdown of the household types these units would serve and possible sources of capital funding, rental subsidies, and supportive services (see pages 5-6 of the Indianapolis plan).

Indianapolis has two advantages in being able to develop such a detailed and ambitious plan. The city's Coalition for Homelessness Intervention and Prevention hired the Corporation for Supportive Housing, which has spearheaded development of supportive housing in communities around the country, to recommend housing strategies. In addition, Indianapolis has a surplus of about 40,000 housing units. Though not currently affordable to people with limited incomes, the city envisions that much of its need for affordable housing can be met through rent subsidies and rehabilitation of existing units.

Other housing strategies: In addition to the need to increase the supply of affordable housing to people with extremely low incomes, many of the 10-year plans call for such strategies as the use of housing specialists to help individuals find affordable housing (Indianapolis) and some type of affordable housing clearinghouse (Chicago) or centralized housing information center (Memphis). Montgomery County, MD, proposes appointing and funding a high-level interagency housing workgroup, while the plan prepared by the Greater Philadelphia Urban Affairs Coalition (GPUAC) calls for development of a 5-year housing plan. Montgomery County also suggests reviewing zoning laws and policies that may impede affordable housing development (for more information on regulatory reform, visit the HUD-sponsored web site www.regbarriers.org). The GPUAC plan recommends the city consider a surcharge on entertainment activities that would help fund supportive housing and job training for homeless people.

What other cities are doing:

Supportive housing/Housing first

(The following is from an article Susan Wells wrote for *Healing Hands*, 2003, and a PATH-sponsored teleconference on housing first. See www.nhchc.org/healinghands.htm for the *Healing Hands* issue on supportive housing. For a transcript of the PATH call, see www.pathprogram.samhsa.gov/tech_assist/default.asp).

Pathways to Housing in New York City is one of the most frequently cited models of housing first for people with multiple disabilities, including mental illnesses, physical health problems, and substance use disorders. Pathways clients, 90 percent of whom have alcohol or other substance use problems, go directly from shelters or the streets into permanent housing in scattered-site New York City apartments that are privately owned. They get housing first, says

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Founder and Executive Director Sam Tsemberis, Ph.D., because "they want housing first." He can get a person into housing in two weeks if he has an opening. Once housed, Tsemberis says, "individuals' priorities shift from ensuring their survival to improving the quality of their lives, and that's when they become interested in the other services we offer."

To support Pathways' 450 clients in housing, modified Assertive Community Treatment (ACT) teams provide a wide range of health, mental health, substance abuse, and vocational services. About a quarter of ACT team member are consumers, because Tsemberis believes peers better understand how services should be delivered to other consumers. Clients have two requirements: they must meet with staff a minimum of twice a month and pay 30 percent of their income toward their rent by participating in a representative payeeship arrangement. Pathways may hold the lease and sublease to the tenant; other times the program signs as the guarantor. Vouchers are between the tenant and the landlord, and sometimes the tenant holds his or her own lease.

Tsemberis funds his program with a complex mix of federal, state, and local funds, including McKinney-Vento Homeless Assistance programs. Pathways costs about $20,000 per person per year, including $9,000 for the apartment and $11,000 for the ACT team. *Contact*: Sam Tsemberis, Executive Director, Pathways to Housing, Pathman101@aol.com or 212-289-0000.

Direct Access to Housing (DAH) in San Francisco, a program of the San Francisco Department of Public Health, takes a slightly different approach to housing first. Homeless individuals who are high users of the public health system—including those with active substance abuse disorders, serious mental health conditions, and/or complex medical problems—are eligible for permanent supportive housing in one of five single-room occupancy (SRO) residential hotels or a licensed residential care facility (for people coming from locked psychiatric institutions who have chronic medical problems). Currently, the DAH program operates 370 units in its 5 SROs, which range in size from 33 to 92 units, and 33 units in the residential care facility. The majority of SRO units have private baths and shared cooking facilities.

The Public Health Department "master leases" the units, and owners are responsible for making improvements such as space for supportive service and property management offices, community meeting rooms, community kitchens, and additional bathrooms. Residents have rights of tenancy, pay 50 percent of their income (largely Supplemental Security Income) for rent, and are required to participate in a money management program. Federal, state, and local funds pay the balance of the costs, which amount to approximately $1,200 per month per resident in the SROs.

DAH receives referrals from street outreach teams, emergency shelters, high-utilizer case management teams, primary care clinics, and institutional settings. Each unit in the DAH buildings is attached to a specific referral point. For example, because the first DAH facilities were designed to house people directly from the streets, a large percentage of the units are controlled by Healthcare for the Homeless and other street outreach teams. Services are available on-site, but are voluntary. All six sites have between three and five on-site case managers, which may include peer advocates, and an on-site director. In addition, all sites have access to medical care and to a roving behavioral health team. Of 650 chronically homeless

people housed by DAH since it began five years ago, 85 percent have remained housed (*San Francisco Chronicle*, May 9, 2004).

Beyond Shelter in Los Angeles is credited by the National Alliance to End Homelessness as the national leader in the development and promotion of housing first strategies for homeless families. Beyond Shelter's housing first program serves homeless families with children referred from more than 50 agencies throughout the Los Angeles area, including shelters, transitional housing programs, residential drug treatment programs, domestic violence programs, and homeless access centers. The majority of the 400 families served each year face multiple challenges that lead to unstable living patterns and/or histories of homelessness. For example, approximately 50 percent of mothers are in recovery and approximately 40 percent became homeless due to domestic violence.

Unlike Pathways to Housing, which takes people with substance use disorders directly from shelter or the streets into housing, Beyond Shelter requires that an adult family member with a history of substance abuse have at least 6 months in a recovery program before moving into permanent housing. Families who have experienced domestic violence must have at least 4 months separation from their abusive partner.

Beyond Shelter staff work with families to develop a Family Action Plan, and each family is assigned a case manager to help them carry out the plan. Most get permanent housing within 3 months. The goal is to provide 6 months of home-based case management after the family gains permanent housing to help them make the transition to mainstream services. Approximately 75 percent of families access a Section 8 subsidy through targeted Section 8 programs. Primary funding is from HUD, particularly the Supportive Housing Program. From 1989-2001, the program enrolled more than 2,500 homeless families, with approximately 2,200 relocated to, and stable in, permanent housing. *Contact*: Tanya Tull, President and CEO, Beyond Shelter, TanyaTull@beyondshelter.org or 213-252-0772.

Rebuilding Lives in Columbus, OH, is a program of the Columbus Community Shelter Board designed to meet the short-term needs of homeless men and women through an improved safety net of emergency shelter and their long-term needs through the development of 800 units of supportive housing. As of March 2004, 450 units of supportive housing were operational, and another 75 units were in the development process; 80 percent of tenants have maintained their housing for a year or more (Rebuilding Lives Status Report, March 2004).

Housing types are mixed. Rebuilding Lives housing includes scattered site and single-room-occupancy (SRO) high-rise housing, public housing, and Section 8-based housing. All programs are relapse tolerant, and only one program has sobriety as a condition of admission. Services are generally voluntary but engagement is high, according to a report by HUD (2004)—60 to 100 percent of residents participate, mostly in case management, employment, treatment and recovery, and basic life skills. Recently, the city received one of the 11 Collaborative Initiative to Help End Chronic Homelessness grants, and it will use these funds in part to establish a Rebuilding Lives PACT (Program of Assertive Community Treatment) Team Initiative.
One interesting partnership in the Rebuilding Lives program is between the YMCA of Central Ohio and the Columbus Metropolitan Housing Authority (CMHA), which joined into an

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agreement to revitalize a public housing high-rise building (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. In addition to the Sunshine Terrace development, CMHA provides Section 8 subsidies, both project-based and tenant-based, for a majority of the supportive housing units that are part of Rebuilding Lives (HUD, 2004).

Of special note is the fact that resources for Rebuilding Lives are managed through a specially created Funders Collaborative, whose members include representatives of city and county government, all of the major public agencies, private agencies, and philanthropic organizations. 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 toward those goals" (HUD, 2004). The annual cost per bed of service-enriched housing in Columbus is $13,000-$14,000, compared to $21,188 for a minimum security jail, $69,800 for sub-acute medical detox, and $172,900 for a state psychiatric hospital. *Contact*: Barbara Poppe, Executive Director, Community Shelter Board, BJPoppe@CSB.org or 614-221-9195.

Affordable housing

The National Alliance to End Homelessness and HUD list the following resources for information on innovative ways to finance affordable housing (neither source makes clear whether the housing developed by these programs is affordable to people with extremely low incomes, i.e. 0 to 30 percent of area median income):

For information on Seattle's housing tax levy, see www.cityofseattle.net/housing/Levy.htm. According to HUD (2004), four times since 1981, voters have approved legislation that taxes homeowners to raise capital to develop affordable housing. The levy averages $49 per homeowner annually. *Contact*: Bill Rumpf, Deputy Director, Office of Housing, bill.rumpf@seattle.gov or 206-615-1577.

For information on the Los Angeles Affordable Housing Trust Fund, see www.ci.la.ca.us/lahd/afhsgtrstfd.htm. The fund was established in 2000 by the Mayor and the City Council through the city's budget process to support proposed housing developments the city hadn't funded. From seed funding of $5 million, the Mayor announced in 2002 a $100 million multi-year funding plan to help meet the critical housing needs in Los Angeles.

For information on how Montgomery County, MD, has used inclusionary zoning (a practice that requires developers to include affordable homes when they build a particular number of market-rate homes), see www.brookings.org/dybdocroot/es/urban/publications/inclusionary.pdf.

What Raleigh is doing/could do: Raleigh has a number of pluses and minuses in the area of permanent supportive/affordable housing. The pluses can be built upon, and the minuses need to be addressed: For example:

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Pluses:

- The city issued a $14 million housing bond in November 2000 for 700 units of housing for low and moderate-income households. Wake County began awarding Capital Improvement Plan (CIP) funds for affordable housing in 1999. (Are any of the units financed through these mechanisms affordable to households at 0-30 percent of area median income?)

- The City of Raleigh supports affordable housing development through its Joint Venture Rental Program and Rental Property Acquisition Program. (Are any of the units developed by these programs affordable to households at 0-30 percent of area median income?).

- The county plans to complete a design for a Safe Haven by December 2004.

- The City of Raleigh's HOME program funds support numerous Community Housing Development Organizations that provide housing and services to people with low incomes and special needs.

- Wake County's HOME program and CIP funds support numerous housing activities that benefit homeless and special needs groups.

- The Raleigh Housing Authority and Wake County Human Services provide 700 vouchers and supportive services, respectively, for families in the Work First program. Though this is aimed at TANF families, this is similar to the cooperation noted above between the YMCA of Central Ohio and the Columbus (Ohio) Metropolitan Housing Authority on behalf of homeless people.

- Raleigh received a commitment from the city and the county to match annual HUD permanent housing dollars. Both the city and the county have been very successful in using federal dollars to leverage other federal, state, local, and private support.

- The Wake County Housing Affordability Task Force recommended development of a housing resource center, and the Wake County Consolidated Plan calls for developing a seamless system between housing providers and central access to housing resources.

- A number of agencies in the city have housing specialists, who have access to housing readiness packets.

- The city and county support a number of HUD Shelter Plus Care and Supportive Housing Program projects.

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Minuses:

- Raleigh has a gap of 25,000 housing units affordable to people at 0-30 percent of area median income.

- In *Out of Reach 2003*, the National Low Income Housing Coalition estimated that a minimum wage earner in Wake County (making $5.15 an hour) would have to work 119 hours a week to afford a two-bedroom unit at the area's Fair Market Rent (NLIHC, 2003).

- The Community Development Block Grant (CDBG) program in the City of Raleigh targets households at 50-60 percent of area median income.

- Neither the Raleigh Housing Authority nor the Housing Authority of Wake County includes homeless people as a preference for public housing or Section 8 vouchers. The Section 8 waiting list for both agencies is at least 2 to 3 years. HUD requires that a PHA generally must target 40 percent of annual public housing admissions to families at 0-30 percent of area median income; comparable figures for the Section 8 tenant-based program and the Section 8 project-based program are 75 percent and 40 percent, respectively (see the *Federal Register* of March 29, 2000, 24 CFR Parts 5, 880, et al., page 16692). Public housing authorities control the bulk of affordable housing resources within a community and must be at the table in any serious attempt to end homelessness in Raleigh and Wake County.

- Landlords generally refuse to accept Section 8 vouchers. Some communities' 10-year plans include provisions to advocate with landlords on behalf of homeless people, particularly those with substance abuse and/or criminal justice histories.

- As in many communities, there is a preponderance of transitional housing compared to permanent supportive housing, reflecting years of accepted practice of requiring a period of transition for people with disabilities.

- Lack of political will and NIMBY issues have been cited as barriers to affordable housing development.

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INCOME/EMPLOYMENT

People who are homeless want and need to work. A survey of homeless assistance providers revealed that their clients cited "help finding a job" as their number one need, followed by help finding affordable housing, and help paying for housing (Burt et al., 1999). To maintain residential stability, individuals need a source of income, either from public benefits such as Supplemental Security Income (SSI) or, for most people, from employment. Because homeless people face numerous barriers to employment—such as lack of education, job skills, child care, and transportation; serious mental illnesses and substance use disorders; criminal justice histories, etc.—employment services designed to assist them must be comprehensive and coordinated. With the right combination of housing, services, and support, even individuals with multiple barriers to work can find some level of employment. Indeed, employment can be an adjunct to an individual's recovery from serious mental illnesses and substance use disorders. Those who can't maintain a sufficient level of work to support themselves may need help accessing the public benefits to which they are entitled.

What the research/literature says:

Income Supports

By virtue of their poverty and in many cases, their disabilities, most homeless people are eligible for public benefits, including SSI and food stamps. However, a survey of homeless assistance providers found that only 11 percent of clients were receiving SSI and 37 percent were receiving Food Stamps (Burt, et al, 1999). Homeless people face numerous barriers to applying for public benefits. The General Accounting Office (2000) reports that most homeless people cannot complete the complex and lengthy SSI application process without assistance. Often, homeless people lack the necessary financial and medical documentation needed to make a claim, and many have no other income to fall back on while their applications are being reviewed.

Outreach designed to identify eligible individuals and help them apply for benefits can be successful. Evaluation of a two-year joint outreach initiative by the Social Security Administration and the U.S. Department of Veterans Affairs to increase awards for disability benefits to eligible veterans found that veterans at the intervention sites were almost twice as likely to apply for benefits and to receive awards as those in the comparison groups (Dennis, Cocozza, and Steadman, 1999).

Finally, a change in eligibility criteria for SSI enacted by Congress has negatively impacted many homeless people. As of 1997, individuals with substance use disorders—no matter how severe—are not considered disabled under Social Security Administration guidelines for the purpose of receiving SSI, unless they have other disabling health conditions not attributable to their substance use (SAMHSA, 2003). It can be difficult to tease out the relationship between substance abuse and other mental and physical disorders.

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Employment

Findings of the federal Job Training for the Homeless Demonstration Program reveal that successful employment and training programs for people who are homeless must be comprehensive enough to address an individual's multiple and complex needs. A core set of services designed to help homeless people find and retain jobs includes the following (DOL, 1998):

- Outreach
- Case management
- Mental health and substance abuse assessment and referrals
- Other supportive services (e.g., child care, transportation, health care, life skills training)
- A full range of job training services, including remedial education, job search assistance, vocational skills training, work experience, on-the-job training, and placement services
- Post-placement follow-up and support
- Housing services, including emergency housing assistance and referrals to housing providers

In addition, the U.S. Department of Labor noted that housing and employment are inextricably intertwined. The final report of the demonstration program noted that, "Individuals in supported housing are more likely to become self-sufficient if they are given the opportunity to develop the skills needed to obtain and retain employment. Homeless individuals in employment and training programs are more likely to complete training and obtain and retain employment if they are living in stable housing" (DOL, 1998, p. ES-11).

The Corporation for Supportive Housing (CSH) tested a housing-based employment strategy for people with multiple barriers to work, including people with limited education and skills, mental illnesses and substance use disorders, histories of domestic violence and sexual abuse, physical disabilities, records of incarceration, and homelessness, among other barriers. The Next Step: Jobs Initiative was a three-year demonstration program that began as a partnership between CSH, the Rockefeller Foundation, and 20 nonprofit supportive housing providers in New York, Chicago, and San Francisco to enhance employment opportunities for their tenants. The participating nonprofit housing and service providers reoriented their existing social services to support the goal of work. Specifically, their strategies were to (Fleischer and Sherwood, 2000):

- "Vocationalize" the culture of their buildings to encourage and support work.
- Provide client-driven case management services to link tenants with education, jobs, training, and a variety of services that help them overcome their barriers.
- Make tenants a "standing offer of work" by hiring them within their organizations, placing them in competitive settings, and creating nonprofit businesses to employ them.

CSH refers to this as a "place-based" employment strategy. Results show that more than 70 percent of tenants in nine buildings tracked by an independent evaluation team voluntarily took part in employment services; half or more of the tenants were employed at least once during the initiative; and those working were more likely to have received employment services (Fleischer and Sherwood, 2000). CSH further reports that in a subset of buildings included in the

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evaluation, “the rate of employment doubled among tenants compared to their employment rate one year before their entry into supportive housing.”

However, Rog and Holupka (1999) note that there was a substantial degree of job turnover. Nearly two-thirds of the jobs were within the supportive housing industry and many were part-time or temporary. Further, the majority of people who were newly employed still relied on public benefits. Indeed, only a small percentage of people who receive SSI or Social Security Disability Insurance (SSDI) leave the rolls because of work (Bianco and Wells, 2001). Fear of losing health care benefits is the single largest impediment, according to the Social Security Administration (SSA). Increases in income can also cause rent increases in Section 8 housing and/or loss of food stamps and other cash assistance payments. Work incentive programs may be problematic for people with multiple barriers to employment, since providers who work with them are only paid when the individual leaves the SSA rolls (Bianco and Wells, 2001). Many agencies don’t have the fiscal resources to work with people who may not be successful.

These findings support a larger body of research on job training programs which shows that success in obtaining employment is rarely able to move a person out of poverty, even if the person has continuous, full-time employment (Rog and Holupka, 1999). This means that employment and training programs need to be complemented by efforts to increase wage levels (such as raising the minimum wage) or expand the scope of programs like the Earned Income Tax Credit. In its report *Out of Reach 2003*, the National Low Income Housing Coalition reports that the national housing wage for 2003 was $15.21 an hour or $31,637 a year—almost three times the federal minimum wage (NLIHC, 2003). The housing wage is the amount a person working full-time has to earn to afford a two-bedroom rental unit at the HUD Fair Market Rent while paying no more than 30 percent of income for rent.

Employment programs for people with disabilities. Several employment models developed for people with disabilities show promise for people who are homeless. These include transitional employment; supported employment, an evidence-based practice for people with psychiatric disabilities; and the Individual Placement and Support (IPS) Program (Shaheen et al., 2003). Transitional employment provides participants with work in time-limited, competitive jobs to gain employment experience and skills. Supported employment is federally defined as “competitive employment in an integrated setting with ongoing support services for individuals with the most severe disabilities” (Rehabilitation Act Amendments of 1986). In the IPS program, employment specialists link to an individual’s case management or mental health treatment team.

These models employ a “work, then train” mentality that differs from the earlier sheltered workshop approach. As opposed to extensive pre-vocational training, a work-first approach can motivate a person who is homeless to address other problems in his or her life (SAMHSA, 2003). Results from limited research on supported employment show that rapid placement in training and employment programs leads to greater and sustained employment, with no evidence that prevocational training is required. Ongoing support—such as a job coach or other support services—is important to help people stay in jobs (Rog and Holupka, 1999).

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Because many people who are homeless had their educations interrupted due to mental illnesses, addictions, or family separation, supported education can help them define their educational objectives and get their GEDs or post-secondary degrees (Shaheen et al., 2003). People re-entering school need the same housing and supportive services provided to those entering a competitive work environment.

What other cities are proposing: The plan prepared by the Philadelphia Committee to End Homelessness makes the boldest statement about the need for employment, calling it the "companion of housing" in building stability for people who are homeless. Several of the plans—including Indianapolis, the Greater Philadelphia Urban Affairs Coalition (GPUAC), and Montgomery County, MD, note the importance of providing subsidized child care and affordable and accessible transportation to make work possible. Montgomery County's plan also calls for supporting an increase in the minimum wage. The GPUAC plan notes the need to provide "reverse commuting" services to transport inner-city residents to suburban jobs.

The Indianapolis plan includes a series of well-defined steps designed to help ensure development of a continuum of employment services to support single adults, youth, and families in reaching their full potential. These include expanding both transitional and supported employment and exploring development of supported education programs. The plan also calls for requiring employment providers to demonstrate strong links to housing and support services as a condition of receiving funding; coordinating employment-based case managers with case management teams; and conducting joint trainings of employers, employment services providers, and providers of other services to homeless people.

Specific strategies for job creation and placement are also outlined in the GPUAC plan, which calls for placing 1,000 people in transitional, part-time jobs, paying at least the minimum wage, within the first two years of the plan (this plan was written in 1998 and is one of the earliest plans reviewed). These jobs would be in the nonprofit sector, with the city and the local school district, and would be combined with case management and GED preparation. The GPUAC plan also calls for placing an additional 1,000 individuals in jobs paying at least $6 per hour, with employer-paid medical benefits after 30 days. Provider reimbursement would be based on job retention, with payouts after 30 days, 90 days, and six consecutive months on the job, at a total cost not to exceed $5,000 per client.

Most plans propose connecting or re-connecting homeless people to mainstream resources, which include public benefits. The Atlanta plan specifically recommends creation of a city ombudsman/consumer advocate to help people who need benefits assistance. The advocate would link people to appropriate services.

What other cities are doing:

Income

The Maryland SSI Outreach Project helps homeless people who have serious mental illnesses enroll in the SSI program. The program began in 1993 as a demonstration project of the Social Security Administration and is now part of the Baltimore Continuum of Care, receiving $190,000 in HUD funding each year. Staff conduct outreach to people with serious mental illnesses living on the streets, help them gather necessary records and complete their application, and advocate on their behalf. The staff includes a project director, two counselors, and an administrative assistant. The terms of their grant require that they serve at least 100 people a year, and they spend an average of 30 hours on each case. The ability of the SSI Outreach Project to provide "presumptive" benefits to people who seem certain to qualify for SSI is a key program feature. This means that individuals receive up to six months of SSI payments while waiting to be deemed eligible. Since 1994, only two people of nearly 450 the project has deemed eligible have been denied SSI. *Contact*: Yvonne Perret, Project Director, SSI Outreach Project, 701 West Pratt Street, Room 216, Baltimore, MD 21201.

To hear an audio presentation on access to public benefits for people who are homeless, go to http://www.pathprogram.samhsa.gov/tech_assist/WeCanDoThis.asp. The SSA Service to the Homeless web site is at http://www.socialsecurity.gov/homelessness/.

Employment

Project Renewal in New York City is a multi-faceted program serving more than 15,000 homeless men and women who have mental illnesses and addictions with outreach, treatment, transitional and permanent supportive housing, and a full range of employment programs and services. Project Renewal's Next Step department coordinates education, training, placement, and retention services. Participants can take part in the culinary arts and computer technician training programs; more than 86 percent of culinary arts graduates have jobs, and the average starting salary for computer technician graduates is $22,000. Project Renewal also participates in the federal Jobs Access Reverse Commute Program, finding jobs in the New York and New Jersey suburbs for participants and transporting workers to and from their jobs. In addition, Project Renewal runs Job Links, a supported employment program for people with serious mental illnesses, and operates social purpose ventures that create employment opportunities for clients and generate revenue for the agency. These include catering, specialty farming, printing, and construction businesses. Part of the program's success is its focus on working with employers and new employees to ensure a smooth transition to work, including drug abuse relapse prevention programs. Funding sources include McKinney-Vento Homeless Assistance Act programs, the U.S. Department of Transportation, the New York State Office of Mental Health, the New York City Board of Education, and private foundations. *Contact*: Jason Shaplen, Next Step Project Director, jasons@projectrenewal.org or 212-620-0340.

The St. Francis House Moving Ahead Program (MAP) in Boston is a 14-week job readiness and life skills program for men and women who have experienced chronic homelessness, unemployment, and substance abuse. They must be drug and alcohol free and committed to

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returning to work. MAP participants, who live in residential treatment facilities while completing the program, learn how to set goals, search for jobs, write resumes, and conduct themselves in interviews, and each student completes an internship in his or her area of interest. An independent evaluation showed that more than 80 percent of program graduates are working and living independent, drug and alcohol-free lives. St. Francis House also operates the First Step Employment Program, to help participants set goals and explore barriers to work; *HirePower*, a nonprofit employment agency; and a collaboration between MAP and the Norfolk County Correctional Center in Dedham, MA, to help inmates in recovery from substance abuse reintegrate into their communities. Inmates complete the first part of the MAP program in custody and the balance of the program at St. Francis House after their release. *Contact*: Jocelyn Josette at the Moving Ahead Program, joet@stfrancishouse.org or 617-654-1257.

Larkin Street Youth Services' HIRE UP Program in San Francisco is part of the agency's comprehensive services for homeless youth ages 12-23 (for more information about Larkin Street services, see the subgroups section of this report). The program offers six components to help youth at all stages of their development, from immediate work, to workforce readiness and placement, to advanced training for specialized careers. Specific services include day labor; a job readiness certification program; a computer training class; educational services such as GED preparation and English as a Second Language instruction; job placement; and industry-specific technical skills training, currently offered in culinary arts, digital audio, animal care, and nonprofit/human services. All elements of the HIRE UP Program are designed to motivate and empower youth to take charge of their lives and ultimately gain independence and self-sufficiency. HIRE UP staff maintain regular contact with a youth's case manager to coordinate employment and education plans with the youth's other short and long-term goals. *Contact*: Rebecca Cherin, Director of Education and Training, rebeccacherin@larkinstreetyouth.org or 415-749-2848.

Triangle Residential Options for Substance Abusers (TROSA) in Durham, NC, is the largest therapeutic community for people with substance use disorders in the state. TROSA is a highly-structured, two-year residential treatment program for men and women with substance use disorders, approximately 20 percent of whom are homeless. The majority of residents have criminal justice involvement, and more than 70 percent of residents are minorities. As part of its services to help men and women recover from substance abuse, TROSA sponsors a number of educational and vocational opportunities. All TROSA residents who lack a high school diploma or GED are required to attend adult literacy or GED classes. Vocational training is available in services that maintain TROSA facilities, including transportation, vehicle maintenance, building construction, facility maintenance, and security. In addition, residents work in a number of agency businesses that serve customers outside of TROSA. These include moving, masonry, lawn care, catering, painting, framing, and contract labor. Residents preparing to graduate receive training in interviewing, resume writing, and personal finance skills. TROSA allows graduates to purchase donated cars for the price of the parts used to repair the vehicle at TROSA's automotive shop. *Contact*: Rosita Daye at TROSA, 919-419-1059, ext. 252 or send e-mail inquiries to TROSA@trosainc.org.

Ending Chronic Homelessness through Employment and Housing Cooperative Agreements were awarded in October 2003 to Boston, San Francisco, Indianapolis, Los Angeles, and

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Portland (OR). This is a new program of the U.S. Department of Labor's Office of Disability Employment Policy (ODEP), in cooperation with the U.S. Department of Housing and Urban Development (HUD), to increase and improve employment opportunities for chronically homeless individuals with disabilities. Department of Labor awards to the communities are supplemented by HUD permanent housing grants. This program will allow ODEP to evaluate whether partnerships of employment and permanent housing services result in a higher employment rate for people with disabilities. *Contact*: Randee Chakfin, ODEP, chafkin-randee@dol.gov or 202-693-7850.

What Raleigh is doing/could do:

Raleigh faces the same constraints as many other communities relative to the employment and educational needs of area residents, especially those living in poverty. According to the 2000 Census, 11.5 percent of Raleigh residents are living below the poverty line (defined as $9,310 for an individual). Even those earning significantly more than this are unable to afford the Fair Market Rents in the Raleigh-Durham-Chapel Hill area of $680 per month for a one-bedroom apartment and $799 for two bedrooms (Fair Market Rents can be found in the *Federal Register*, October 1, 2003). The average income of Wake County Mental Health/Developmental Disabilities/Substance Abuse Services clients is less than $6,600 per year, which is 21 percent of area median income. Twenty-five percent of students in Raleigh drop out of school, and 15 percent of adults over the age of 25 do not have a high school diploma or GED. Lack of transportation and affordable day care are cited as barriers for individuals and families that want and need to work.

In response, the city and county sponsor a number of programs designed to address the employment needs of their citizens. For example:

- Working for Kids helps non-custodial parents find jobs so they can meet their child support obligations.

- PRO-Familia is an employment program targeting low-income Hispanic families.

- JobLink Career Center is a mainstream service co-located with a wide range of Wake County Human Services' programs (e.g., social services, public health, mental health, child support, and housing).

Wake County Human Services' Work First Program serves approximately 3,500 families who receive Temporary Assistance to Needy Families (TANF) with supportive services such as day care, transportation, cash assistance, training opportunities, and Medicaid. However, according to the Corporation for Supportive Housing (2000), "while the nation's Welfare-to-Work program is placing an emphasis on people with multiple barriers [to work], it is restricted to [TANF recipients] and noncustodial parents of children receiving TANF. It leaves out the entire population of single adults with multiple barriers who do not meet the official definition of TANF recipient or 'noncustodial parent.'"

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Raleigh does offer employment services to non-TANF recipients, including the county-funded Supportive Employment Program that helps people with disabilities find and maintain jobs. The McKinney Team and the Women's Center run innovative greeting card businesses that employ formerly homeless people with serious mental illnesses and women on disability, respectively. The Inter Faith Food Shuttle's Fisherman's Project teaches cooking and food preparation skills to men and women who are homeless.

Unfortunately, the county-funded Jobs for the Homeless Program (JHP) was a victim of budget cuts. JHP offered jobs readiness and needs assessment, counseling, job development and placement, comprehensive case management, and peer support services for unemployed or under-employed homeless adults seeking permanent employment.

Regarding benefits, Triangle Disability Advocates is the only agency in the state dedicated to helping individuals who are homeless, destitute, and disabled—especially those with serious mental illnesses—secure disability benefits. Individuals in Raleigh who require less intensive help can complete an application for SSI with a number of community service providers. In addition, the Social Security Administration has staff located at Dorothea Dix Hospital, Central Prison, the Women's Prison, and the Wake County Jail. SSA has requested additional funding to hire an outreach specialist to serve homeless people.

Raleigh/Wake County has many of the program elements needed to help homeless and formerly homeless people find and retain jobs, from job readiness to social enterprises. However, the city and county do not appear to have a comprehensive program focused on homeless people, such the former Jobs for the Homeless. Missing elements also include an emphasis on post-placement follow-up for employees and employers, employment assistance for individuals leaving the criminal justice system, involvement of the local business community, and any connection between a person's housing and his or her employment (such as in the CSH Next Step: Jobs Initiative). Perhaps the Work First Program model, which includes tenant-based rental assistance from the Raleigh Housing Authority, could be adapted to serve people who are homeless; the experiences of the new ODEP/HUD grantees mentioned above may prove useful in this regard.

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SERVICES

Housing is necessary but not sufficient to help homeless people—particularly those with multiple physical health, mental health, and social service needs—achieve residential stability, psychiatric stability, and sobriety. Many individuals and families require some level of supportive services. Several of these services—such as Assertive Community Treatment (ACT) teams and integrated treatment for co-occurring serious mental illnesses and substance use disorders—are considered to be evidence-based practices (SAMHSA, 2003). Equally important are such essential services as primary health care; mental health and substance abuse treatment; psychiatric rehabilitation; income support and entitlement assistance; employment, education, and training; crisis care; child care; and parenting education and support. (Please note that preventive services; income support and entitlement assistance; and services for children, youth, and parents will be discussed in separate sections of this report.)

Services vary in type and intensity depending on individual and family needs. A recently homeless family with a history of stability may require primarily short-term support: help finding an apartment and a job, a subsidy to make the housing affordable, and reasonably priced child care. A single individual who has been chronically homeless and has mental and substance use disorders may require a full complement of wraparound services available on an ongoing basis as part of permanent supportive housing. Frequently, the services homeless people require are offered by different agencies with separate eligibility criteria, administrative structures, and funding streams. Some services may be part of the homeless services system while others are offered by mainstream agencies. Homeless people often are ill-equipped to negotiate these fragmented systems of care.

More than a decade ago, researchers and policy makers began to call for an integrated, comprehensive system of care for homeless people, especially those with special needs (e.g., Federal Task Force on Homelessness and Severe Mental Illness, 1992). Such a system includes housing and a full range of supportive services. In later years, researchers began to make the distinction between *systems integration*, such as that called for by the Task Force, and *services integration*, neither of which can be successful without the other (Dennis, Cocozza, and Steadman, 1999).

Systems integration refers to administrative-level strategies designed to change service delivery for a defined population as a whole; co-location of services, interagency agreements, and strategic planning are examples of systems integration strategies. The U.S. Department of Housing and Urban Development's (HUD) Continuum of Care plan encourages systems integration in communities that apply for HUD McKinney-Vento Homeless Assistance funds. In contrast, services integration refers to case-oriented strategies aimed at changing service delivery for individual clients. Case management and wraparound services are examples of services integration strategies (Dennis, Cocozza, and Steadman, 1999).

What the research/literature says: An evaluation of the federal Access to Community Care and Effective Services and Supports (ACCESS) research demonstration program revealed that systems integration leads to improved housing outcomes for homeless people with serious

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mental illnesses (Rosenheck et al., 1998). However, systems integration efforts can't impact client outcomes if there are insufficient services to integrate (Dennis, Cocozza, and Steadman, 1999). Therefore, communities must address both the overall lack of resources for homeless people and the fragmented nature of service systems designed to address their needs. Further, neither systems integration nor services integration can be successful without access to decent, safe, and affordable housing.

Several specific services offered to homeless people, especially those with mental illnesses and substance use disorders, are considered to be evidence-based or promising practices. These include multidisciplinary treatment teams/intensive case management, integrated treatment for co-occurring disorders, and motivational interventions.

Multidisciplinary treatment teams/intensive case management

Homeless people with complex needs require comprehensive treatment. A multidisciplinary treatment team, such as an ACT team, includes clinicians and social service staff who provide, or arrange for, the full range of an individual's clinical, housing, and rehabilitation needs. Client/staff ratios are low (typically 10 to 1), and services are available around the clock (SAMHSA, 2003). Begun in the late 1970s with the Program of Assertive Community Treatment in Madison, WI, the ACT model has been successfully modified to meet the needs of people who are homeless.

Research indicates that ACT and similar models of intensive case management reduce inpatient hospitalizations, decrease substance use and symptoms of mental illnesses, and increase community tenure for homeless people with special needs (SAMHSA, 2003). Factors believed to be responsible for positive treatment and housing outcomes include regular assertive outreach, lower caseloads, and the multidisciplinary nature of the services offered. Evaluations of the cost-effectiveness of ACT compared to services as usual for people with serious mental illnesses and/or co-occurring disorders and people who are homeless have found cost savings, largely from reductions in inpatient and emergency room care, or no cost difference (e.g., Lehman et al., 1999; Clark et al., 1998). ACT has been shown to be most cost-effective with individuals who are high users of the mental health system (National Association of Mental Health Planning and Advisory Councils, undated).

Integrated treatment for co-occurring disorders

Because homeless people with co-occurring disorders tend to be more symptomatic, have other health and social problems, and require more costly care, they are at risk for homelessness and incarceration (NASMHPD and NASADAD, 1999). Among people with serious mental illnesses who are homeless, approximately half have a co-occurring substance use disorder (SAMHSA, 2002). Various studies indicate that the integrated approach to treatment —in which the individual receives treatment for both disorders at the same time by the same clinician or treatment team—is superior to a parallel (treatment from two different agencies at the same time) or a sequential approach (treatment from first one agency and then the other) for people who have the most severe co-occurring disorders. Integrated treatment reduces alcohol and drug use,

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the severity of mental health symptoms, and homelessness for these individuals (CMHS and CSAT, 2000: Drake et al., 1998; Drake et al., 1997).

Motivational interventions

Motivational interventions that emerged in the substance abuse field (Miller and Rolnick, 1991) and were designed to help enhance a client's willingness to engage in treatment have been adapted for people with serious mental illnesses or co-occurring disorders and for people who are homeless (SAMHSA, 2003). The five key principles of motivational interviewing are as follows: express empathy, note discrepancies between current and desired behavior, avoid argumentation, refrain from directly confronting resistance, and encourage the individual's belief that he or she has the ability to change (Swanson et al., 1999). Research has demonstrated that motivational enhancement techniques are associated with greater participation in treatment and positive treatment outcomes (SAMHSA, 2003).

What other cities are proposing: In its report titled *Strategies for Reducing Chronic Street Homelessness* (Burt et al., 2004), HUD notes that efforts to reduce homelessness require "significant commitment of mainstream public agencies and local dollars. The goal can't be met if the homeless assistance network providers are the only players and federal funding streams are the only resources." Accordingly, a number of other cities' 10-year plans, including Chicago and the Philadelphia Committee to End Homelessness (PCEH) plan, call for formal integration of mainstream services with community services. The PCEH plan also calls for increasing the community's access to mainstream resources.

Maricopa County, AZ, calls for a coordinated system of client-centered, comprehensive care. The plan proposes that current and formerly homeless people participate at all stages of planning and implementing services. Further, Maricopa County proposes creation of a multi-purpose service center and a day resource center. The multi-purpose center, called the Human Services Campus, will host other service providers such as the Maricopa County Healthcare for the Homeless program and Central Arizona Shelter Services. The day center will offer typical drop-in center services along with case management, behavioral health screening, and legal and employment assistance. In similar fashion, the Atlanta plan recommends creation of a homeless services administration office center that provides a combination of core services and houses the administrative offices of service organizations.

The risk, of course, is that the homeless services system will become so accomplished at serving individuals and families that the mainstream system will defer to it. Indeed, the authors of Maricopa County's plan are quick to point out that although the Human Services Campus is "an integral part of the homeless services system, the Campus is not the answer to homelessness" (Maricopa Association of Governments, 2003). Maricopa also calls for identification of a sustainable and dedicated revenue source to adequately fund services (and housing) necessary to end homelessness.

Of those plans that call for the use of evidence-based practices, Atlanta recommends an intensive case management program for individuals who are frequently institutionalized. Memphis

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proposes development of an ACT team and a forensic ACT team, the latter to work with people with serious mental illnesses being released from the criminal justice system.

A strengths-based case management approach is the focus of the Indianapolis plan to provide services to 2,100 individuals and families over a period of five years. Four hundred of those served will already be in housing, and the other 1,700 will be housed in affordable rental units to be developed (see the housing section of this report for more information on the Indianapolis housing plan). The city plans to fund these services with the Community Development Block Grant, Medicaid and the Medicaid waiver program, Housing Opportunities for Persons with AIDS (HOPWA), Temporary Assistance to Needy Families (TANF), and other sources.

Many of the 10-year plans call for improved access to transportation and subsidized child care as essential services that will help end homelessness. The plan prepared by the Greater Philadelphia Urban Affairs Coalition offers several specific suggestions for improving services to homeless people, such as expanding access to primary health care clinics by adding evening hours and reinvesting managed behavioral health care savings into a case management program. Atlanta recommends establishing and implementing a plan to provide public toilet facilities. Though this won't end homelessness, it will go far in addressing the dignity of homeless people.

What's remarkable for its absence in other plans is the lack of a recovery focus. Research and practice tell us that people with serious mental illnesses and/or co-occurring substance use disorders can and do recover (SAMHSA, 2003). Individuals also recover from homelessness. As a basic value, the concept and practice of recovery should be the foundation for all services provided to homeless individuals and families, especially those with special needs.

What other cities are doing: It is difficult to tease out services from housing, since many of the models highlighted as exemplary by the National Alliance to End Homelessness (NAEH), for example, offer services in the context of housing. Thus, several programs discussed in the housing section of this report offer important approaches to service provision. Pathways to Housing in New York City uses ACT teams to serve people with serious mental illnesses and/or substance use disorders who move directly from the streets or shelters to permanent housing. Staff of Beyond Shelter in Los Angeles helps homeless families create and follow a plan for self-sufficiency after moving into permanent housing. Case managers at San Francisco's Direct Access to Housing SRO sites provide or arrange for a full range of services for individuals with mental and physical disabilities and substance use disorders.

Additional projects are highlighted below. It is important to note that although each of the following programs is part of the homeless services system, the aim of all three is to connect or re-connect homeless individuals with mainstream systems.

Philadelphia's Project H.O.M.E., founded in 1989, provides a full range of services to help individuals and families break the cycle of homelessness, including street outreach, entry-level housing, transitional housing, permanent housing, and supportive services. All Project H.O.M.E. residents have access to supportive services designed to help them achieve self-sufficiency. These services include health care, mental health services, recovery services, education, and employment. Each person at Project H.O.M.E. is recognized as an individual with unique needs,

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and services at Project H.O.M.E. facilities are different depending on the needs of the residents. In some sense, Project H.O.M.E. is a model for, and a microcosm of, Philadelphia's approach to chronic street homelessness, which is exemplary in part because the city's mainstream agencies have made a serious commitment of public funds. For more information on Project H.O.M.E., contact Sister Mary Scullion, Executive Director, at 215-232-7272, ext. 3108, or visit www.projecthome.org.

For more information on the City of Philadelphia's approach to street homelessness, contact Robert Hess, Deputy Managing Director for Special Needs Housing, robert.hess@phila.gov.

Birmingham Health Care in Birmingham, AL, a grantee of the federal Health Care for the Homeless Program, provides a range of services to project clients. Birmingham Health Care has grown from providing health, substance abuse, and mental health services for homeless people into a multi-faceted agency that does outreach, case management, transitional housing, and permanent supportive housing for homeless people, as well as a wide range of services for housed poor people (HUD, 2004). Birmingham Health Care has the advantage of having a strong service component in place to go with its housing. *Contact*: Jonathan Dunning, Chief Executive Officer, JWDunning@cs.com or 205-439-7201.

St. Francis House in Boston is the largest, most comprehensive day program for poor and homeless adults in New England. Shelter and emergency services include a day shelter serving 300 to 550 adults per day, food programs, clothing services, hot showers and toiletries, medical and dental care, and mail services and photo identification. Rehabilitative services include case management and advocacy; psychiatric and substance abuse counseling; employment, housing, and legal assistance; literacy classes and English as a Second Language classes; nondenominational pastoral counseling; HIV/AIDS education and support; and an expressive arts program. Other services provided in the St. Francis multi-service center include the Moving Ahead Program (MAP), a job readiness and life skills program for formerly homeless men and women in recovery from substance use disorders (MAP will be featured in the income section of this report); the Next Step Transitional Housing Program, a sober living program for formerly homeless people; and on site services by the welfare office, Social Security Administration, and Veterans Affairs office. Seminars on HIV/AIDS are presented in English and Spanish. *Contact*: St. Francis House, (617) 542-4211 or info@stfrancishouse.org.

What Raleigh is doing/could do: Raleigh and Wake County have an impressive number of agencies that provide services to homeless people, as evidenced by the list of agencies on pages 23-29 of the current Wake Consolidated Plan. As with the city and county's outreach efforts, however, there is concern about possible duplication of services, inefficiencies, and difficulties for homeless people who may not know where to begin their search for help. In practice, the popular concept of "no wrong door" means that a homeless person can walk into any agency, be assessed, and be referred to or provided with needed services. It does not appear that such a system is in place in Raleigh.
Some positive signs toward creation of a more comprehensive system and one that promotes access to mainstream services are the co-location of Wake County Human Services staff at Cornerstone and Horizon Health, and of Social Security Administration staff at the hospital, prison, and jail (this will be noted again in the income section of this report). Also, the city's

Homeless Working Group had discussed the possibility of developing a shared screening tool to determine eligibility for mainstream resources.

Perhaps most promising is the Triangle Alliance to Resolve Chronic Homelessness comprehensive plan, developed in response to the HUD/HHS/VA Collaborative Initiative to Help End Chronic Homelessness grant announcement. This plan made reference to the development of a Community Support Team that would use a number of evidence-based and promising practices, including ACT/intensive case management, integrated treatment for co-occurring disorders, and motivational enhancement. As proposed, the team would take a person-centered, strengths-based approach and focus on recovery/empowerment through psychiatric rehabilitation. Combined with a harm reduction/housing first approach, this appears to be an excellent model for providing services to homeless people to help them achieve self-sufficiency. Particularly laudable is its call for a recovery focus, which few if any other city plans address.

Finally, as with most other cities, lack of transportation and subsidized child care are gaps in the system of services for homeless individuals and families in Raleigh and Wake County.

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SUBGROUPS

The homeless population is heterogeneous and includes single adults, homeless families with children, and unaccompanied youth. (Unless otherwise noted, the following statistics are from Burt et al., 1999.) The majority of homeless people (66 percent) are unaccompanied adults, but the number of homeless families is growing. Nearly one-fourth of homeless people are children under age 18 with a parent; 42 percent of the children are under the age of 5. In its *Toolkit for Ending Homelessness*, the National Alliance to End Homelessness reports that each year, 5,000 runaway and homeless youth die from assault, illness, and suicide.

Minorities are overrepresented in the homeless population. Forty percent are African American, 11 percent are Hispanic, and 8 percent are Native American (the remaining 41 percent are non-Hispanic whites). According to Burt (2001), "The high percentage of minorities in the homeless population compared with housed people stems from their higher likelihood of being very poor and has no correlation to their race or ethnicity."

A significant percentage of homeless people have mental illnesses and/or substance use disorders and chronic physical conditions. Almost half (46 percent) of homeless adults who use services report chronic physical disorders. Thirty-eight percent report alcohol use problems, 26 percent report other drug problems, 39 percent report some form of mental health problems (with 20 to 25 percent meeting criteria for serious mental illness), and 66 percent report either substance use and/or mental health problems. These are the individuals we now refer to as the "chronically homeless." According to research by Kuhn and Culhane (1998), this group accounts for 10 percent of shelter users but consumes half of the total shelter days. Another 10 percent are considered episodically homeless (they shuttle frequently in and out of the shelter system), and the remaining 80 percent are transitionally homeless (they typically exit the shelter system after a short stay). Any attempt to end homelessness in a city, a state, or the nation must take into account all of these various groups and their special needs.

What the research/literature says: There are few studies to date that quantify the effectiveness of specific interventions for particular groups. This may begin to change with publication of findings based on current and recent research, such as the Substance Abuse and Mental Health Services Administration's Homeless Families Program (Wake County's Pan Lutheran Ministries is participating in this research). Based on their study, Kuhn and Culhane (1998) suggested that people who are transitionally homeless would benefit from preventive and resettlement assistance, people who are episodically homeless could be served by transitional housing and residential treatment, and people who are chronically homeless require supportive housing and long-term care. More recently, the emphasis has shifted from transitional housing to permanent supportive housing for homeless individuals and families who have special needs.

On a broader level, there has been a great deal of attention in recent years to culturally competent service delivery. Racial, ethnic, and cultural differences can determine how individuals define their problems, how they express them, whether or not they seek help, from whom they will accept help, and the treatment strategies they prefer (HHS, 2001). The basis tenets of cultural competence—accepting differences, recognizing strengths, and respecting choices—are critical

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to providing appropriate services to people who are homeless, especially those who have serious mental illnesses and/or substance use disorders.

Though homeless people do not represent a separate culture per se, they have made adaptations to their circumstances that may affect the choices they make (Milstrey, 1994). Successful strategies for offering culturally adapted services include providing services in minority communities; matching clients with providers who have the same language and culture; offering flexible hours and walk-in services; including families in treatment, where appropriate; and allowing clergy and traditional healers to participate in the treatment process if the client desires (*Blueprint for Change*, 2003, and additional citations therein).

What other cities are proposing: Most other cities' 10-year plans recognize that the needs of subgroups within the homeless population must be addressed. Beginning with this premise, the Planning Subcommittee of the Regional Continuum of Care Committee on Homelessness in Maricopa County, AZ, formed eight work groups to review the needs and analyze the gaps in housing for homeless subpopulations. These groups included ones on housing, HIV/AIDS, veterans, domestic violence, institutional releases, elderly/undocumented/economically disadvantaged, behavioral health, and youth on their own. Many of the group's recommended strategies are included in the plan's overall recommendations. For example, the plan's recommendation to secure comprehensive, standardized pre-release planning for people exiting the criminal justice system was one of the strategies suggested by the institutional releases group.

The Indianapolis plan includes a section called "Strategies for Coordinating Services for Special Populations." Included are plans to coordinate service systems to promote family stability; coordinate housing and service delivery for veterans; coordinate housing, shelter, and services for survivors of domestic violence; and coordinate services for youth and young adults. Interestingly, the Indianapolis plan includes recommendations to enhance services for homeless people with mental and addictive disorders in a broader section titled "Strategies for Enhancing Services." Perhaps this relates to the size of this group in Indianapolis (20 percent of respondents to a survey of local homeless adults reported having serious mental illnesses or addiction problems) and to the extent of their needs (fewer than half of survey respondents said they received treatment for their problems) (Indianapolis Housing Task Force, 2002).

The Memphis plan divides a discussion of its homeless population into three major subgroups—people with substance abuse problems, people with serious mental illnesses and/or co-occurring mental illnesses and substance use disorders, and families with children—and into three major categories that cut across the subgroups—veterans, people with HIV/AIDS, and victims of domestic violence. However, it does not tailor its recommended strategies to these groups, beyond the larger strategy of filling "gaps in services and housing options for chronically homeless individuals with mental illnesses and/or chemical dependencies" (Memphis/Shelby County Mayors' Task Force on Homelessness, 2002).

Several plans, including Indianapolis and Columbus, recognize the importance of attending to the educational needs of homeless children. The Indianapolis plan recommends working with the Indiana Department of Education and the Indianapolis Public Schools to consider adoption of a "one child, one school, one year" policy to minimize disruption in the education of homeless

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children and youth. In its plan, Columbus suggests it will assess current compliance with federal and state laws regarding enrollment of homeless children in public schools and create an action plan if areas for improvement are identified. The Atlanta plans recommends creation of a 24/7 youth crisis center to ensure a continuum of services to homeless, runaway, or at-risk youth and young adults.

What other cities are doing: Several of the programs discussed previously in this report are instructive in terms of serving subgroups within the homeless population. Pathways to Housing in New York City, Philadelphia's Project H.O.M.E., and Direct Access to Housing in San Francisco all serve multiply disabled homeless adults, many of whom fit into most definitions of "chronically homeless." Beyond Shelter in Los Angeles helps families develop plans for self-sufficiency. The programs profiled below provide services to infants, youth, and women with substance use disorders and their children.

Horizons for Homeless Children in Boston, formerly The Horizons Initiative, provides early education and childcare for homeless children and support services for parents. Horizons offers two programs designed to enhance the daily lives of homeless children while helping their families achieve self-sufficiency: Community Children's Centers and the Playspace Program. The two Community Children's Centers are comprehensive, full-time childcare centers in Boston for homeless children and their families. While their children are actively engaged, parents work toward social and economic self-sufficiency through on-site counseling, education, job training, and parenting workshops. The Playspace Program creates playrooms in family shelters to stimulate and educate children through play. Trained volunteers act as Playspace Activity Leaders (PALs) to play with children in family shelters. Horizons for Homeless Children is supported primarily by charitable gifts from individuals, corporations, and foundations. *Contact*: Sue Heilman, Executive Director, 617-287-1900, ext. 103, or send e-mail to hiinfo@horizonsforhomelesschildren.org.

Larkin Street Youth Services in San Francisco provides a continuum of comprehensive services to young people ages 12 to 24. Each year, Larkin Street serves more than 2,000 youth in 19 programs at 10 sites. Eighty-two percent of the youth served have histories of physical or sexual abuse, 73 percent cannot return home because their families are unwilling or unable to care for them, and more than 62 percent have histories of suicidal ideation or suicide attempts. Services include outreach, a drop-in center, case management, a medical clinic, mental health and substance abuse assessment and treatment, emergency shelters, transitional housing, and permanent supportive housing. Larkin Street also has special services for youth diagnosed with HIV/AIDS and runs a fully accredited education program for youth up to age 18 that is located in its drop-in center and staffed by the local school district. Larkin Street's award-winning employment program called HIRE UP will be discussed further in the income section of this report. *Contact*: Larkin Street Youth Services, 415-673-0911 or mail@larkinstreetyouth.org.

Project RISE (Recovery through Information, Support, and Engagement) in Cambridge, MA, a project of the Institute for Health and Recovery, received a grant from the federal Substance Abuse and Mental Services Administration to serve homeless women with substance use disorders and their children living in motels and shelters in northeastern Massachusetts and Boston. Many of the mothers also had psychiatric disorders and backgrounds of both childhood

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trauma and domestic violence. The focus was on providing gender-specific, trauma-informed services through clinical case management. Family care coordinators worked with the mothers and a child care specialist worked with the women's children. Using an engagement philosophy, the family care coordinators conducted assessments, facilitated links to community-based resources, and provided intensive case management, referral, integrated service planning, and follow-up for two years. One of the goals of the study, in which 204 women participated, was to engage the women in treatment. In all, 63 percent of study participants entered mental health, substance abuse, or trauma-related treatment. *Contact*: Susan Hart, Program Director, RISE@healthrecovery.org or 617-661-3991.

What Raleigh is doing /could do: The image of homelessness in Raleigh and Wake County is not unlike that of the national picture. Based on the December 2003 point-in-time count conducted by the Continuum of Care (see pages 21-22 of Raleigh's One Year Action Plan FY 2004-05), 65 percent of homeless people are single adults, 33 percent are families, and 2 percent are unaccompanied youth. Minorities are overrepresented compared to their prevalence in the general population. Sixty-three percent of homeless people in Raleigh/Wake County are African American, 28 percent are white, and 9 percent are other races. This compares to 66 percent white, 28 percent African American, and 6 percent other races in the general population. The Hispanic population in Raleigh has grown 500 to 700 percent in a decade (Triangle Alliance to Resolve Chronic Homelessness, 2003).

Regarding homeless people with special needs, approximately 10 percent of homeless people in Raleigh/Wake County have serious mental illnesses, 39 percent have chronic substance use disorders, and 33 percent have been victims of domestic violence (it's interesting to note that the percentage of homeless families and the percentage of the homeless population that has been victims of domestic violence are the same). Of special interest, 19 percent of homeless people in Raleigh are considered to be chronically homeless, which is nearly twice the national average. In addition, the current Wake County Consolidated Plan (pages 16-17) lists housing gaps for special needs population who are not homeless. With significant gaps for people with mental illnesses, substance use disorders, developmental disabilities, and HIV/AIDS, one might expect many of these individuals to be at risk of becoming homeless.

Fortunately, Raleigh is already doing much to meet the needs of homeless people who make up these subgroups. One only has to look at the list of service providers in the current Wake County Consolidated Plan (pages 23-29) to see that the city and county are serving the following individuals and groups (programs listed are illustrative but not exhaustive):

- Homeless families (New Beginnings, Pan Lutheran Ministries, Step-Up Ministries, Matthew House [a program of Passage Home], Salvation Army, Raleigh Rescue Mission, the Women's Center])

- Homeless people with medical problems (Urban Ministry Open Door Clinic and Horizon Health Center)

- Women who have been victims of domestic violence or sexual assault and their children: (Interact)

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- People with HIV/AIDS (Hustead House [a program of the AIDS Service Agency])
- Women with HIV/AIDS, serious mental illnesses, and substance use disorders (Glory to Glory House of Refuge)
- Women (Mission House for Women) and men (Jacob's Ladder) with co-occurring serious mental illnesses and substance use disorders
- Men with histories of chronic homelessness (South Wilmington Street Center)
- People with mental illnesses, developmental disabilities, and/or co-occurring disorders (CASA, PATH, the Community Outreach Team, the McKinney Team, the Inner City Mental Health Clinic, the Drop-in Center, Cornerstone)
- Men with substance use disorders (The Healing Place)
- Adults and youth with substance use disorders (SouthLight)
- Women who have left the criminal justice system and their children (Harriet's House [a program of Passage Home])
- Youth (Haven House Services)
- Veterans (Veterans Service Office, with a full-time officer who works specifically with homeless veterans)

Some of the missing elements include services targeted specifically to Raleigh's growing Hispanic population, additional services for youth and for women impacted by domestic violence and for both men and women leaving the criminal justice system, and more permanent and permanent supportive housing. With the exception of CASA, many of the programs that provide housing offer transitional housing. People in transitional housing must eventually move to permanent housing, which disrupts both continuity of care and relationships with providers that staff have worked hard to forge.

Currently, the South Wilmington Street Shelter—which offers emergency and transitional shelter and a wide range of services to homeless men—comes closest to targeting services specifically to people who are chronically homeless. Numerous city and county programs address the needs of people with multiple problems, such as mental illnesses and substance use disorders, who tend to be among this group. These are the individuals with whom a housing first approach may be particularly useful.

It is also worth noting that Raleigh and Wake County will have both opportunities and challenges responding to the state's mental health reform plan. In the North Carolina State Plan for Mental Health Reform, the needs of people with severe disabilities who are limited in resources and supports are defined as taking precedence in the allocation of state-funded services

and supports. This will include such groups as people with co-occurring serious mental illnesses and substance use disorders, people who are homeless and have mental illnesses, and parents with severely disabling substance abuse concerns. As noted by the Triangle Alliance to Resolve Chronic Homelessness, "This focus presents an opportunity for collaborating with the Division of MH/DD/SA to develop and sustain best practice interventions for chronically homeless persons in the public sector" (TARCH, 2003).

However, as part of its broader reform efforts, the state expects to cut state hospital beds by approximately 50 percent over the next five years. Currently, Dorothea Dix Hospital in Raleigh discharges as many as 15 people per month with serious mental illnesses to shelters or the streets. This necessitates a greater effort in discharge planning, which will be discussed further in the prevention section of this report.

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PREVENTION

Preventing homelessness is more cost-effective and humane that allowing people to become homeless in the first place, and any community's effort to end homelessness must include substantial prevention resources. Indeed, as Burt (2001) notes, "When assistance is restricted to those who are homeless tonight, not much can be done to prevent homelessness tomorrow." Homelessness prevention strategies range from emergency rent payments to keep families from being evicted; to comprehensive discharge planning that avoids homelessness for people leaving jails and prisons, psychiatric hospitals, and foster care placements; to efforts to rapidly "re-house" people who become homeless. The National Alliance to End Homelessness refers to prevention efforts as "closing the front door," while re-housing people is "opening the back door." Thus, ending homelessness becomes a two-pronged strategy to keep individuals and families from falling into homelessness and to help them exit homelessness as rapidly as possible.

What the research/literature says: Strategies to prevent homelessness must be designed to *reduce risk factors* that make individuals and families more susceptible to becoming homeless and to *enhance protective factors* that mitigate against homelessness for people at risk (Lezak and Edgar, 1998). For people with serious mental illnesses and/or substance use disorders, lack of integrated treatment for co-occurring disorders is a risk factor, while supportive services in housing is a protective factor. Job loss may be a risk factor for a homeless family and subsidized housing can be a protective factor.

A Substance Abuse and Mental Health Services Administration study called the *Collaborative Program to Prevent Homelessness* studied homelessness prevention efforts among adults with serious mental illnesses, substance use disorders, physical disorders, and poverty. Researchers compared a traditional treatment approach to treatment with an enhanced program that featured such efforts as a specific focus on preventing housing loss, resource or money management, and family support and respite care. Both traditional and innovative approaches were associated with improvements in housing and quality of life and reductions in psychiatric symptoms and substance use, but the enhanced programs were more successful in reducing homelessness. Programs that included a specific focus on preventing homelessness and that had access to housing resources were more successful than programs without these interventions (Herrell, in press).

Discharge planning is an effective prevention strategy. In particular, providing short-term, intensive support services immediately after discharge from jails, hospitals, or residential treatment helps prevent homelessness during the transition to other treatment providers (Rosenheck and Dennis, 2001; Shinn and Baumohl, 1999; Lezak and Edgar, 1998). Ideally, discharge planning begins when the individual first enters a hospital or jail. Elements of an effective discharge plan, which should be developed with the individual and must be culturally appropriate, include housing, health care, treatment, income, employment, entitlements, personal support, and life skills training (SAMHSA, 2003).

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In resource poor communities, Shinn and Baumohl (1999) worry that prevention programs that offer scarce goods risk reallocating homelessness. They point out that subsidized housing, with or without supportive services, can be effective in preventing family homelessness. This bolsters their contention that communities should reorient their prevention efforts from projects aimed at at-risk individuals to efforts that increase affordable housing, promote sustainable sources of income, and address the social capital of impoverished communities. Additionally, they believe that focusing efforts on communities from which large proportions of homeless people originate may be a successful prevention strategy (Shinn and Baumohl, 1999).

Kuhn and Culhane (1998) also propose a more systemic approach to homelessness prevention. Speaking about people who are transitionally homeless (i.e., who typically exit the shelter system after a short stay), the researchers conclude that "the sheer size of this group also raises questions about the sufficiency of the current 'safety net' and about whether 'homelessness prevention' should be conceived more broadly as a fundamental function of the larger system of income, employment, health and housing supports."

What other cities are proposing: Eviction prevention and discharge planning are two key strategies highlighted in other cities' 10-year plans to end homelessness. Some, such as Maricopa County, AZ, focus discharge planning efforts on individuals leaving the criminal justice system, while others, such as Montgomery County, MD, include people exiting the child welfare and foster care systems, hospitals, and mental health facilities. Most plans also include the broader goal of increasing the stock of affordable housing as a prevention strategy.

At least two plans—Indianapolis and the Greater Philadelphia Urban Affairs Coalition (GPUAC)—recommended expanding or creating community-based resources to address homelessness prevention. Philadelphia has community-based prevention centers that offer case management, emergency rental assistance, referrals, and job training. The GPUAC plans calls for expanding the work of these centers by providing increased staff and resources to focus on such services as housing and budget counseling, adequate and flexible rental assistance funds, information on tenant rights and legal assistance, and appropriate and comprehensive referrals to supportive agencies and programs.

The Indianapolis plan calls for establishing homelessness prevention programs in high-poverty neighborhoods to identify people most vulnerable to becoming homeless and provide them with assistance to avoid homelessness. Neighborhood sites for prevention programs might include churches, food pantries, community centers, workforce development centers, schools, neighborhood groups, or community development corporations. The plan does not specify sites or services but gives that responsibility to the Coalition for Homelessness Intervention and Prevention (CHIP), the lead agency for implementing the Blueprint.

As part of its prevention strategies, Memphis recommends creation of a central housing information center to help individuals and families locate available rental housing and assist them in becoming responsible renters (see the discussion of the Philadelphia Housing Support Center, below). The Maricopa County plan suggests reviewing crime-free housing policies and advocating with landlords to accept people with immediate or past criminal records. Indianapolis recommends creation of a crisis response team to help people with mental illnesses or substance use disorders maintain their housing and become linked to community services.

What other cities are doing: Programs in Hennepin County, Minnesota, and in Philadelphia help individuals and families avoid homelessness or become rapidly re-housed. New York has outlined principles and strategies to improve prevention efforts for New York City families. These efforts are highlighted below.

The Rapid Exit Program in Hennepin County, Minnesota, facilitates rapid re-housing for individuals and families residing in the county shelter who have moderate to severe barriers to obtaining market housing. Rapid Exit is funded by HUD and by the Minnesota Family Homelessness Prevention and Assistance Program, a legislatively mandated program designed to prevent homelessness and facilitate people's re-entry to housing. Within one week of entry to the shelter, a Rapid Exit Coordinator does a housing barriers assessment and criminal, credit, and housing checks for an individual or family.

Hennepin County has contracted with a number of service agencies to help individuals and families referred by Rapid Exit. These agencies provide such services as direct financial assistance, legal assistance, case management, provision of transitional housing for people who need to establish a stable rental history, and follow-up case management once people are housed. The county and its contracting agencies also work to expand the supply of affordable housing by, among other strategies, advocating with landlords who may be reluctant to accept Section 8 vouchers, paying double security deposits for those with a poor rental history, or co-signing leases. Eighty-five percent of Rapid Exit clients do not return to shelter in a two-year period. At the county level, the cost of preventive services is $331 per family served. *Contact*: Shirley Hendrickson, Grants Administrator, Adult Housing Program, Shirley.Hendrickson@co.hennepin.mn.us.

For more information on the Minnesota Family Homelessness Prevention and Assistance Program, contact Rhonda McCall at the Minnesota State Housing Finance Agency, 651-297-3294, or Michele Dahl at the Minnesota Coalition for the Homeless, 612-870-7073.

The Philadelphia Housing Support Center coordinates housing and service resources from various city social service departments through one central gateway. Combining homeless program funds with such mainstream resources as Temporary Assistance to Needy Families (TANF), the center serves as a "one-stop shop" for housing resources. In addition to families at risk of homelessness, the center serves individuals and families leaving emergency shelters, transitional housing programs, recovery houses, behavioral health programs, and the corrections system. To provide permanent housing, the center relies primarily on Housing Choice vouchers provided by the local public housing authority, which has the ability to create priorities through an administrative process. Supportive services are funded by a mix of resources, including the HUD Supportive Housing Program, some TANF funds, and additional resources. The center itself has approximately 30 staff members and is funded through existing resources allocated by each of the departments that participate. *Contact*: Robert Hess, Deputy Managing Director for Special Needs Housing, Robert.Hess@phila.gov or 215-686-7176.

New York City's Homelessness Prevention Report was court ordered to evaluate the family homelessness system and recommend improvements. To develop its recommendations, the Family Homelessness Master Panel met with local and national experts on homelessness, community-based organizations working with families at risk of homelessness, city agency

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personnel, and families who have been homeless. The report outlines guiding principles and recommended strategies to improve prevention efforts for New York City families. Some of the key principles the panel put forth include the need to target prevention services to those neighborhoods from which a disproportionate number of families enter the shelter system, make legal services more widely available, offer homeless prevention in a variety of settings in the community, and develop and maintain affordable housing and provide rental assistance.

The panel's recommendations fall into three broad categories: facilitate earlier interventions, expand resources that can prevent homelessness, and improve effectiveness and access to prevention services for those at highest risk. One of the panel's interesting findings was that some families lose housing because they fail to recertify their Section 8 vouchers in a timely manner. Helping them comply with program requirements may avoid a slide into homelessness. The group also noted a need to better coordinate prevention efforts by training prevention staff about welfare programs and public housing department policies and by linking homelessness prevention services to other support initiatives in the community. Finally, the panel suggested a need to focus prevention efforts on people who are doubled-up and are non-leaseholders. To read the complete report of the New York City Family Homelessness Master Panel, see www.kfny.org/publications/Prevention%20Report.pdf.

What Raleigh is doing/could do: A number of Raleigh and Wake County agencies provide various pieces of homelessness prevention strategies. For example:

- The Urban Ministries Crisis Intervention Program helps prevent individuals and families from becoming homeless by providing direct financial assistance for rent, utilities, medications, and food.

- Christian Community Action offers food, crisis funds, household appliances and furniture, infant and toddler supplies, and medical prescription assistance. (Medication assistance is critical for some homeless families living on the edge who may have to choose between buying their prescriptions and paying their rent.)

- East Central Community Legal Services provides free legal advice and assistance for non-criminal matters to financially eligible people in Wake County.

- Neighborhood Options to Combat Homelessness (NOTCH), a homelessness prevention program at Triangle Family Services, provides intensive case management, budget and credit education, tenant education, advocacy, and support to families at risk of homelessness.

There is also an effort, beginning at the state level, to focus on discharge planning. A new Homeless Policy Specialist—funded jointly by the state Department of Health and Human Services, the state Department of Correction, and the North Carolina Housing Finance Agency—will coordinate state-level efforts to improve discharge planning policies and protocols. In addition, members of the Wake County Continuum of Care participate on the Criminal Justice and Homelessness Task Force of the North Carolina Coalition to End Homelessness and in the Going Home Initiative, a federally funded effort to help violent offenders re-enter the community.

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What appears to be missing is coordination of efforts at the front end of the system to reach individuals and families at risk of homelessness and enough affordable housing at the back end for those who do become homeless. It is difficult from reading descriptions of individual agencies or services to know how much, or how little, coordination is taking place. However, there does not appear to be any kind of "one-stop shopping" location for eviction prevention assistance and/or rapid re-housing. NOTCH perhaps comes closest to the type of community-based prevention centers that exist in Philadelphia and are suggested for Indianapolis, though it is not clear how many neighborhoods are served by this effort. Existing agencies that provide prevention services may be able to take on the added responsibility of coordinating a broader range of assistance, especially if the agencies that participate contribute program resources (as is the case with the Philadelphia Housing Support Center). The suggestion to locate such services in high-risk neighborhoods also bears further study in Raleigh/Wake County.

Finally, local discharge planning efforts will have to have the full cooperation and coordination of all relevant institutions and community-based agencies and must take into account the need for a period of assistance after individuals have re-entered the community. Closer coordination with Dorothea Dix Hospital is needed to stem the tide of individuals released to shelters and the streets (estimated to be 15 people a month).

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COMMUNITY BUY-IN/PUBLIC AWARENESS

Efforts to prevent and end homelessness can't occur in a vacuum. They must have the support and backing of elected officials, provider organizations, the business community, faith-based providers, and homeless and non-homeless citizens. Lack of political and social will can thwart the most well-intentioned plans. For example, the not-in-my-backyard (NIMBY) syndrome that often greets plans for affordable housing projects must be confronted head on. Preventing and ending homelessness is not only humane, it is cost-effective, with benefits to the broader community as well as to homeless and at-risk individuals and families.

There are a number of ways to increase public awareness. For example, communities can mount a public information campaign to put a "real face" on homelessness, ask people in recovery to testify before city councils and legislatures about what a difference services and support can make, and invite legislators and other policy makers to visit homeless services and mainstream programs. Participation by key community leaders and groups is also important. Church members can be volunteers for homeless services programs, local supporters can be lined up *before* approaching a neighborhood with a new housing program, and key decisions makers can, and must, be involved in 10-year planning efforts.

What the research/literature says: Perhaps the most relevant findings come from the federal Access to Community Care and Effective Services and Supports (ACCESS) research demonstration project. The ACCESS evaluation reveals three strategies that are key to establishing the basic infrastructure necessary for systems integration to occur: 1) having a designated leader responsible for systems integration; 2) getting the key players and decision-makers to the table (and keeping them there); and 3) using a formal strategic planning process (Dennis, Cocozza, and Steadman, 1999). Key players include public officials, business leaders, nonprofit service agencies, housing agencies, local police, and homeless and formerly homeless people.

"Without broad-based community support for the level of effort and resources required to create an integrated service system, other needs are likely to take priority," Dennis and her colleagues (1999) report. Likewise, the U.S. Department of Housing and Urban Development (Burt et al., 2004) says that efforts designed to end chronic homelessness must have strong leadership and a community-wide organizational structure. Commitment and support from elected officials is critical.

Strategic planning efforts aimed at preventing and ending homelessness must focus on measuring outcomes. Good data can help show policy makers, funders, and the public that preventing and ending homelessness is effective in both human and economic terms (for more about the uses of data, see the HMIS section of this report). For programs that serve homeless people, a General Accounting Office report notes, "The use of outcome measures shifts the focus from outputs, such as the types and numbers of activities performed, to the outcomes, or results achieved" (GAO, 1999). Client-level outcomes for homeless people might include such measures as housing status; mental health, substance abuse, and health status; income; employment; criminal justice involvement; family relationships; consumer satisfaction; and quality of life (SAMHSA,

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2003). Broad dissemination of these outcomes can lead to a greater focus on results (Dennis, Cocozza, and Steadman, 1999).

What other cities are proposing: A number of the 10-year plans reviewed for this report call for increasing public awareness about homelessness, creating community buy-in for the 10-year plan itself, and reporting results to ensure accountability. The plan prepared by the Philadelphia Committee to End Homelessness (PCEH) calls for "making the end of homelessness important again" (Philadelphia Committee to End Homelessness, 2000). To do so, the group proposes a "massive communication effort" to convey that ending homelessness is possible and that it is important to both the city and to "our conscience" to make it happen. The PCEH plan also calls for periodic evaluations by independent researchers to grade performance and ensure accountability.

In similar fashion, the Columbus, OH, plan calls for issuing semi-annual report cards to the community to track the progress of its 10-year plan. Further, the Columbus plan calls for initiating dialogue to create buy-in for the plan by presenting the plan and seeking input from key stakeholders.

The Montgomery County, MD, plan proposes raising public awareness about homelessness, its prevalence in Montgomery County, its impact, and potential solutions. Specific strategies would include working with local papers and radio stations on stories and public service announcements about homelessness; developing a speakers' bureau from membership of the Montgomery County Coalition for the Homeless to address schools, community groups, and business leaders; and working with civic associations, community groups, and congregations to help counter NIMBYism.

In Maricopa County, AZ, the 10-year plan proposes supporting a social marketing campaign to educate the public about homelessness and its relationship to the community's quality of life, including economic development and a safe environment for children. The campaign will collect information on current attitudes, beliefs, and obstacles and present a pro-social image.

What other cities are doing: To help promote support for its Rebuilding Lives permanent supportive housing initiative, the City of Columbus convened a broadly representative Community Advisory Committee to seek the community's input and address any concerns (see the housing section of this report for more information on the Rebuilding Lives initiative). In addition, the Community Shelter Board (CSB) works with all supportive housing and shelter operators to help them implement **Good Neighbor Agreements** that seek to promote communication, respect, and trust among neighbors, residents of permanent supportive housing, service providers, and funders (HUD, 2004). Good Neighbor Agreements are voluntary agreements between a service provider and neighborhood residents that cover such topics as property maintenance and appearance standards, neighborhood codes of conduct, community safety, communication and information, and agreement monitoring and compliance. These agreements do not include matters that are governed by law, such as fair housing laws and municipal codes. For more information on Good Neighbor Agreements and CSB shelter certification standards, see www.csb.org/Publications/gnsc.pdf or contact the Community Shelter Board at info@csb.org or 614-221-9195.

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An Ad Hoc Committee on Downtown Homelessness emerged in San Diego when the downtown business association, city and county staff, and developers needed to address the displacement of homeless people anticipated when a new downtown baseball park was planned. Though it has no formal standing, the committee provides an open forum in which members can discuss issues, establish goals, and work on collaborative solutions. The participants are high-ranking individuals within their own agencies who have 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*: Sharon Johnson, Homeless Services Administrator, City of San Diego, srjohnson@sandiego.gov.

What Raleigh is doing/could do: Raleigh and Wake County have made significant strides in making their 10-year planning process as inclusive as possible. One only has to look at the May 11 update of action plan activities to see the breadth and depth of public participation and input. The partnership of the City of Raleigh, Wake County, and the Wake Continuum of Care—recently joined by Triangle United Way—join together a broad cross-section of public officials, businessmen and women, and community and faith-based providers. Community members have voiced their recommendations and concerns at four public forums, attended by approximately 150 people each. Further, clients of local shelters have participated in the forums and in group discussions.

Community forums will be held June 23 with individuals representing housing authority boards, business leaders, the local Continuum of Care, the City Council and County Commissioners, and the police and public safety officials. The partnership's planning process appears inclusive and respectful of both differing perspectives on the problem of homelessness and various solutions for change. It is also mindful of the fact that all of these stakeholders need to be at the table if the 10-year plan is going to be successful.

The participation of college students is especially commendable. Local universities have established 11 classes specifically focusing on homelessness, and students participated in all forums. The academic year began with an intra-university summit on homelessness and ended with a forum at which university students presented papers on issues recommended to be part of the plan.

Likewise, Raleigh is to be commended for involvement of local media in publicizing homelessness and the 10-year plan, including stories and editorials in newspapers and on radio and television, a regular series on the City Show cable access program that features issues highlighted at the public forums, and production of a video called "The Face of Homelessness." Of course, media coverage can spotlight controversies that are bound to accompany any effort of this magnitude, but it is not unhealthy for different points of view to be aired publicly. If, as the 10-year plan prepared by the Philadelphia Committee to End Homelessness contends, public attention to homelessness has waned in recent years, media coverage of the partnership's efforts are increasing awareness at a critical juncture in the process.

There will be other key points at which the public will need to be reminded about the importance of preventing and ending homelessness. These include when the plan is formally presented and

adopted, and when specific projects (especially permanent supportive housing projects) are proposed. The Community Shelter Board's Good Neighbor Agreements in Columbus may be a model for working with neighbors who are opposed to the siting of new housing for homeless people. In addition, report cards of the type suggested for Philadelphia and Columbus can highlight accomplishments and preview any needed course corrections. Ongoing relationships with sympathetic members of the media and with the local business community will continue to be important as the plan is finalized and implemented.

Finally, Raleigh's web site on the 10-year plan efforts is comprehensive and easy to navigate. It would be nice, however, if the link on the home page were more prominent; right now, it appears to be a subcategory of the NeighborWoods tree program.

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HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS) RESOURCE GUIDE

Like other communities around the country that receive McKinney-Vento Act funds, including jurisdictions that have prepared 10-year plans, the City of Raleigh is complying with requirements of the U.S. Department of Housing and Urban Development (HUD) to have a homeless management information system (HMIS) in place by fiscal year 2004 (beginning October 1, 2004). Some locations, such as Memphis, have an existing system on which to build. At the time their plan was prepared, Memphis and Shelby County were collecting annualized, unduplicated data in a service provider database called the Intake Database System; 83 percent of homeless services providers were participating in the system as of 2002 (Memphis/Shelby County Mayor's Task Force on Homelessness, 2002). The city and county planned a web-based HMIS to replace the current system by 2003. In contrast, as of 2002, many communities were relying for data on their annual point-in-time count of homeless people.

Since much of the research for creating an HMIS system in Raleigh has likely taken place, this section of the report presents brief answers to the following questions: What is an HMIS? What are the benefits of an HMIS? What are some concerns about implementing an HMIS? What additional resources on HMIS design and implementation are available?

What is an HMIS?

According to HUD, homeless management information systems are "computerized data collection tools designed to capture client-level information over time on the characteristics and service needs of men, women, and children experiencing homelessness" (Center for Social Policy, 2002). In 2001, Congress directed HUD to take the lead in requiring every jurisdiction to collect client-level data within three years in order to develop an unduplicated count of homeless people, determine how they use services, and evaluate the effectiveness of homeless assistance programs in meeting their needs (*Federal Register*, July 22, 2003). Basic HMIS components that would generate the data required by the congressional directive include client intake, case management, service tracking, and a report generation tool. Some systems also include an information and referral component and/or a benefits eligibility tool (Center for Social Policy, 2002).

What are the benefits of an HMIS?

Collecting client-level data can help streamline services, improve access, reduce duplication of effort, and inform public policy (SAMHSA, 2003). In particular, an HMIS has the following benefits to individuals, service providers, state and local policy makers, and national policy makers (SAMHSA, 2003; *Federal Register*, July 22, 2003):

Individuals—Homeless individuals benefit from streamlined referrals, coordinated case management, and reduction of duplicative intakes and assessments.

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Service providers—Agencies that serve homeless people gain reporting tools, mechanisms for internal and external service coordination, and information that can inform service and systems planning and advocacy. Systems that include real-time information about available services, such as shelter beds, can help providers serve individuals and families as quickly as possible.

State and local policy makers—Policy makers and advocates in state and local Continuums of Care benefit from access to data that describe the extent and nature of homelessness and provide a greater understanding of service use, effectiveness, and gaps. This information can be used to target limited resources, demonstrate the need for additional funding, and inform planning and policy decisions.

National policy makers—HMIS data can help national policy makers and advocates more effectively address homelessness. HUD will develop a representative sample of 80 jurisdictions and will help those jurisdictions develop their HMIS, collect good quality data, and conduct analyses to support unduplicated counts of homeless service users and their characteristics at the local level (*Federal Register*, July 22, 2003). HMIS data will be used by HUD McKinney-Vento Act grantees to generate annual progress reports.

Cities and States around the country that have a functioning HMIS have begun to see some of these benefits. For example, San Diego reports that its HIMS has resulted in streamlined client referrals, improved case management, more effective use of emergency resources, and more accurate and timely reporting. Users of the HMIS system in the Kansas City metropolitan area estimate they save eight hours of staff time each month that previously would have been spent compiling reports. In Massachusetts, data from the HMIS system developed in Boston and now used statewide have affected allocation decisions. For instance, one state agency allocated more resources to homeless youth programs after learning that 12 percent of homeless individuals in shelter were between the ages of 18 and 24. (Unless otherwise noted, information on specific programs in this section is from the 2003 HUD document, *What Works in Partnership Building for HMIS*; see www.hud.gov/offices/cpd/homeless/hmis/implementation/whatworks.pdf).

What are some concerns about implementing an HMIS?

Inability to capture non-service users—Researchers Culhane and Metraux (1997) report that one of the major limitations of collecting administrative data on homeless people is that such data can only provide information for people who use the services being tracked. This, and the reluctance of some service providers to participate in an HMIS, may result in an undercount of the homeless population. Undercounts caused by those who do not use services can be mitigated, in part, by tracking street outreach contacts or using survey methods to estimate the number or proportional size of the group of homeless people who do not use services (Culhane and Metraux, 1997).

Concerns about confidentiality—Individuals share a good deal of personal information with intake workers and case managers that must be protected for clients to feel confident revealing the type of data providers need to collect. This is especially the case for victims of domestic violence and individuals diagnosed with HIV/AIDS. For this reason, HUD has outlined a set of minimum confidentiality and security standards required by federal law (see the *Federal Register*

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of July 22, 2003, beginning on page 43430); stricter state and local laws may supersede these standards. HUD's requirements are based on common practice and standards within the information technology field, as well as on the HIPAA (Health Insurance Portability and Accountability Act of 1996) standards for securing and protecting private medical information.

Some important caveats about client confidentiality include the following (Center for Social Policy, 2002):

- Web-based systems, created for optimal accessibility and technology, entail greater risk than the use of paper-generated or decentralized electronic record-keeping systems.
- High levels of turnover among shelter staff contribute to the likelihood of inadequate training and ineffective enforcement of security policies and standards.
- Most security breaches are by people authorized to use the system.
- Particularly in cases of domestic violence, the consequences of lapses in client security can be grave.

In response, many communities have well-developed policies about how to protect client confidentiality; what type of information, if any, can be shared between agencies; and what type of consent clients are required to give. (HUD encourages, but does not require, HMIS data to be shared among agencies.) For example, in Georgia, HMIS users must attend a class on privacy and confidentiality issues and pass a test on the material before receiving a user password. The passwords are valid for one year, and individuals must be retrained before passwords are renewed. Confidentiality training in Georgia is coordinated with Georgia State University.

Each community handles client consent and data sharing in different ways. In Georgia, there are no pre-arranged data sharing agreements, and clients are not asked ahead of time which agencies should have access to their information. At the time of service delivery, individuals determine whether that agency can access their data. Likewise in the Kansas City metropolitan area, clients are asked to sign a release of information each time service is rendered and entered into the system; agencies can elect to share data or be designated as a hidden agency. In Massachusetts, identifiable client data can be shared only between agencies that have explicit written agreements and written client consent forms for each client. Written consent is also required for data sharing in Wisconsin; the consent is good for up to three years unless the client rescinds permission. Wisconsin has a standard written consent form for general agencies, one for domestic violence agencies (which typically close their records), and one for HIV/AIDS agencies.

One of the best ways to ensure that an HMIS protects consumers and meets their needs is to involve them in planning and implementing the system (Center for Social Policy, 2002). Massachusetts is often cited as an excellent model of consumer participation. Consumers helped develop privacy protection and informed consent procedures. They also design and deliver workshops for case managers focused on sensitivity training and privacy protections. Consumer representatives hold seats on the steering committee that oversees HMIS operation, and they have a consumer advisory group that reviews system policies and procedures, offers consumer

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involvement training to community agencies, and disseminates information on the HMIS to other local consumers and to providers (Center for Social Policy, 2002).

Ensuring provider buy-in—For an HMIS system to be successful, a broad representation of agencies should participate. Recognizing that creating such as system is difficult and time-consuming, HUD has created a set of priorities regarding which agencies should participate and when they should join (*Federal Register*, July 22, 2003). The first priority is for outreach programs, emergency shelters, and transitional housing programs, including McKinney-Vento Act programs and those funded by other federal and non-federal sources, such as the Projects for Assistance in Transition from Homelessness (PATH) funded by the U.S. Department of Health and Human Services (Substance Abuse and Mental Health Services Administration). Permanent supportive housing programs funded by McKinney-Vento and mainstream HUD programs should be brought on line next. Permanent supportive housing programs operated by non-federally funded service providers are last on HUD's priority participation list.

Communities and states with an operating HMIS have found various ways to encourage provider participation. Wisconsin has used a series of incentives to encourage providers to join the HMIS. For example, the state Department of Administration (DOA), which is the lead agency for the HMIS, reduced and/or eliminated monthly and quarterly program reporting requirements for DOA-funded providers that were on-line by January 1, 2002, and fulfilled the minimum data entry requirements. As the system was first being implemented in 2001, DOA offered bonus points in the competitive, statewide Emergency Shelter Grant/transitional housing program application process for agencies that agreed to participate in the HMIS. Agency word of mouth helps recruit new agencies in the Kansas City metropolitan area. In similar fashion, existing users in San Diego who are confident of system security help sell the system to their peers. Agencies funded to provide homeless services in the District of Columbia are required to enter data into the HMIS.

Staff training—Staff training can be time-intensive and costly, but is absolutely critical to ensure good quality data and client confidentiality. Wisconsin offers the following staff training recommendations: 1) provide adequate time and resources for training and retraining; 2) assess computer literacy prior to attendance at HMIS training; 3) establish a training database for users to practice on; and 4) provide a paper manual and an on-line help function. San Diego uses two student interns who provide on-site training, facilitate group training sessions, and prepare training documentation. The Kansas City metropolitan area HMIS has an outreach and training coordinator who is primarily responsible for user training. Massachusetts provides monthly training to users throughout the state.

What additional resources on HMIS design and implementation are available?

HUD has prepared a comprehensive set of resources on HMIS implementation, all of which can be accessed at the HIMS web site, www.hud.gov/offices/cpd/homeless/hmis/. They include the following:

Homeless Management Information Systems: Implementation Guide (Center for Social Policy, 2002). This publication presents a set of steps to implementing an HMIS, from planning through implementation. www.hud.gov/offices/cpd/homeless/hmis/implementation/implementation.cfm

Homeless Management Information System (HMIS) Consumer Guide: A Review of Available HMIS Solutions (Center for Social Policy, 2003). This is a companion piece to the first. It assesses different functional and technical capabilities of a wide range of HMIS software packages and related services (e.g., data hosting, training, and support). www.hud.gov/offices/cpd/homeless/hmis/assistance/consumerguide/index.cfm

What Works in Partnership Building for HMIS: A Guide for the Los Angeles/Orange County Collaborative (HUD, 2003). To help inform implementation of a countywide HMIS in Los Angeles/Orange County, this document presents descriptions of how other jurisdictions around the country have implemented an HMIS in their communities. The report highlights "what works" in Georgia, the Kansas City metropolitan area, Massachusetts, San Diego, Washington (DC), and Wisconsin. Each write-up begins with a general description of the project, followed by sections on community information, HMIS information, data elements and information sharing, local participation, system outcomes, and lessons learned. Complete contact information is provided for each project.
www.hud.gov/offices/cpd/homeless/hmis/implementation/whatworks.pdf

In addition, the National Alliance to End Homelessness has published *Using HMIS for Effective Planning to End Homelessness* (2003), the report of an audio conference that featured Dennis Culhane, Ph.D., of the University of Pennsylvania and Julie Hovden of the Wisconsin Department of Administration. Much of the discussion is about the Wisconsin system.
www.endhomelessness.org/best/summary010903.htm

Innovative solutions to data collection and management are discussed in the 2004 HUD publication, *Strategies for Reducing Chronic Street Homelessness*. Programs in Columbus, Philadelphia, and Seattle are highlighted (see the section in each appendix titled "Practices of Potential Interest to Other Jurisdictions"). However, at 384 pages, this document is not a quick read. www.huduser.org/Publications/PDF/ChronicStrtHomeless.pdf

A description of the Philadelphia HMIS is also available from the National Alliance to End Homelessness. www.endhomelessness.org/best/PhillyHMIS.htm

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U.S. Department of Housing and Urban Development. (April 30, 2003). *What Works in Partnership Building for HMIS: A Guide for the Los Angeles/Orange County Collaborative*. HUD Office of Community Planning and Development. www.hud.gov/offices/cpd/homeless/hmis/implementation/whatworks.pdf

If you have questions or comments on Ending Homelessness – The Ten Year Action Plan, please feel free to contact City, County, Triangle United Way, and Continuum of Care partnership representatives:

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For more information see www.raleigh-nc.org select "Ending Homelessness

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