

# Review of best practice in services, programs and systems related to homelessness

Deliverable #3

December 7, 2005

## The Homeless Initiative

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Final Report

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# Introduction

The purpose of this report is to identify practices that other communities have found worthwhile and beneficial as they seek to address the issue of homelessness. The report organizes this information into four categories: prevention, those programs, services and activities that prevent someone from entering a homeless state and enable them to remain in their current or some alternative residence; mainstream services, those programs, services and activities that enable homeless persons to attain health and behavioral health care, economic security or other services that are provided to persons in need in our society; support services, programs, services, and activities targeted specifically to the needs of homeless persons including food, clothing, legal assistance and temporary housing and housing which in this case includes permanent supportive housing and affordable housing.

## Method

This study utilized both primary and secondary sources. Primary sources included a direct review of programs that have been identified as a best practice. Secondary sources included best practice studies conducted by other parties. As stated in the introduction, four categories were used to organize the data.

Critical Point: Unlike other reports of this initiative, wherein the consultant originated the document, much of this report simply adapts an existing written description. Sources have been identified wherever possible and should be viewed as the authors of the text they are cited for. Minor editing has been done for flow and consistency. While quotation marks have not been used for stylistic reasons, each program description should be read as a quotation.

Organization of the report.

The report is organized into six major sections: prevention, access to mainstream services, support services, housing, systems and funding. Within each of these major sections there are themes.

Programs or examples may be cited more than once since many have multiple features which are of value from different perspectives. Some assignments are arbitrary.

## Findings

### Prevention

Theme: Financial Assistance

#### Rental Assistance Programs

**Philadelphia, PA ▪ Prevention Center sites<sup>1</sup>:** The Philadelphia Community-Based Homelessness Prevention Program provides six Prevention Center sites located in neighborhoods where a high concentration of persons resided just prior to becoming homeless. The Centers assists low-income renter and homeowner households (both individuals and families) to maintain their housing or move to more affordable housing through a variety of services provided in the household's community.

Assistance is provided through budget counseling; case management for up to six months; employment assistance; grants for back rent, mortgage or utility payments; grants for security deposits and emergency employment needs; and grants for forward payments of rent, mortgage, or utilities. Partial and forward payments of emergency funds are contingent upon meeting monthly case management goals set by the client and the Prevention Program staff, to reinforce that a grant alone will not solve a complex situation or effectively prevent homelessness, and to encourage self-sufficiency. Up to \$1,200 may be made available to a household, per year, in a combination of arrears and forward payments.

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<sup>1</sup> City of Philadelphia Office of Emergency Shelter & Services website. Retrieved October, 2004 from: [www.phila.gov/services/emergency/](http://www.phila.gov/services/emergency/).

**Montgomery County, Maryland<sup>2</sup>.** Montgomery County has been able to obtain funding from a variety of sources to implement a comprehensive prevention plan. Three regional Montgomery County Department of Health and Human Services (DHHS) Crisis Intervention Units that administer state and county rental assistance programs are located throughout the county. In addition, Montgomery County has 20 eviction prevention programs offering a wide range of emergency assistance and orchestrated through the Emergency Assistance Coalition. The program is supported with county funds, Federal Emergency Management Agency funds, state homeless assistance grants, and donations from local congregations.

**Hennepin County, Minnesota<sup>3</sup>:** With a housing vacancy rate below 1% and very high rental rates, Hennepin County is promoting efforts that will keep families in sustainable housing and preventing them from ever requiring emergency shelter. The state Family Homelessness Prevention and Assistance Program provides the financing for homelessness prevention activities. The county sub-contracts with eighteen nonprofit agencies to deliver services that include financial assistance, case management and other assistance to eligible families to prevent the loss of housing.

**Indianapolis, MN ▪ Blueprint to End Homeless<sup>4</sup>:** A key strategy of this plan is to develop a neighborhood homelessness prevention initiative that provides rental subsidies and other services to help people especially vulnerable to becoming homeless. This effort will be linked to the mayor's Family Investment Centers initiative, providing supportive housing to people at risk of becoming homeless who are leaving the criminal justice system, treatment institutions and the foster care system.

**Dade and Broward Counties<sup>5</sup>** utilize a rental assistance program that incorporates gradually decreasing subsidies designed to motivate recipients to increase their income and achieve self sufficiency. The program utilizes

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<sup>2</sup> <http://www.endhomelessness.org/best/prevention.htm>

<sup>3</sup> <http://www.endhomelessness.org/best/prevention.htm>

<sup>4</sup> <http://www.endhomelessness.org/best/prevention.htm>

<sup>5</sup> Personal communication, D. Raymond, The Homeless Trust of Miami-Dade County.

Workforce or TANF funds (so eligibility is limited to families eligible for those funds), for persons at risk of losing their housing, persons who need relocation (like victims of domestic violence), or persons already homeless.

**Winston–Salem/Forsyth County, North Carolina: Prevention<sup>6</sup>.** Winston–Salem has been able to leverage significant resources for emergency assistance (EA). Four local agencies—Crisis Control Ministries, Sunnyside Moravian Ministry, the Salvation Army, and Forsyth County Department of Social Services (DSS) — provide emergency financial assistance to individuals and families to help prevent events that could lead to homelessness. The local United Way recently received a grant from the local Kate B. Reynolds foundation to establish an internet-based network that allows the agencies to share information on EA clients. Funding can be used for such things as rent, utility bills, automobile repairs, and healthcare bills. Assistance averages between \$300–\$350 and is limited to once in a six month period. For individuals or families to receive emergency assistance, they must demonstrate how the money will solve their problem by developing a plan for paying bills in the future. Financial counseling is offered to help them with the financial planning. Although assistance averages \$300–350, providers have begun to notice a more insidious problem in the community: homeless clients owing large sums of back rent to the local housing authority or a private landlord. The money owed becomes a significant barrier to housing placement. To address this problem, the EA agencies used federal TANF dollars granted by the state for housing assistance. Each of the EA providers collaborated with the local DSS, and DSS co-located a staff member at the largest provider of EA funds. The TANF funds helped significantly, but the program was not renewed.

**Rental housing support Illinois<sup>7</sup>.** Illinois' new Rental Housing Support Program, hailed as perhaps the largest rental assistance fund in the nation, added a new surcharge on real estate document filing that is projected to raise \$30 million and assist 5,500 families. Illinois joins a growing number of states investing funds in solutions identified by 10–Year Plans. The law places a new \$10 fee on documents filed during home sales by both buyers and sellers. The program will reward landlords who agree to charge affordable rent to low-income tenants. The subsidies will help families that make below 30 percent of the Area Median

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<sup>6</sup> <http://www.endhomelessness.org/best/prevention.htm>

<sup>7</sup> <http://www.endhomelessness.org/best/prevention.htm>

Income. This means a family of four will qualify if its income is below approximately \$19,000.

The Illinois Housing Development Authority will distribute the funds to administering agencies, such as local housing authorities, municipalities or community groups. Those agencies will then contract with landlords, inspect units, and determine tenant eligibility. The landlord agrees to charge qualifying families a flat fee of 30 percent of their monthly income, and the administering agency will pay the balance of the rent. 70% of rental units subsidized through the program must be located outside of the city of Chicago.

**Illinois Department of Children and Families, Youth Housing Assistance Program<sup>8</sup>.** With the implementation of the Chafee Foster Care Independence Program, Illinois embarked on developing a Youth Housing Assistance Program, which provides housing advocacy and cash assistance to youth aging out of foster care. The program was modeled on Illinois' Norman housing advocacy program, which provides housing services to families at risk of involvement in child protective services due to the lack of safe and stable housing.

**Anoka County Rivercity Housing Collaborative<sup>9</sup>,** Anoka County, Minnesota. Anoka County Rivercity Housing Collaborative is administered by the local Division of Human Service. The Collaborative keeps funds in a "resource pool" which is drawn down by grantees as needed, maximizing resources and ensuring a collaborative versus competitive relationship among grantees to achieve program goals. They have also developed a tenant education curriculum they are planning on introducing statewide.

**Atlantic County Department of Family, and Community Development<sup>10</sup>.** The Atlantic County Department of Family and Community Development (DFCD) has undertaken the following initiatives:

- Committing financial and staff resources to engage families residing in motels and provide assistance to help them re-enter permanent housing as soon as possible;

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<sup>8</sup> <http://www.endhomelessness.org/best/ILyouth.htm>

<sup>9</sup> <http://www.endhomelessness.org/best/collaborative.htm>

<sup>10</sup> John McLernon, MSW, LSW Atlantic County Department of Family and Community Development  
1333 Atlantic Avenue Atlantic City, NJ 08401 Telephone: 609-442-4504 Email: [mclernon\\_john@aclink.org](mailto:mclernon_john@aclink.org)

- Increasing payments to a local homeless shelter to fund a housing specialist; and
- Partnering with child welfare workers to address housing crises and prevent or minimize foster care placements.

Project Check-Out evolved because of concerns regarding the high number of families who were residing in motels in the county for extensive periods of time. In 2003, approximately 75 families were living in motels in Atlantic County, New Jersey. DFCD frequently filled every room of several area motels with families experiencing homelessness.

Like many states, New Jersey retained an Emergency Assistance (EA) Program under the state's TANF plan. Typically, welfare agencies can use EA funds to help pay rent or utility arrears for families who are at risk of eviction, cover security deposits, and provide short-term rent assistance. Welfare offices have also used EA resource to subsidize the cost of providing shelter to homeless families and, when shelter space is not available, motel stays.

Concerned over the increasing length of stays in motels, the welfare agency crafted Project Check-Out to help families move out of motels. The diverse strategies adopted include:

- Developing an "evening snack program" to engage and foster relations with families residing in the motels;
- Relocating staff persons from the welfare office to work intensively with the families;
- Ensuring quick access to EA resources for security deposits and other costs; and
- Linking families with New Jersey/s Temporary Rental Assistance Program (TRA) that provides a rent subsidy to welfare recipients for up to 12 months;

The staff can use EA resources to pay for security deposits, moving expenses, furniture, clothing and supplemental food and other initial expenses that might otherwise prevent families from re-accessing housing. Another tool at their disposal is a state-financed rental assistance program, the Temporary Rental Assistance Program (TRA). New Jersey commits TANF resources to the TRA program. Families on TANF cash assistance can use the rental subsidies for a period of 12 months. TRA pays a maximum of \$700 a month. TRA complements

the EA resources and helps ensure that families who move back into housing will be able to meet their rental payments.

DFCD is now undertaking another initiative to prevent homelessness and foster care placements in Atlantic County. Under this new initiative, DFCD approves families receiving child welfare services for EA services to help address pressing housing needs. This referral occurs when a child welfare worker identifies a family whose poor housing may lead to a foster care placement or delay children's return to the family from foster care. DFCD staff meets regularly with the N.J. Division of Youth & Family Services (DYFS) and case-conferences all open child abuse/neglect cases. The welfare office prioritizes all open DYFS cases and provides as much financial support as regulations allow to eliminate as many financial barriers as possible to stabilize families.

**Community Care Grant Program, Washington, DC<sup>11</sup>.** The program is a collaborative effort of the Community Partnership for the Prevention of Homelessness and federally funded Family Support Centers. The staff of seven community-based Family Support Centers helps families to access housing and offers transitional, intensive case management services to ensure they stabilize in that housing. The Community Partnership provides funds to support the transitional case management and flexible, time-limited resources to help defray the cost of housing.

The program provides the services and support families require while diverting many from shelter stays. The Community Care Grant program costs an average of \$7,000 per family served and provides up to a year's support. In contrast, the average stay of six months in a family shelter costs \$11,439.

The city's shelter system for families has a central intake site, where each receives a preliminary assessment. The majority of families seen at central intake are not immediately placed into shelter unless their situation is dire; instead they are placed on a wait list. Following the preliminary assessment, families may be offered the opportunity to participate in the city's Community Care Grant program as an alternative to entering the shelter program. The program serves families that are at imminent risk of homelessness. This includes families who are doubled up and those with a pending eviction. The adult family member(s) must be employed or be able to obtain employment.

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<sup>11</sup> <http://www.endhomelessness.org/best/DCCCG.html>

They are also assessed as to whether they are able to become and remain permanently housed and self-sufficient in a short period of time. Eligibility for the program is determined within 30 days.

Accepted families can elect to work with one of seven Family Support Centers located throughout the city. It is recommended that the family work with a program near their community of origin or the community in which the family intends to reside.

A grant of up to \$7,000 is provided to the Family Support Center for each family that is referred by the Community Partnership. The Family Support Center uses \$4,000 to finance the provision of transitional case management and can use the remaining \$3,000 more flexibly to help the family transition quickly into permanent housing. If necessary, more resources can be provided to help re-house a family. However, additional expenditures must have pre-approval from the Community Partnership. The housing portion of the grant can cover security deposits, first month's rent, a short term housing subsidy, furniture, utilities, or needed household items.

Through a Memorandum of Understanding the Family Support Centers agree to provide case management services until the family's goals are met and to prioritize efforts to help the family obtain permanent housing as soon as possible. The Family Support Centers do not receive the final payments until the families actually obtain housing.

Several of the Family Support Centers have housing specialists on staff. This has proven useful as the staff have developed on-going relationships with landlords in their neighborhood and with the housing authority. The housing specialists keep abreast of available units in the neighborhood, advocate with the landlords on the family's behalf, help the family manage paperwork, and resolve credit history issues. If the family has not been placed on the waiting list for a housing voucher, the agency will help them through that process. Some families entering the program are already eligible or have received a housing voucher, so the housing specialist helps them identify viable units. Other families are housed without a housing subsidy.

Building from the initial demonstration, the city has committed \$1.43 million to the program over the last three years – primarily state TANF resources. The cost, including adapting services, is estimated at \$7,186 for every family housed. This

is equivalent to the cost of providing 116 days in shelter. In each year, more families have been successfully housed.

The provision of a grant with a value of up to \$7,000 to a Family Support Center that successfully prevents a homeless stay is seen as a cost effective alternative to a "typical" stay in the city's emergency shelter system. The typical length of stay in the city's shelter system for a family is 186 days and costs \$62 a day. An average length of stay, costs \$11,439.

**Lakes & Pines Community Action Council, Aitkin, Carlton, Chisago, Isanti, Kanabec, Mille Lacs & Pine Counties, Minnesota**<sup>12</sup>. Lakes & Pines Community Action Council serves rural Minnesota counties without an emergency homeless shelter. With access to the Family Prevention and Housing Assistance Program resources, Lakes & Pines Community Action Council focuses on preventing homelessness and stabilizing families in housing in their own communities. Without access to a homeless shelter, they are working with families with multiple challenges to help them achieve housing stability, either in their own home or in new housing following a homeless episode. This allows families who would otherwise seek shelter elsewhere to retain access to their existing support systems and prevents needless disruption in families' lives and their children's education. It provides:

- Financial assistance to pay past due rent, mortgage or contract to prevent eviction or mortgage foreclosure.
- Financial assistance for damage deposit, first month's rent or a two-month stabilization period.
- Individually tailored supportive services including information, guidance and referral, development of a self-sufficiency plan to prevent future homelessness.
- Case management/services to stabilize family for an average of two months.

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<sup>12</sup> <http://www.endhomelessness.org/best/actioncouncil.htm>

**Philadelphia Housing Support Center, Philadelphia, PA**<sup>13</sup>. The Center coordinates housing and service resources from various City social service departments through one central gateway. Pulling together resources such as Family Unification Program Vouchers, TANF dollars, and other mainstream and homeless program funds, the Center serves as a "one-stop shop" for housing resources -- providing both prevention and back-door mechanisms to decrease the actual number of people experiencing homelessness while helping to reduce the length of time others have to remain homeless. The Center serves mainly families experiencing or at risk of homelessness. The Center also accommodates people who do not fit neatly into other housing program models, such as those facing barriers to being housed by public housing authorities due to former criminal convictions or substantial debt.

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

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

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

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

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<sup>13</sup> <http://www.endhomelessness.org/best/SupportCenter.htm>

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

**Project SAFE, Everett, WA<sup>14</sup>.** Project SAFE – resources for parents of teens was initiated in 1999 to prevent teen homelessness in Snohomish County Washington. Project SAFE offers three services to parents/caretakers of teens: phone consultation, groups and workshops, and a resource library. Parent/caretakers who are concerned about their teen can call and speak with a therapist who provides consultation and links to various resources in the community. They then receive a follow-up phone call, can opt to participate in support and educational workshops, and have access to project SAFE newsletters, "tip sheets" and other resource library materials. Project SAFE serves parents and caretakers of youth who are currently, or may be in the future, at risk of homelessness due to a number of problematic behaviors. Project SAFE also works with parents of younger children to address problematic behaviors early on to curtail teen homelessness. Interventions in every phase of the project are based on research identifying the parental risk factors that often lead to teen homelessness including teen substance abuse, violence and criminal acts, mental illness, promiscuity, running away and/or exposure to abuse and neglect.

Cocoon House receives funding for their \$1.3 million budget through federal and regional government grants, such as HUD McKinney Supportive Housing Program, ACF Runaway and Homeless Youth Transitional Living Program, Community Service and Community Development Block Grants. Key corporate and foundation supporters include The Boeing Company, Medina Foundation, Paul G. Allen Foundation, and Everett Clinic Foundation. Cocoon also receives funding from community organizations and individuals. Project SAFE is funded by: Boeing, Whitehorse Foundation, Washington Alliance to Prevent Child Abuse and Neglect, Everett Clinic Foundation, and Butler Trust.

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<sup>14</sup> <http://www.endhomelessness.org/best/ProjectSAFE.htm>

## Theme: Income support

These citations illustrate innovations in providing ongoing financial security.

### Public Fund approaches

**The Maryland SSI Outreach Project, Baltimore, MD<sup>15</sup>.** The Maryland SSI Outreach Project helps homeless mentally ill people become enrolled in the Supplemental Security Income (SSI) program. It does this by providing services that the Social Security Administration does not: outreach, help with record gathering and application completion, and advocacy on the clients' behalf. The SSI Outreach Project is geared toward severely mentally ill people who are living on the streets. In addition to the street outreach done by the staff, the SSI Outreach project takes referrals from all over the city -- from the Department of Social Services, transitional housing programs, emergency shelters, and drop-in centers. Clients are usually those who are clearly good candidates for SSI, but by virtue of their disabilities, have been either unable to navigate the application process or simply unaware that they might be eligible for such an entitlement.

The SSI Outreach Project is also able to provide "presumptive" benefits to people they are certain will join the SSI rolls. This means that for up to six months while waiting for their eligibility determination, clients receive SSI payments. This part of the program is a remaining perk from the original demonstration project, which allowed for presumptive eligibility. After the first year of the demo, all of the 54 people who received their benefits presumptively were eventually enrolled in the SSI program. Those who do not receive presumptive eligibility are less visibly disabled -- either they may not have received treatment for their mental illness, or there is difficulty teasing out the substance addictions from the mental illness. The SSI Outreach Project is part of the Baltimore continuum of care, and receives \$190,000 per year from HUD.

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<sup>15</sup> Yvonne Perret, Project Director SSI Outreach Project 701 West Pratt Street Room 216 Baltimore, MD 21201

**METRO LOUISVILLE–JEFFERSON COUNTY, Family Works<sup>16</sup>.** Family Works is a Welfare-to-Work initiative established to increase child support payments from non-custodial parents who have children on, or eligible for, public assistance. Intensive case management services are designed to increase child support payments through an array of Welfare-to-Work programs that help non-custodial parents secure career employment. While the primary goals of the program are to upgrade employment and increase child support payments (and thus reduce welfare dependence), enhancing the non-custodial parents' relationship with their children is a significant feature and added benefit of the program.

**CITY OF ROCKFORD. Individual Development Account Program<sup>17</sup>.** Rockford's Human Services Department offers an Individual Development Account Program for working families who are striving to achieve homeownership, begin a small business, or pursue higher education for themselves or their children. The program combines extensive financial literacy classes in both English and Spanish with a 2:1 matched savings account for participants. Participants may save up to \$2,000 in three years; when matched, this provides them with a total of \$6,000 to use toward their asset purchase. In addition, participants must complete preparatory classes in homeownership, small business or higher education. The Rockford Housing Authority, the School District, and a variety of faith-based providers, banks and realtors are among the many community entities referring working families to the program. Funding is provided through the federal Assets for Independence Act, the Illinois Community Action Association, National City Bank and the City's Community Development Block Grant and Community Services Block Grant.

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<sup>16</sup> Joanne Weis, Director, Louisville Metro Human Services, at (502) 574-6022 or [Joanne.weis@loukymetro.org](mailto:Joanne.weis@loukymetro.org).

<sup>17</sup> Granada Williams, Executive Director, Human Services Department, at (815) 987-5782 or [Granada.Williams@ci.rockford.il.us](mailto:Granada.Williams@ci.rockford.il.us).

## Earned Income Tax Credit Approaches

**Denver Earned Income Tax Credit<sup>18</sup>.** The federal Earned Income Tax Credit is a tax incentive that has been shown to significantly improve the rate of job placement and job retention for low-income working families, particularly those who have recently left the welfare rolls. In January 2002 Mayor Webb announced the launch of the Denver Earned Income Tax Credit, which provides a 20 percent match of the federal EITC for Denver residents with children. In the first year of the Denver EITC initiative, more than 6,200 families benefited from the credit; the average check was \$415. The Denver EITC is supported by Temporary Assistance to Needy Families (TANF) funds that are intended to assist both the families still on welfare and the much larger number of families that are working but remain poor. Denver is the first local government in the nation to offer an EITC funded with TANF dollars.

**Houston Asset Building Coalition, Houston TX.<sup>19</sup>** The Houston Asset Building Coalition is a partnership of the Mayor's Citizens' Assistance Office, the Internal Revenue Service, area financial institutions, government agencies, and other community organizations.

**Earned Income Tax Credit. Boston, MA<sup>20</sup>.** The Boston EITC Campaign provides tax filing services at no cost to Boston's low- and moderate-income and immigrant communities and helps taxpayers receive their refunds quickly through direct deposit. The Campaign, a member of the National Tax Assistance for Working Families Campaign, promotes better access to mainstream financial services, encourages and promotes individual and community asset building, and provides education in personal money management and financial literacy.

The Boston EITC Campaign demonstrates that a well-organized coalition is an effective method for reaching diverse populations. Each member of the collaboration - City, State, and federal government organizations, regulators, foundations, community-based organizations, and members of the local

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<sup>18</sup> Elisabeth Alkire, Tax Credit and Asset Development Project Director, Mayor's Office of Workforce Development at (720) 865-5660 or [Alkire@mowd.org](mailto:Alkire@mowd.org).

<sup>19</sup> Richard Cantu, Director of Citizens' Assistance, at (713) 247-2511 or [Richard.cantu@cityofhouston.net](mailto:Richard.cantu@cityofhouston.net).

<sup>20</sup> Mimi Turchinetz, Office of Jobs and Community Services, at (617) 918-5259 or [Mimi.Turchinetz.jcs@cityofboston.gov](mailto:Mimi.Turchinetz.jcs@cityofboston.gov)

business community – represents a key constituency and forms a critical component of the Campaign. In addition to Mayor Menino and the City, members include the Internal Revenue Service, Federal Reserve Bank of Boston, Greater Boston Chamber of Commerce, Annie E. Casey Foundation’s Making Connections Boston, Action for Boston Community Development, Codman Square Health Center, Hispanic Office of Planning and Evaluation, American Association of Retired Persons, Federal Deposit Insurance Corporation, Boston Housing Authority, Massachusetts Association of Community Development Corporations, Boston Cares, Boston College, Jewish Vocational Services, Greater Boston Legal Services, and Legal Advocacy Resource Center. The Internal Revenue Service provides free software and training materials to the sites. Together, the Campaign and the IRS train site staff and volunteers. The Annie E. Casey Foundation, Boston Foundation, Citizens Bank, Sovereign Bank, One United, and the law firm of Nixon Peabody provide financial support..

**CITY OF SAN ANTONIO, Family Economic Success Program<sup>21</sup>.** San Antonio’s Department of Community Initiatives (DCI) has instituted the Family Economic Success Program (FESP) to help low-income families move from poverty to economic success. The program is based on the interwoven strategies of asset building and asset protection. Financial literacy, Volunteer Income Tax Assistance/Earned Income Tax Credits (VITA/EITC) and Individual Development Account (IDA) programs are the principal components of the asset building model. DCI partners with several community agencies to implement the FESP initiatives and build the capacity of community organizations.

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<sup>21</sup> Samantha Rapoza, Special Projects Coordinator, at (210) 207-8762 or [Srapoza@sanantonio.gov](mailto:Srapoza@sanantonio.gov).

## Living Wage Approaches

A “living wage” is a wage that is measured by some as the hourly take-home set above the poverty line for a family of four. That is about \$3.00 above the federal hourly minimum wage of \$5.15, but this does not come close to equally Florida’s “housing wage,” which exceeds \$12.20. A move to increase wages would allow lower income families to better afford their housing. On the other hand, the ramifications of an increase in wages are unknown.

Many communities have adopted some type of living wage ordinance. These fall into several categories:

- Public contracts with private service providers, requiring these providers to pay a living wage (specified in the ordinance) to their employees; and
- Tax assistance, economic development funds, or other state aids going only to corporations paying a living wage.

### Living Wage ▪ Government Initiated Examples<sup>22</sup>

**Miami-Dade County<sup>23</sup>:** In 1999, Miami-Dade County established a living wage requirement for county employees and those employers having county service contracts. The county requires a service contractor who is paid in whole or part from one or more of the County’s revenue funds, directly or indirectly, to pay a living wage of no less than \$8.56 per hour with health benefits as described in the ordinance, or \$9.81 per hour. The ordinance also requires the county to set an example in this regard by paying a phased-in living wage that began in 2001.

**Baltimore:** Baltimore now requires companies with city service contracts to pay \$6.50 per hour as a result of a living wage ordinance passed in 1994.

**St. Paul and Minneapolis:** The City Councils of both St. Paul and Minneapolis passed laws demanding that companies that get over \$100,000 in subsidies pay their employees at least \$8.25 per hour. The Minneapolis ordinance also extends to companies which receive contracts from the City.

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<sup>22</sup> Eshenfelder, B. 2004. Best practices report, PCCH.

<sup>23</sup> Personal communication. D. Raymond.

**Santa Clara County:** Santa Clara County, California requires manufacturing firms which get tax abatements from the County to pay at least \$10 per hour to all permanent employees and to provide them with health insurance.

### Living Wage ■ Private Sector Living Wage

**Holland & Knight:** Some private companies are also deciding to institute living wages for their employees. A Florida business that recently reported establishing a living wage is Holland & Knight, one of the nation's largest law firms.

### Public policy approaches

**Chicago Anti-Predatory Lending Initiative, Chicago, IL<sup>24</sup>.** Concerned that predatory lending had led to an increase in foreclosures in the City, Mayor Daley launched a multi-faceted strategy to create program and policy initiatives to combat predatory lending on the local, state and federal levels. On August 30, 2000, the City passed a predatory lending ordinance, the first of its kind in the nation. The ordinance requires that any financial institution wishing to do business with the City must sign a pledge stating that neither it nor any of its affiliates engages in predatory lending. It precludes home repair contractors from receiving payments directly from lenders, enabling homeowners to withhold payment for substandard or nonexistent work. The ordinance also authorizes the City's Department of Consumer Services to take action against contractors who engage in consumer fraud, unfair competition or deceptive practices, especially those practices that may result in foreclosure.

Complementing the City's predatory lending ordinance is the SAVE HOME Campaign, an anti-predatory lending public education campaign. The City developed SAVE HOME to educate and warn the public about the dangers of predatory mortgage lending, and to improve awareness about access to conventional credit. It uses informal networks including community groups, religious institutions, and grocery stores along with more traditional communication media including Chicago Transit Authority buses, neighborhood signs, and radio advertisements to promote the Campaign.

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<sup>24</sup> Marti Wiles, Coordinating Planner, Department of Housing, at (312) 747-9481 or [mwiles@cityofchicago.org](mailto:mwiles@cityofchicago.org).

## Theme: Healthy Neighborhoods and Communities

Another approach to prevention is to focus on the health of neighborhoods and communities under the working theory that they then will have greater capacity to assist themselves. Citations of best practices are given below.

**CITY OF INDIANAPOLIS, Fostering Commercial Urban Strategies<sup>25</sup>.** Fostering Commercial Urban Strategies (FOCUS) is a pilot commercial and economic development initiative aimed at bringing commercial development back to historically underserved Indianapolis neighborhoods. The purpose of the collaboration is to build longstanding relationships that connect neighborhoods and their Community Development Corporations (CDCs) with the business community in order to rebuild and revitalize urban commercial markets.

The collaboration represents an attempt to make a systemic change in the planning, advocacy and delivery of commercial development projects in core Indianapolis neighborhoods. It is designed to give these neighborhoods a level of control in the economic development initiatives that will affect them most, with the ultimate goal of restoring goods, services, and jobs. Along with the City, the key partners in FOCUS include the Local Initiatives Support Corporation (LISC), the Indianapolis Coalition for Neighborhood Development, and the Indianapolis Chamber of Commerce.

**Family Investment Centers, Indianapolis, IL<sup>26</sup>.** Indianapolis's Family Investment Centers, which serve the goal of making services more accessible to the City's families, are part of a pilot initiative in three neighborhoods. The pilot is a partnership of, and is supported by, the City, the State of Indiana, and the Annie E. Casey Foundation.

The Centers provide comprehensive, unified services for Indianapolis families and children. They are not a "bricks and mortar program;" rather, they represent

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<sup>25</sup> Melina Kennedy, Director, Economic Development, at (317) 327-7456 or [mmkenned@indygov.org](mailto:mmkenned@indygov.org)

<sup>26</sup> Jane Henegar, Deputy Mayor for Public Policy, at (317) 327-3611 or [jhenegar@indygov.org](mailto:jhenegar@indygov.org).

an effort to provide simplified access to services by building on existing neighborhood-based services. The government and non-profit providers involved in this effort are partnering with neighborhoods to develop and operate the human services delivery system in new and better ways. Together, the partners are identifying priorities, obstacles and opportunities. Community centers, community based operations, or faith-based facilities could become neighborhood hubs for Family Investment Centers, eventually coordinating support services, education, job training, job placement, and other opportunities for neighborhood residents.

### Theme: Maintaining Community Linkages

Another approach to preventing homelessness is to ensure that persons who will re-enter the community at some future point maintain a set of linkages so that they are not isolated when they return. Some examples are provided below.

**The Oklahoma Marriage Initiative<sup>27</sup>** (OMI) uses TANF funds to provide programming to strengthen both married and unmarried couples, especially those with low income. Because many people in prison and jail fall into this target population, OMI partnered with the state Department of Corrections (DOC) to train DOC staff chaplains to teach the evidence-based Prevention and Relationship Enhancement Program curriculum. OMI provides the training and workshop materials for inmate participants and evaluates the programs while DOC covers the cost of staff time and expenses incurred around training.

**The Maryland Re-Entry Partnership<sup>28</sup>** brings together participants from public and private agencies and systems, including criminal justice, health, and housing, to support the re-entry of prisoners in Baltimore. Community-based case managers (CCMs) meet with people incarcerated in state facilities before they are released to develop individualized re-entry plans. After those people return to Baltimore, the CCMs continue to meet with them. The CCMs act as “boundary spanners,” connecting released individuals to services in different systems.

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<sup>27</sup> Report of the Re-entry Policy Council. No date. U.S. Department of Justice.

<sup>28</sup> Re-entry report. Op. cit.

**The Missouri Department of Corrections**<sup>29</sup> (DOC) assesses and re-assesses individuals in prison and after release to allocate supervision resources efficiently. Institutional staff develop individualized Transition Accountability Plans and provide the parole board with varying release and community supervision options designed to achieve successful reintegration of prisoners back into society. Community corrections officers then match varying degrees of intervention, control, and treatment with the individual needs of the offender and his or her environment and progress.

**The Illinois State Department of Corrections**<sup>30</sup> pays St. Leonard's Ministries, a local supportive housing provider, just under what it costs the Department to supervise a given number of parolees. St. Leonard's then not only provides housing and other social services for the parolees but also assumes a large share of the responsibility for their supervision.

**New York's La Bodega de la Familia's**<sup>31</sup> family case management model brings together a parolee, a family case manager, a supervision officer, and family members of the parolee. Together, they work to identify the family's resources and to build a supportive network of healthy relationships. Among other positive results, informal encouragement and support—even without increased drug treatment—led to a 36 percent decline in substance abuse for program participants, compared to a five percent drop for a comparison group. Re-arrest was cut nearly in half, with 11 percent of participants arrested during the six months following their involvement in the program, compared to 18 percent of the comparison group.

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<sup>29</sup> Re-entry report, op. cit.

<sup>30</sup> Re-entry report, op, cit.

<sup>31</sup> Re-entry report, op. cit.

## Access to Mainstream Services

The second major category of best practice falls into those programs and services which are intended to foster and enhance access to mainstream services, i.e. services that all people need, regardless of housing status. Examples here cover both program or service models as well as system re-design approaches.

### Theme: Program Models

**Mobile Medical Van, Pinellas County**<sup>32</sup>. The Mobile Medical Van provides outreach medical and dental care to the homeless population of Pinellas County. The van visits shelter, soup kitchens, drop-in centers, and other location where the homeless are known to congregate. The van contains an examination room, wheel chare lift, interview area medical equipment and records, cellular phones, a fax machine and laptop computers. There are no drugs on-board. The Mobile Medical Team consists of a medical director, program supervisor, physician nurses, social worker and social work assistants/drivers.

**Every Child Matters Program**<sup>33</sup>. In 1997, the City of Stamford, in partnership with the United Way of Stamford, conducted a comprehensive needs assessment to determine the health and human service needs of the community. This assessment revealed that the single most serious human service need in the City was lack of health insurance. In response to this finding, the Mayor convened the Stamford Human Services Planning Council to address the issue. The Council, made up of a diverse coalition of community agencies, immediately recognized that the HUSKY program, like many State Children's Health Insurance Programs nationwide, was not successfully enrolling uninsured children. After reviewing the HUSKY program enrollment strategy, the Stamford Health Department took responsibility for putting together a local program to improve the enrollment of Stamford children. Thus was born the Every Child Matters program and, with it, the goal of insuring all children in Stamford, including the 2,500 found to be lacking health insurance.

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<sup>32</sup> Personal communication, C.E. Smith

<sup>33</sup> Dr. Anthony Iton, Director of Health and Social Services, at (203) 977-4396 or [aiton@ci.stamford.ct.us](mailto:aiton@ci.stamford.ct.us).

The Health Department designed a unique school-based health insurance outreach system which capitalizes on existing stable and trusted relationships to link the families of uninsured children to HUSKY. Stamford has a Health Department-employed school nurse in every school. In partnership with these school nurses, principals, parent-faculty organizations, and other school-based resources, outreach workers have added 2,500 children to the Health Department health insurance database. The families of these children receive letters introducing them to the Every Child Matters program, and each family is then telephoned by outreach workers who offer to schedule personal appointments to assist them in submitting a HUSKY application. Families are also offered the direct assistance of a bilingual (Spanish/English) Health and Social Services Department employee; this is a critical element of the program, as the Hispanic population of the City has doubled in size since 1990, and national and local studies consistently indicate that this population has the lowest rate of health insurance coverage.

**Common Ground, New York<sup>34</sup>.** This is a recuperative care transitional residence that breaks the cycle of hospital recidivism and shelter use for the medically frail homeless in New York City. The program addresses the needs of homeless individuals who are ready to be discharged from the hospital, yet require additional medical care for complete recuperation. Length of stay will average 90 days to allow patients to achieve medical recuperation, secure available benefits, and engage in the exploration of transitional or permanent housing alternatives. The Respite Center takes a unique, integrated approach to recovery and the concept of health care for the homeless.

**WestCare Nevada Community Triage Center<sup>35</sup>.** The Community Triage Center provides local law enforcement and emergency services personnel with a drop-off point for drug-addicted individuals, chronic public inebriates and individuals experiencing mental health crises. The project alleviates hospital emergency department overcrowding and provides law enforcement and emergency services personnel with a “one-stop” drop-off site for individuals in need of

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<sup>34</sup> <http://www.commonground.org/>

<sup>35</sup> <http://www.westcare.com/slnevada.htm>

detoxification and mental health screening. The majority of persons served are indigent or homeless. Services provided include:

- Crisis Stabilization
- Intake, Assessment and Treatment Referral
- Drug and Alcohol Detoxification/Civil Protective Custody (CPC)
- Mental Health Evaluation and Treatment
- Homeless Outreach Services
- 24-hour Transportation Support System

**Vitamins for the Homeless**<sup>36</sup> benefits homeless men and women by providing them the minimum essential vitamins and minerals – regardless of whether they have eaten sufficient food that day. In this way, Vitamins for the Homeless helps homeless adults restore their health, a critical first step to becoming self-sufficient again.

**Central City Concern Health Services, Portland, OR**<sup>37</sup> include the Old Town Clinic, Hooper Detox with sobering center and subacute medical detox beds, and Portland Alternative Health Center (PAHC), a multidisciplinary, integrated care system that includes Alcohol and Drug-Free Community (ADFC) housing. Medically supervised respite care is also provided. Through the multiple services offered, CCC does more than medically manage detox or other health concerns. It provides primary care, prevention, and education as well as a Community Engagement Team that meets individuals while in detox and connects them with Assertive Case Management or professional mentoring, depending on the person's needs.

These services lead to linkages with Central City Concern's housing and workforce development programs or provide access and engagement with other needed services.

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<sup>36</sup> [www.vitaminrelief.org](http://www.vitaminrelief.org)

<sup>37</sup> <http://www.centralcityconcern.org/>

**State of Oregon Mental Health Housing Initiatives<sup>38</sup>.** This effort addresses serving the mentally ill in the community. It is comprised of a number of specific programs.

MHS Housing Fund: The Mental Health Services Housing Fund, initiated in 1989, awards modest grants to financially assist the development or renovation of housing for person with mental illness. As of October 2004, \$3.9 million has been awarded to 94 housing projects in 27 Oregon counties to create and preserve housing for over 1,800 people with severe and persistent mental illness. Another \$630,000 has been awarded to 135 housing operators for renovations to correct health, safety or accessibility problems. With these funds, housing has been improved for 976 persons, and in some cases, prevented from closure. Grants for housing development are usually \$30,000 – \$40,000 per housing project. Grants for renovations are up to \$4,999.

Real Choice Housing Assistance Fund: With about \$270,000 from a federal grant from the federal Centers for Medicare and Medicaid Services, local community mental health programs receive funds to assist people with serious mental illness to obtain or retain integrated community housing. To date, 373 individuals have been provided financial assistance averaging \$367 to obtain or maintain integrated community housing. About 100 individuals were assisted in moving to a private apartment or home from more structured or transitional accommodations or homelessness; 84 individuals were assisted in transitioning to housing from homelessness; and 130 people were assisted in maintaining their housing and avoiding homelessness or re-hospitalization. OMHAS is considering ways this fund may be maintained when the grant expires.

Community Mental Health Housing Fund: This fund was established with the proceeds from the sale of the Dammasch State Hospital property in Wilsonville. Application materials for the first round of awards have been distributed with applications due February 15, 2005. Applicants can request up to \$100,000 for the development of new housing capacity for people with serious mental illness.

Villebois: The "new urban village" under development at the former state hospital site will include housing for people with mental illness. Approximately 22 individual housing sites, totaling 8 acres in the 500-acre development area,

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<sup>38</sup> Vicki Skryha, Oregon Department of Human Services. 500 Summer Street, NE, E-86, Salem, Oregon 97301-1118, Phone: 503.945.9722, Fax: 503.947.5547

will be integrated throughout the new community. The first two projects, a small group home and a 20-unit apartment complex are currently under development.

### **State of Oregon Alcohol Drug Free Housing Initiatives<sup>39</sup>:**

ADF Housing Assistance Services: These were initially funded in 1999–2001 biennium and provide housing coordination and/or rent subsidies. There are 8 projects awarded to Coos, Josephine, Lane, Lincoln, Linn, Multnomah, and Washington counties and Siletz tribe. During 2003–04, these eight projects assisted 678 families and individuals who are in treatment for alcohol and drug addictions by making available housing that supports a clean and sober life style.

Oregon Recovery Homes: OMHAS contracts with Ecumenical Ministries of Oregon to administer a Revolving Loan Fund and two Outreach Coordinators. Oregon Housing and Community Services funds the second outreach coordinator. This program primarily supports the Oxford House model. Currently there are 123 Oxford Houses in Oregon accommodating 925 people in recovery.

ADF Housing Funds in the CFC: In partnership with the Oregon Housing and Community Services (OHCS), \$2.6 million has been awarded to twenty-one housing projects in eleven counties to provide housing for 216 persons in recovery from serious substance use disorders.

**Pathways to Housing** <sup>40</sup> , New York New York .Pathways to Housing offers scattered site permanent housing to homeless individuals with psychiatric disabilities and addictions. Despite the challenges this population presents, Pathways is unique in what it does not require of its residents: "graduation" from other transitional programs, sobriety, or acceptance of supportive services. The vast majority of clients are moved directly from the streets into permanent, private market housing. The program then uses Assertive Community Treatment (ACT) teams to deliver services to clients in their homes. The ACT teams help clients to meet basic needs, enhance quality of life, increase social skills, and

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<sup>39</sup> Skyrka, op. cit.

<sup>40</sup> <http://www.pathwaystohousing.org>

increase employment opportunities. The program currently serves over 400 people.

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

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

**Stop Abusive Family Environments, Inc, Wyoming<sup>41</sup>.** The mission of S.A.F.E is to eliminate violence within the family and society, and to assist the victims in taking control of their lives. Programs include on-site child care, peer counseling and advocacy services, self and family esteem, positive parenting skills, job readiness, transportation services and financial counseling. S.A.F.E. provides services in McDowell, Wyoming and Mercer counties of West Virginia. Housing is provided for up to twenty-four months. In the fiscal year of 1995-1996 S.A.F.E. served in over one thousand domestic cases. Funding for S.A.F.E is provided by local, state, and federal block grants and private donation.

## Theme: Co-location of Service Providers in Mainstream Agencies

One way that mainstream agencies have increased access to their own services and supports or access to other agencies' services for their own clientele is through co-location. Co-location is when staff members from one agency are

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<sup>41</sup> <http://www.endhomelessness.org/best/bpsafe.htm>

located within the building of another agency to reduce barriers to services. The following citations are examples of co-location.

**Seattle's Downtown Emergency Service Center**<sup>42</sup> has outreach staff located at the Department of Health and Social Services one day a week so eligibility workers can refer clients directly to the person for services if necessary.

**The Los Angeles County Sheriff's Department**<sup>43</sup> has created the Community Transitions Unit to empower jail inmates to be successful once they leave custody. Homeless veterans are one of the unit's target populations. The unit staff members contact VAGLAHS to verify veteran status of inmates prior to placement in the veteran portion of the facility. (Offenders can be in the veteran portion of the facility as long as they are not mentally ill or are not charged with murder or sex offenses. Mentally ill inmates are housed in a different portion of the facility). The VAGLAHS, US Vets, and the Salvation Army each have staff located in the facility to provide services and classes to veterans.

### Theme: New Roles for Mainstream Agencies

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

**Philadelphia**<sup>44</sup>. The city Office of Emergency Shelter and Services (OESS) maintains two central intake systems, one for single men and one for women with or without accompanying children. Emergency shelter occupancy went from about 80 percent to 97 percent once the central intake system was fully operational. While it does not run any shelters or transitional programs itself, the city pays for shelter for all people that OESS places into emergency or transitional programs. The intake databases link to a management information system that can provide an unduplicated count and other information about people served, going back to 1989.

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<sup>42</sup> Burt, M. et. al. 2004. Strategies for reducing street homelessness. U. S. Department of Housing and Urban Development.

<sup>43</sup> Burt, op. cit.

<sup>44</sup> Burt, op. cit.

The Housing Support Center is a new program just getting under way within the city Office of Adult Services (AS). When fully operational, it will bring together resources from AS, Department of Human Services, Community Behavioral Health (CBH), the County Assistance Office (cash assistance), the Philadelphia Housing Authority (PHA), and other public agencies whose clients face challenges to housing stability. It will serve as the city's central referral point for all households needing help because they are experiencing homelessness or facing homelessness, including families whose involvement with child welfare arises chiefly from their lack of housing. Agencies under Philadelphia's Behavioral Health System offer prevention, outreach, substance abuse, and mental health services through their own staff and by contracting with nonprofit homeless assistance programs. The Coordinating Office of Drug and Alcohol Abuse Programs and the Office of Mental Health are city offices whose staff provides care directly and who also pay for services and shelter/housing through contracts for people meeting their eligibility criteria. Both work closely with the outreach teams under the Outreach Coordination Center run by Project H.O.M.E., as well as supporting outreach teams of their own. Direct mental health and substance abuse treatment is also supplied through CBH, the city's nonprofit managed behavioral health care entity covering poor people with behavioral health disorders, whether Medicaid beneficiaries or not. All are components of Philadelphia's Behavioral Health System (BHS).

**Los Angeles**<sup>45</sup>. The Department of Mental Health (DMH) Adult Systems of Care administers the AB 2034 program in Los Angeles County. AB 2034 is a state-funded program to address the mental health needs of persons whose illnesses have led them to homelessness and incarceration. In Los Angeles, these funds focus on providing appropriate supports to incarcerated people with serious mental illness, to prevent (return to) homelessness upon release. They thus link DMH and the County Sheriff's Department in a new and important partnership. Several mainstream agencies cooperate in providing outreach for the program. Most AB 2034 clients enter the program from jail. When jail staff members identify a prospective AB 2034 client, they contact the Program Evaluator who begins the intake process into the AB 2034 program to determine program eligibility. At this point, the agency initiates the engagement process and remains connected with the client during incarceration. While in jail, the inmate is followed by one of two AB 2034 case managers who advocate for the client

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<sup>45</sup> Burt, op. cit.

and work with the sheriff's department to produce an effective discharge plan. Referrals can also come from the courts, prosecutors, parole officers, county mental health programs, self-referrals and referrals from family members. The AB 2034 Program Evaluator works with police departments, prosecutors, and parole officers to negotiate alternative sentencing programs for inmates who qualify for the AB 2034 program.

The Adult Systems of Care's Housing Coordinator provides technical assistance to the agencies in leasing and purchasing housing and in completing applications for Section 8 housing vouchers. The Housing Coordinator also works with the Los Angeles City Housing Authority on a case-by-case basis to apply for exemptions for clients with criminal histories. AB 2034 funds give Housing Specialists the flexibility to overcome property owner resistance by employing such innovative strategies as paying the rent until the client receives his/her housing voucher and placing an early deposit on a housing unit so the property owner will have funds available to make necessary repairs to bring the building up to Section 8 standards. The Housing Specialists can also intervene if an eviction is imminent or use AB 2034 funds to repair any damage done by the client. To recruit more landlords willing to rent to AB 2034 clients, the Department of Mental Health hosted a landowner/property owner breakfast for which they brought in speakers to speak on such topics as how to become Section 8 landlords and how to obtain low interest loans. The Housing Specialists have made such an impact that some landlords have taken their names off the HUD Section 8 list and only rent to AB 2034 clients. Not only do the housing specialists provide technical assistance and temporary financial relief for Section 8 landlords serving their clients, but the AB 2034 clients come with case managers who resolve problems between tenants and landlords.

## Theme: Comprehensive Systems

**The State of Vermont, comprehensive, community-based support system for mental health clients<sup>46</sup>.** This system attends to case management, support for consumer-run initiatives, crisis resolution options, and access to a range of affordable housing. Vermont's Department of Mental Health (DMH) has actively

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<sup>46</sup> Lezak, A. and Edgar, E. 1996. Preventing homelessness among people with serious mental illness. Center for Mental Health Services. U.S. Department of Health and Human Services.

encouraged a significant expansion of scattered-site, independent housing with supports, and consumer choice in housing is a priority.

Vermont's ability to build a system of community-based care has been greatly aided by the transfer of funds to community programs from Vermont's one State hospital. This was done with the help of a 3-year Robert Wood Johnson Foundation grant awarded in 1987 that was aimed at strengthening the community service system as the hospital census declined. Part of the money was used to develop programs to prevent individuals who were discharged from becoming homeless.

### **Initiatives Targeted to Individual Risk Factors**

**Treatment and supports for people with co-occurring disorders.** Vermont has recognized the need to treat people with dual disorders as a priority and is in the process of developing more capacity and expertise to do so within local mental health systems. Community mental health centers (CMHC's) generally provide treatment groups for individuals with co-occurring disorders, and staff work to find housing for those who are not yet engaged in treatment. Although housing options are limited for people who are actively abusing substances, Vermont takes the position that housing needs to be available for these individuals as long as they are able to meet the requirements of tenancy.

**Support and training for community living.** Vermont has developed a strong system of case management, with an emphasis on outreach, reduced caseloads, and the flexibility to provide varying intensities of service as needs change. Case managers help consumers develop the skills they need to live independently and provide the supports they require to maintain a home in the community. They also work with landlords and housing managers to help clients meet the requirements of tenancy. Several local catchment areas have developed effective assertive community treatment team models.

### **Initiatives Targeted to Environmental Risk Factors**

**Discharge planning.** Each CMHC has a staff liaison to the Vermont State Hospital who is responsible for ensuring close coordination between the agencies. A system of extensive, individualized discharge planning has been developed. If a client is hospitalized, CMHC staff work closely with the hospital to sustain continuity of care and to maintain the individual's housing during brief hospital stays. Good working relationships have also been developed with police, jails,

and the courts. In Burlington, Vermont's largest city, the CMHC has a staff liaison to the local police department.

**Crisis services and temporary housing.** Crisis resolution options have been strengthened in Vermont with the help of extensive consumer and family involvement. The emphasis is on a flexible, mobile crisis team approach. Mental health centers have created new programs of in-home crisis care, with staff available to provide around-the-clock assistance in an individual's home. Crisis housing has been developed as another option to avoid hospitalization. CMHC's are expected to continue to work with consumers who lose their housing. If an individual is evicted, which often occurs due to behaviors associated with substance abuse, case managers are expected to help clients learn from their experiences and find another suitable housing placement. CMHC staff work with landlords to help maintain positive relationships with tenants who must be evicted.

**Flexibility in services and funding.** DMH has strengthened the ability of CMHC's to develop systems of care that respond to local conditions and needs. Although all CMHC's have received funding to strengthen case management services, each has also funded a number of other supports determined by local needs.

**Promoting consumer support.** Consumer support efforts have become a key aspect of supported housing in Vermont. Apartment support groups, formed with the help of CMHC's, are active in many service areas; members turn to one another for problem solving, to avoid loneliness, and for regular support and celebrations of important events. Consumer-run groups are an important source of friendship and assistance.

**Offering daytime activities.** Meaningful daytime activities are seen as a key to community stability and consumer satisfaction. From the early 1980's, DMH has encouraged the development of clubhouses and other rehabilitation options. Supported employment opportunities are offered by all CMHC's.

**Residential options that respond to consumer preferences.** DMH has a policy of supporting consumers in the housing they choose to the greatest extent possible. By promoting development of housing expertise in mental health centers, DMH has strengthened the ability of mental health providers to help people with mental illnesses locate a variety of independent housing options and make appropriate choices. At the same time, DMH has promoted expansion of a range of supportive services for clients to enable them to succeed in regular housing in the community.

**Increasing affordable housing options.** DMH has encouraged the creation of several nonprofit housing development corporations that have been successful

in securing funding to develop new, independent housing options for people with serious mental illnesses. CMHC's have formed partnerships with the housing development corporations, including formal memoranda of understanding in some cases, to provide the services that assist people in independent housing.

**State rent supplement program.** A major resource in Vermont is the Housing Contingency Fund, which provides rent supplements to consumers while they are on Section 8 waiting lists. Partially supported with moneys shifted from the State hospital, the fund gives priority to housing developed by nonprofit developers and can only be used in regular housing that is available to the general public. It is available through CMHC's and CMHS-administered PATH (Projects for Assistance in Transition from Homelessness) programs. In Vermont, PATH projects are located within a variety of organizations, including community action agencies, Health Care for the Homeless projects, and a consumer-run drop-in center. Making the Housing Contingency Fund available through these nontraditional providers has enabled the State to reach consumers at risk of homelessness who are not involved with mental health centers.

**Developing housing expertise among mental health staff.** Creating a strong housing coordinator role in each service area has been instrumental in enabling Vermont to move toward a supported housing model. Each CMHC has a housing coordinator, with all of them meeting at least quarterly with the DMH housing coordinator for training, technical assistance, and other support. Staff from State housing agencies, PHA's, nonprofit developers, Social Security offices, and others are invited to provide information, training, and opportunities for cross-systems collaboration. Locally, CMHC housing coordinators serve as client advocates in housing issues and act as liaisons between and among case managers, PHA's, municipal housing offices, private landlords, and nonprofit housing developers. They ensure that eligible clients are on Section 8 waiting lists, help negotiate problems with tenancy, and are actively involved in local housing development issues. Organizing a strong housing advocacy voice in State and local government has also expanded access to housing for people with serious mental illnesses. Mental health staff, consumers, and families, some of whom are associated with the Alliance for the Mentally Ill and Vermont Psychiatric Survivors, have become active participants in organizations such as the Vermont Affordable Housing Coalition and the Coalition for Disability Rights.

**Reducing the stigma of mental illness.** Part of the rationale for Vermont's endorsement of the supported housing model is its potential for reducing

stigma. DMH policies address the goal of assisting consumers with living in regular housing in the community, rather than in segregated or group residences, where they will be readily identified as different from other community members. Supported employment programs that enable people with serious mental illnesses to have mainstream jobs are also viewed as helping to reduce discrimination.

**Housing as Housing, The State of Ohio**<sup>47</sup>. Beginning in 1986, the Ohio Department of Mental Health (DMH) began aggressively shifting resources from facility-based housing and services to independent housing with flexible, individualized supports. In 1988, DMH issued what became a widely read position paper, the *Housing-as-Housing Discussion Paper* (Ohio Department of Mental Health, 1988), describing its commitment to the principles of independent housing, comprehensive community supports, and the value of consumer choice. The supported housing model is considered central to enabling people with serious mental illnesses to gain stability and acceptance in their communities.

#### **Initiatives Targeted to Individual Risk Factors**

**Support and training for community living.** As independent housing opportunities have been developed, DMH has also recognized the need for individualized treatment and supports. The 1988 Housing-as-Housing paper stated that "supportive services must be available to people in their own homes to assist and sustain them in a natural environment." Increased funding has enabled significant expansion of intensive case management and individual rehabilitation services, which have been crucial to supporting individuals in their own homes. Extensive staff training and improved coordination of services with independent housing have contributed to the success of the supported housing approach.

#### **Initiatives Targeted to Environmental Risk Factors**

**Comprehensive, integrated systems of care.** The community mental health boards in Ohio have responsibility for planning, purchasing, and coordinating local services. DMH has provided direction, training, and increased funding to enable them to provide a full complement of needed services; to provide ready access to all services through a single point of admission; and to develop approaches that are directly responsive to the expressed needs of consumers and their families. Grants from the Robert Wood Johnson (RWJ) Foundation

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<sup>47</sup> Lezak, op .cit.

Program on Chronic Mental Illness enhanced the ability of three recipient sites in Ohio (Columbus, Toledo, and Cincinnati) to implement responsive, coordinated systems of care.

**Residential options that respond to consumer preferences.** The driving force behind Ohio's supported housing movement is a belief in the importance of responding to consumer preferences. To help put these principles into practice, DMH has adopted policies and funding strategies that have expanded supported housing. Specifically, the department has (1) required community mental health boards to develop residential services and housing plans that emphasize consumer choice in housing and supportive services; (2) helped community mental health boards found housing development corporations that concentrate on integrated, scattered-site housing for consumers; and (3) provided ongoing guidance and training on ways to increase consumers' access to supported housing and help them be successful.

**Increasing affordable housing options.** After it made a commitment to encourage the development of supported housing, DMH took a number of steps to add to the availability of regular, scattered-site housing for people with mental illnesses.

**State rent supplement program.** The DMH Housing Assistance Program (HAP) offers rent subsidies similar to Section 8 vouchers for people with mental illnesses who have very low incomes. The program gives priority to consumers who are being released from State hospitals, those who are at risk for homelessness, or those who are homeless. In addition to rental assistance, HAP provides flexible funding to cover deposits, furnishings, and other housing related expenses, as needed.

### **Family/Community Factors**

**Reducing the stigma of mental illness.** With supported housing now well accepted throughout the State, DMH has set a goal of helping people with serious mental illnesses to attain a further level of community integration. A strength of the supported housing model is that it enables consumers to live in integrated, scattered-site housing that, because it is not identified as mental health housing, helps reduce stigma and increase community acceptance of people with mental illnesses. Efforts are being made to help consumers develop strengths and skills that enable them to integrate comfortably into community living and to be appreciated for what they can contribute.

## **Expanding Housing and Services in Oregon**

Faced with the twin problems of funding shortages and increasing need, the State of Oregon Office of Mental Health Services (OMHS) has taken a number of steps in recent years to develop comprehensive, individualized, and responsive local systems of care for people with serious mental illnesses. These steps include improving access to independent housing, expanding the number and variety of community-based services, and overcoming organizational barriers to move toward a more integrated system of care.

**State of Oregon System of Care model<sup>48</sup>.** Oregon has made a concerted effort in recent years to help people with serious mental illnesses remain stable in the community and avoid homelessness by promoting innovative housing approaches, financing affordable housing, promoting interagency collaboration, and providing flexible treatment and supports. Some of these efforts, such as programs for consumers with extensive hospitalization histories, have directly targeted the risk factors for homelessness. Others are aimed at creating more opportunities for people with serious mental illnesses to succeed in community living, thus protecting them from homelessness. A number of specific initiatives are outlined below.

### **Initiatives Targeted to Individual Risk Factors**

**Treatment and supports for people with co-occurring disorders.** OMHS has recognized the need to develop specialized services and housing for individuals with co-occurring mental health and substance use disorders. A number of mental health centers and other providers have recently added clinical teams focused on individuals with dual disorders, and some drug-free housing options have been funded.

**Support and training for community living.** All people with serious mental illnesses in Oregon are eligible for case management services, which can range in intensity from a 1:5 case manager to-client ratio to 1:60, depending on an individual's functional level and specific needs. To help support people with serious mental illnesses in the community, OMHS has expanded psychiatric rehabilitation and active outreach to those individuals not engaged in treatment and services. Many providers have identified money management as key to helping consumers maintain independence. In response, some programs have added a money manager to assist clients, and several agencies have worked with banks to create special low-interest, no-fee accounts for consumers.

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<sup>48</sup> Lezak, op. cit.

## **Initiatives Targeted to Environmental Risk Factors**

**Discharge planning.** The State has taken a leadership role in promoting development of permanent community options for many long-term patients with the most serious disabilities at State psychiatric hospitals. Key to the success of these models are substantial attention to discharge planning and the development of highly individualized treatment and support services designed to help people avoid repeated hospitalizations.

**Crisis services and temporary housing.** OMHS has funded several crisis/respice programs throughout the State that have been effective in preventing hospitalization and, thereby, reducing the risk of homelessness. These programs provide 24-hour supervision and crisis stabilization in nonhospital settings.

**Flexibility in services and funding.** Oregon has funded several programs aimed at responding to the needs and preferences of different groups of consumers. These innovative service approaches provide people who have had difficulty maintaining stability with intensive support in the community.

**Comprehensive, integrated systems of care.** Recognizing the importance of interagency collaboration to develop integrated systems of housing and services for people with serious mental illnesses, the Oregon Department of Human Services convened a State-level interagency task force that included OMHS. The group has encouraged collaborative efforts between housing agencies and service providers at the systems level, and has provided information and technical assistance to local groups developing housing and supportive services for people with serious mental illnesses.

**Formal linkages between public housing and mental health agencies.** OMHS has worked with the State housing agency and has encouraged mental health agencies to develop collaborative initiatives with their local PHA's. Several of these cooperative ventures have increased housing options for people with serious mental illnesses. In Yamhill County, for example, the PHA is developing 12 units that will support a mixed population of people with mental illnesses, drug and alcohol problems, and developmental disabilities.

**Increasing affordable housing options.** To help finance affordable housing, the OMHS Housing Fund was initiated in 1989 to provide grants for as much as \$35,000 for acquisition and development and for as much as \$6,000 for renovation, for projects that house adults with serious mental illnesses. Priority is given to housing for people at high risk for psychiatric hospitalization or homelessness and to housing owned by public or nonprofit entities. As of July 1993, OMHS Housing Fund awards totaled \$1 million to help preserve or

develop housing valued at \$13 million for approximately 400 people. An additional round of grants was awarded in June 1994.

**State rental assistance.** People with serious mental illnesses are eligible for two programs for low-income residents that provide temporary rental assistance.

**Developing housing expertise among mental health staff.** The OMHS housing specialist leads a Housing Technical Assistance Work Group to which local mental health agencies involved in housing throughout the State are invited. The group, which meets every 2 months, provides ongoing training and updates on housing issues, including presentations by local groups that have developed housing for people with serious mental illnesses.

## Theme: Frequent User Initiatives

One area that has potential interest for mainstream agencies is cost-saving initiatives dedicated to reducing “frequent users.”

**San Francisco General Hospital**<sup>49</sup> piloted a case management intervention program with 53 persons who had used the Emergency Department five or more times in the previous 12 months. The case management program was responsible for providing and coordinating all needed services, including crisis intervention, therapy, housing and financial benefits arrangements, and links to other community agencies. A year later, average emergency visits among the target group had dropped by 40%, and inpatient costs had dropped by two-thirds. Even more impressive was the fact that homelessness had decreased by 57%. The cost savings of each dollar invested in case management was estimated at \$1.44.<sup>25</sup>

## Theme: Alternative Health Care Approaches

**The Boston Healthcare for the Homeless program**<sup>50</sup> operates 90 recuperative care beds in two facilities. These facilities were developed to provide a bridge from hospital to community, and are an integral part of discharge planning efforts in Boston. Developing these facilities was a long and complex process, but it has paid off for the program, which reports 103% occupancy.

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<sup>49</sup> Gale, K. 2003. Holes in the safety net. Charles Schwab Foundation.

<sup>50</sup> Gale, K. op. cit.

**Savannah, Ga.** A collaboration of hospitals, foundations, local government and the leading homeless provider developed a 32-bed respite care site for homeless people. In its first quarter, the facility is estimated to have saved the two hospitals \$1.8 million, more than doubling their individual \$250,000 investments.

**"Sex, Games, and Videotapes."**<sup>51</sup> The "Sex, Games, and Videotapes" curriculum was developed as an HIV sexual risk reduction intervention for homeless men with mental illnesses in a New York City municipal shelter. This curriculum addresses the life circumstances of participants through a blending of proven skills development strategies, including social learning theory and psychiatric rehabilitation, and culturally appropriate techniques. While the intervention does not adhere to any one approach, it uses key principles from several programs and adapts them to the shelter setting.

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<sup>51</sup> Susser E, Valencia E, Torres J. 1994. A Curriculum for HIV prevention among homeless mentally ill men. *Psychosocial Rehabilitation Journal*, 17(4): 31-40.

## Support Services

These are service designed specifically for homeless persons. Included in this category are emergency shelter and transitional housing.

### Theme: Outreach

**Philadelphia's Outreach Coordination Center.**<sup>52</sup> Philadelphia's Outreach Coordination Center (OCC) developed in 1998 as part of the city's commitment to develop systematic approaches to ending street homelessness following enactment of a Sidewalk Behavior Ordinance. Its innovative aspects include outreach teams from several agencies working together and coordinated through a single entity, the OCC; daytime rather than nighttime outreach; direct access to safe havens and other low demand residences that were developed simultaneously; full cooperation and backup from city health, mental health, and substance abuse agencies; and a comprehensive database. The OCC also operates in an environment with existing and increasing permanent supportive housing resources.

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

The OCC coordinates most of the city's outreach efforts, including a 24-hour homeless hotline, one comprehensive response team, two mental health specialty teams, two substance abuse specialty teams (one peer and one professional), and emergency backup from city agencies. The teams cover center city and west and southwest Philadelphia, where the majority of chronically homeless individuals who avoid shelters are found. In addition to these regular street "beats," OCC outreach workers respond to hotline calls from businesses, civic and neighborhood associations, and private citizens about

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<sup>52</sup> Burt, M. et. al. 2004. Strategies for reducing street homelessness. U.S. Department of Housing, Office of Policy Development and Research.

homeless people in need. OCC has a case management component and access to the city's list of available shelter beds.

Representatives of all outreach teams meet monthly to review activities and needs. Through radio contact with teams, the OCC facilitates resolution of the immediate needs of any homeless person in contact with an outreach worker on the street that the worker cannot handle independently. OCC workers have also conducted street counts of homeless people every quarter since 1998, and are now doing it monthly.

Since its inception, OCC has maintained a database of all persons contacted by the participating outreach teams, averaging about 2,000 unduplicated individuals annually. OCC teams repeatedly see about one-fourth of those they contact over a span of years. These are the chronic street homeless people the teams try hardest to induce off the streets. The database provides a history of their service receipt and an excellent picture of who they are and what their needs are.

Through common identifiers, the OCC database can be linked with the city's database that chronicles most emergency shelter and some transitional housing stays. Using this link, OCC workers can see whether any of their consumers have used shelter, and how much. Conversely, the city's analysts can assess the proportion of people making heavy use of emergency shelter who are also well known to outreach workers.

**San Diego's Police-Based Outreach Teams.**<sup>53</sup> San Diego city has two innovative outreach programs developed by and located in the San Diego Police Department—the Homeless Outreach Team (HOT) and the Serial Inebriate Program (SIP). Both can offer housing options that bypass emergency shelter, connecting street homeless people directly to safe havens, transitional housing programs, or residential treatment settings.

HOT combines a police officer, a mental health worker, and a benefits eligibility technician in outreach teams operating during the day and evening hours to engage mentally ill street people and connect them to services. It also has access to “dedicated” safe haven beds to which it can bring people if they are

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<sup>53</sup> Burt, op. cit.

willing to leave the streets. The team approaches people on the street or at homeless services. Each HOT team member's skills and agency affiliation enhances those of the others, to make the combination more effective than any one or two acting without the others. Because they combine police and mental health expertise and authority, they are the only outreach teams on the streets that have the ability to remove people either voluntarily or involuntarily, in addition to building rapport and making referrals.

The mental health worker opens up options for care that the police officer could not access, the police officer adds an element of protection and authority that the mental health worker could not command, and the eligibility technician offers connection to or reinstatement of benefits that serves as a positive inducement for street people to accept services. HOT focuses on people who are likely to have mental illness as a primary problem and are not likely to get arrested. HOT gets them into treatment facilities, safe havens, board and care facilities, and skilled nursing facilities, depending on their level and type of need. When HOT encounters alcoholics or other substance abusers it offers rehabilitation and help getting into appropriate care for those who are interested.

SIP comes into play for chronic inebriates who do not voluntarily accept treatment. SIP is a collaboration of four city and five county agencies, including law enforcement, the city attorney's office, the public defender, the Superior Court, health care, and homeless agencies working as a team in a court context. Mental Health System, Inc. is contracted to coordinate the program. SIP follows the Drug Court model in offering addicts a choice of jail or treatment, after assuring that the community was willing to pay for treatment if requested. SIP's focus is on chronic alcoholics who populate the downtown streets of San Diego. Police officers arrest chronic street alcoholics for public drunkenness, and bring them to jail and subsequently to court. Once arraigned, caseworkers approach each person, conduct assessments, and offer treatment plus transitional housing as an alternative to six months in jail (the maximum allowed under California state law) to those who pass the assessment. Many people eventually accept the offer, although they may first serve a full jail sentence or even two before they are convinced to try. The court monitors treatment compliance; leaving treatment means returning to jail. This approach is "something different" for this population, for which the revolving door of arrest and detoxification was

not working. The approach is also designed to reduce the impact of public drunkenness on the community.

**The Veterans Affairs Greater Los Angeles Healthcare System<sup>54</sup>** has used Health Care for Homeless Veterans programs to conduct outreach to severely mentally ill veterans to link them with VA clinical services, contracted residential treatment programs, and contracted transitional or permanent supported housing programs. The VA operates some of these programs on its own campus, and has developed an elaborate system of contracts with nonprofit agencies to supply a variety of housing and service options. Also in Los Angeles, the County Sheriff's and Mental Health Departments and nonprofit mental health providers collaborate in a partially state-funded program to prevent first or repeat homelessness among inmates of the county jail who have a serious mental illness. The program begins with integrated outreach focused on individuals who are homeless, at risk of homelessness or incarceration, and who have a serious mental illness.

**Downtown Emergency Service Center, Seattle<sup>55</sup>.** In Seattle, the Downtown Emergency Service Center (DESC) operates many programs and services that make it a mini-continuum in its own right, all focused on street homeless people. One of its programs is outreach, which is able to connect street homeless people to the various DESC offerings including transitional and permanent supportive housing. DESC's Homeless, Outreach, Stabilization, and Transition Project (HOST) has Outreach and Engagement Specialists who work within specific geographic regions or in other targeted programs or facilities such as drop-in centers for women, local hospitals, and jails to find chronically street homeless people and help them connect to services and housing. Sometimes they approach potential clients directly and other times they develop an engagement plan with staff members from other agencies who have had interactions with the person. HOST staff members receive referrals from concerned citizens, jail, the Department of Social and Health Services, the mental health court, hospitals, the Harborview Medical Center Crisis Triage Unit, the Seattle Public Library, family members, and other mental health professionals, shelters, and drop-in centers.

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<sup>54</sup> Burt, op. cit.

<sup>55</sup> Burt, op. cit.

### **Seattle's Mental Health Chaplaincy<sup>56</sup>.**

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

### **Theme: Comprehensive services**

**Project H.O.M.E. Philadelphia, PA<sup>57</sup>.** It provides a full range of services for chronically homeless people with mental illness and/or substance abuse disorders, including street outreach, safe havens, permanent supportive housing and a range of services to supplement housing. Services at each facility are different; some residents are not ready to accept regimented drug or alcohol treatment, while others may be able to live almost independently.

Project H.O.M.E. is unique in its method for reaching clients for 1515 Fairmount. All referrals to 1515 Fairmount come through the Office of Mental Health. OMH stays involved with referred clients by continuing to provide one-on-one case management. All clients must have a history of homelessness or have been at risk of imminent homelessness.

**Bailey House, New York City<sup>58</sup>.** Bailey House serves over two hundred clients per

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<sup>56</sup> Burt, op. cit.

<sup>57</sup> <http://www.endhomelessness.org/best/projecthome.htm>

<sup>58</sup> <http://www.endhomelessness.org/best/bpbs.htm>

fiscal year with direct supportive housing and social services designed to address a range of psycho-social needs throughout New York City. Bailey House operates a congregate housing facility, Bailey-Holt House, and offers scatter-site apartments to homeless PWA's. Bailey House also provides a range of case management and counseling services, vocational education and job skills training and technical assistance to agencies nationwide to enable them to create housing models in their own communities. Bailey House is a non-profit organization that receives approximately 70% of funding from public sources. 27% of funding comes from private sources including foundations, special events, direct mail, and thrift shop sales. 3% of the operating budget is comprised of resident program fees.

## Theme: Employment

**STRIVE/ East Harlem Employment Services Inc**<sup>59</sup>. STRIVE, one of the several privately owned job training programs in New York City has a history of securing employment for the hard-to-employ. Its strategy includes a network of 18 job training sites in four cities including New York, Boston, Chicago, and Pittsburgh; 30 job trainers interacting with about 1,000 employers annually. Strive also works with clients after placement to insure their continual success. Since its inception in 1984 the program has employed a two step process of helping people find employment and attain self sufficiency. Technical job training focuses in three career fields: telecommunications, financial services, and environment-technology/automotive technician. STRIVE's Fragile Families Initiative for men is a parenting/manhood development course designed to enhance young fathers sense of responsibility. The Rites of Passage Programs are an attempt to support and promote the safe and positive development of men and women into responsible adulthood. STRIVE Training Academy is a program designed to train other leaders on STRIVE's program techniques, philosophy, and program design and training techniques. Primarily private funded with the exception of several federal grants, STRIVE enjoys the flexibility of running its own program with its own policies.

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<sup>59</sup> **STRIVE East Harlem Employment Service, Inc.:** President & CEO: **Robert Carmona**  
Contact: **Julius Penn** 1820 Lexington Avenue New York City, NY 10029 Phone: (212)360-1100 Fax: (212)360-5634

## **IMPACT Employment Services, Boston, Massachusetts<sup>60</sup>**

IMPACT, a program of the Friends of the Shattuck Shelter, is Greater Boston's largest employment service for homeless individuals and families. Since 1994, more than 2500 skilled job seekers have successfully obtained employment through the program. IMPACT's professional staff of employment counselors, job developers and educational and training specialists speaks a variety of languages and represents diverse cultural and economic backgrounds. The program serves people experiencing homelessness as well as people leaving correctional facilities. The primary funding for IMPACT comes from HUD McKinney SHP funds. Since summer 2001, IMPACT has secured funding from the Massachusetts Department of Corrections for services for people that have entered the program through the Department's closed referral system.

**Cambridge Employment Program, Cambridge, MA<sup>61</sup>.** While One-Stop Career Centers are valuable resources for self-directed professionals and for customers eligible for publicly-funded career counseling and job search assistance, City residents who constitute the middle-ground between the professional classes and the population eligible for public assistance often have a difficult time obtaining the assistance they need at such Centers. These working class families typically face one or more barriers to finding employment which will meet their cost of living - barriers such as limited English literacy, limited or outdated skills, and difficulty communicating and/or coping in typical workplace settings, often because of a disability which falls below the threshold of eligibility for vocational rehabilitation or disability benefits.

To meet the needs of Cambridge residents not adequately served by existing programs, the City established the Cambridge Employment Program (CEP). Operated by the City, CEP assists unemployed and underemployed residents in obtaining employment and/or the education or training needed to improve their employment opportunities. Services include individualized career counseling and job search assistance which is provided at no cost to program participants.

Because CEP staff members maintain connections to a broad array of area service providers, they can help clients deal with some of the underlying issues

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<sup>60</sup> <http://www.endhomelessness.org/best/IMPACT.htm>

<sup>61</sup> Ellen Semonoff, Deputy Director, Department of Human Services, at (617) 349-6200 or [esemonoff@cambridge.ma.gov](mailto:esemonoff@cambridge.ma.gov).

that prevent them from being successful in their search for jobs. And because staff members spend time getting to know clients, they can help them clarify their goals and make the most appropriate matches to jobs. Approximately half of the CEP budget is funded by municipal tax revenues, and half through a contract with the local Housing Authority, which receives U.S. Department of Housing and Urban Development funding under the Resident Opportunity for Self-Sufficiency program.

## Theme: Shelter/Temporary Housing

**HomeAid America, Costa Mesa, CA<sup>62</sup>.**, helps homebuilding associations develop their own independently operated HomeAid chapter programs to help fulfill the HomeAid mission across the nation which is to build or renovate shelters for temporarily homeless individuals and families. Over 80 shelters have been completed to date with 35 currently underway. Owned and operated by non-profit care providers, these shelters typically include specialized counseling and job training to achieve self-sufficiency as a core component of their program.

HomeAid has created a proven model that really works: Identify a local building association, then establish a chapter; Select a community care provider and a project; Recruit a Builder Captain; Secure trade partners to provide in-kind labor, materials or services; Build or renovate a shelter.

**Lakefront SRO, Chicago, IL<sup>63</sup>** Lakefront SRO has spent over a decade striving to preserve vital housing by revitalizing vacant and dilapidated SRO buildings or building them from the ground up and managing them. Lakefront SRO has on-site social service teams at all locations which work to help the tenants stay off the streets through case management, financial advocacy, counseling, and job training. The Community & Government Affairs Program advocates for local policy reform and for the preservation of remaining SRO's. The program also provides technical assistance to housing groups nationwide. All of the men and women living in the SRO's were homeless before the housing developments opened. In 1996 the retention rate of the SRO's by formerly homeless

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<sup>62</sup> <http://www.homeaid.org/>

<sup>63</sup> <http://www.endhomelessness.org/best/bplsro.htm>

individuals was 82.4%. Lakefront is a non-profit organization that receives its funding partially through state and federal funds and partially through private donations.

**Lawson House YMCA, Illinois<sup>64</sup>** Lawson House YMCA is the largest low-income, single room residence provider in Illinois, serving over 583 adults and seniors. Most residents subsist on income levels below the poverty level. Thirty one percent of residents are formerly homeless, twenty-five percent suffer from a mental illness, and over sixty percent suffer from substance addictions. The Life Development Center services include case management, medical treatment, vocational development, psychiatric services, substance abuse counseling, and socialization activities. The goal is that residents become self-sufficient. Financial support is provided through contributions, public state and local funding, membership fees, and program fees.

**Our Town Family Center, Arizona<sup>65</sup>.** Our Town Family Center is a community based social service organization that serves over 10,000 community members annually. Focusing on children, youth, and families, Our Town has crisis intervention, outreach, stabilization, and permanency planning programs. They also offer a 24 hour crisis hotline that includes in home counseling, an out patient therapeutic counseling program, a school based prevention project, a community mediation program, a street outreach program, a gang prevention program, and an adolescent shelter and transitional/independent living program for homeless youth ages 16-21. Revenues were acquired from six major sources including private and public funds. 44% of the funds in the last fiscal year were through contract programs.

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<sup>64</sup> <http://www.endhomelessness.org/best/bplh.htm>

<sup>65</sup> <http://www.endhomelessness.org/best/bpot.htm>

**Center for Women in Transition, Illinois<sup>66</sup>.** The Center for Women in Transition provides support services and safe transitional housing to homeless women and their children to foster and sustain their self-sufficiency.

The Center for Women in Transition has developed a number of programs to help the residents become self-sufficient, independent individuals. These programs include:

- Assessment & Resource Coordination
- Case Management/Advocacy
- Children's Program
- Support Group
- Skills in Transition Groups
- Aftercare

**First Place Family Center, Oregon<sup>67</sup>.** This program offers a unique and cost effective method of providing services to homeless and low income families by utilizing large numbers of volunteers, both in the night shelter program and the day use facility. To date, 53 local congregations and synagogue presently participate in the night shelter program. They offer their facilities for 1 or 2 weeks for night shelter. In that period of time they will provide sleeping areas, dinners and breakfast, and transportation to and from the day facility to the night shelter. In one week of providing night shelter the host volunteers will prepare over 300 dinners for up to 40 people.

The day use facility provides the following services:

- Intake and Family Needs Assessment
- Case Management
- Free Childcare
- Laundry Facilities
- Food and Clothing
- Cooking Facilities

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<sup>66</sup> <http://www.prairienet.org/cwt/>

<sup>67</sup> <http://www.efn.org/~fpfc/>

- Showers
- Message & Mail Service
- Telephones
- Onsite Counseling
- Onsite Employment Counseling and Job Locating Service
- Resume Writing Onsite
- Referrals to Area Resources

**St. Francis House , MA.**<sup>68</sup> St. Francis House has been repeatedly recognized as a National Model Program by the United States House of Representatives.

St. Francis House operates six emergency services:

1. Day Shelter serving 300 to 550 adults per day
2. Food programs serving an average of 600 hot meals, sandwiches, and hot breakfasts per day, over 17,000 per month
3. Clothing services providing clothing for 150 requests per week
4. Hot showers and toiletries
5. Medical and dental care
6. Mail services and photo identification.

St. Francis House also provides eleven rehabilitative services:

1. Case management and advocacy
2. Psychiatric counseling
3. Substance abuse counseling
4. Employment assistance
5. Housing assistance
6. Legal assistance
7. English-as-a-Second-Language classes
8. Literacy classes
9. Nondenominational pastoral counseling
10. Expressive arts program
11. HIV/AIDS education and support

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<sup>68</sup> <http://www.stfrancishouse.org/welcome.htm>

Other services provided at the St. Francis House multi-service center include: the Moving Ahead Program that teaches formerly homeless people how to live and work drug and alcohol-free lives; the Next Step Transitional Housing Program that supports formerly homeless people living and working drug and alcohol-free lives, and on-site services by Welfare, the Social Security Administration and the Veterans Administration. We also provide seminars and information on HIV/AIDS prevention in English and Spanish, support for guests who are HIV-positive, and information and referral on mental health and health care issues such as medical and dental care.

# HOUSING

## Theme: Innovative Housing Support

### **Employer Assisted Housing<sup>69</sup>**

In tourist communities and other areas with rising land and housing prices, housing is limited or unavailable for those in lower paying jobs. Consequently, some communities and businesses are creating a linkage between housing and jobs. Employers' motivations to offer housing benefits to non-management workers extend well beyond recruitment, retention, and productivity issues. Employers find that they can make and save money on housing benefits. For example, employers can make money by purchasing housing bonds which make it feasible for their workers to achieve homeownership via below-market loans. Employers offering mortgage guarantees to lower or eliminate down payment requirements for those workers purchasing homes near their work not only enhance productivity, they may achieve appreciation in those property values. Several examples of employer assisted housing is included in this review.

**Jacksonville, The Alliance Community Program:** Jacksonville has been chosen by Freddie Mac to be one of eight cities nationally participating in its Alliance Community program. The program includes an employer assisted housing program. The City is working with the Chamber of Commerce and major employers to design programs that encourage increased homeownership among employees through counseling and down payment assistance. Assistance will be available in priority planning districts close to employers' offices. The Alliance's first employer assisted housing program is through Shands Jacksonville Hospital, which provides \$5,000 down payment assistance, matched by the City, to locate in the Springfield area.

### **City of St. Petersburg ■ Housing Assistance for Teachers**

The city of St. Petersburg provides no-interest loans of up to \$18,000 to teachers (and other qualified school personnel) who buy a home in Midtown,

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<sup>69</sup> Eschenfelder, B. 2004. Report prepared to the Pinellas County Coalition for the Homeless.

and \$14,000 to those who buy homes elsewhere in the city. Each year a teacher remains at a St. Petersburg school, 10 percent of the loan is forgiven. If a teacher stays 10 years, the loan is wiped out. A teacher who receives a loan and then leaves a St. Petersburg school, or moves through sale or lease, has to pay the balance of the loan to the city.

Eligibility for the program is based on a teacher's household size and gross income. A single teacher who makes less than \$42,960, for example, would qualify. The threshold climbs for each additional household member to a maximum salary of \$66,360 for a family of five. The city has set aside about \$200,000 for the program. The money was provided by the State Housing Initiative Partnership.

**San Francisco/Santa Clara ▪ Rental Housing For Teachers:** In overheated housing markets such as San Francisco and San Jose, school districts are planning to build affordable rental housing for teachers.

**Milwaukee, WI.** In 1992, Wisconsin Electric Power Company approached Select Milwaukee—a non-profit organization in Milwaukee dedicated to encouraging and supporting home buying in the City of Select Milwaukee, Milwaukee—to develop and administer a program that would help its employees become homebuyers. Select Milwaukee stepped up to the challenge and assisted Wisconsin Electric to build the first EAH program in the city.

Today, Select Milwaukee handles the counseling for and administration of EAH programs for 13 employers in Milwaukee. Together, the organizations have recorded a total of 282 home sales between January 2000 and October 2002 and an estimated 250 homebuyers are currently in the pipeline.

Some communities and businesses are creating a linkage between housing and jobs. Employers' motivations to offer housing benefits to non-management workers extend well beyond recruitment, retention, and productivity issues. Employers find that they can make and save money on housing benefits. For example, employers can make money by purchasing housing bonds that make it feasible for their workers to achieve homeownership via below-market loans. Employers offering mortgage guarantees to lower or eliminate down payment

requirements for those workers purchasing homes near their work not only enhance productivity, they may achieve appreciation in those property values.

### *How the Program Works*

While each company provides varying degrees of financial assistance, they have all retained Select Milwaukee to provide informational and home buying services to clients. These services include pre-purchase guidance to employees and loan packaging services to expedite loan applications.

Some participating employers offer their financial incentives to support homeownership among employees in neighborhoods in and around the worksite. For example, the Harley-Davidson Company offers a Walk to Work program to encourage employees to buy homes in the older and historic Near West Side neighborhoods surrounding their headquarters.

For Employees – benefits include:

- Realization of the dream of homeownership
- Increased job satisfaction and loyalty to employer
- Possibility of reducing commuting time

For Milwaukee – benefits include:

- Increased tax base
- More business for Realtors, lenders and other businesses
- Increased neighborhood stability
- Community revitalization

## Theme: Sustaining and increasing our supply of affordable housing<sup>70</sup>

**San Francisco, CA ▪ Housing Preservation:** San Francisco established an Affordable Housing Preservation Program to save HUD subsidized rental housing at risk of conversion to market rate. To date, the city has assisted in the acquisition of more than 1200 at risk units, leveraging approximately \$40 million of local funds to attract over \$110 million in private funds to purchase and rehab these units. The city also makes rehab loans available to existing nonprofit owned housing to extend the useful life of this permanently affordable rental housing and to low-income homeowners to preserve affordable homeownership.

## Theme: Remove Barriers to Affordable and Supportive Housing<sup>71</sup>

**Education of Planners & Officials:** Local planners and planning commissioners need more training about affordable housing, supportive housing, and fair housing laws to create better planning decisions at the local level. They must be given the tools to appropriately evaluate proposals, starting with a review of zoning and subdivision regulations that may present barriers to affordable housing.

City and County planning professionals should partner in educating planning commissioners and elected officials concerning the need for diverse housing types to serve the homeless, low income and special needs populations and provide tools to better evaluate housing proposals. Planners, planning commissioners and other elected officials should oppose neighborhood efforts to thwart housing for the homeless, low income and special needs populations on the basis of prejudices and fears concerning property values.

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<sup>70</sup> Eschenfelder, op.cit.

<sup>71</sup> Eschenfelder, op. cit.

**Streamline Affordable Housing Development Processes:** Local municipalities should take action to streamline existing programs and lower barriers to producing and preserving affordable housing and support efforts that provide incentives to increase the supply of affordable rental housing: promote infill incentives, property tax abatement, density allowances, land assembly, and fast track permitting.

### **Inclusionary Zoning**

Florida's Affordable Housing Study Commission recommends that local governments consider adopting land use ordinances, such as inclusionary housing and linkage fees, to strengthen the community's capacity to provide affordable housing. Inclusionary zoning is a land use ordinance that assists a local government in meeting its legal responsibilities under the housing element. It requires developers of multiple market rate units, say 25, 50, or 100, to include some percentage of affordable, lower-cost units, usually from five to twenty percent, within their developments. In this way, local governments may ensure that the private sector does not use all the developable residential land only for middle- and upper-income housing.

In Florida, homeless and affordable housing advocacy groups are pushing for the adoption of the **30/30 Vision** to require local and state agencies to ensure that 30% of publicly funded housing units developed are targeted to persons at or below 30% median income.

There are some elements that all inclusionary land use ordinances are likely to share, including:

- A threshold number of market rate units that activates the inclusionary requirement for a corresponding percentage of affordable units;
- A requirement that the affordable units are comparable in quality and aesthetics to the market rate units, so that even if they are smaller or of a different type, they will blend into the community;
- Incentives to assist the private sector in providing the affordable units, such as density bonuses, financial subsidy for construction, or down payment assistance to the affordable homebuyer;

- A provision for payment in-lieu when the nature of the development (for example, a development of exclusively half-million dollar homes) makes it infeasible to include affordable units; and
- A housing trust fund as the depository for the payments in-lieu, and a mechanism for using those dollars to provide affordable housing within the community.

A model inclusionary housing ordinance is available in the Florida's Affordable Housing Study Commission Final Report.

## Theme: Land Trusts & Trust Funds<sup>72</sup>

**Community Land Trusts:** Local governments should recognize the importance of community land trusts to provide affordable housing in perpetuity. Community land trusts are local nonprofit organizations established to hold land for the benefit of a community and individuals within the community. A common goal of most community land trusts is to provide and preserve affordable housing on land that is owned by the trusts. Some communities that have established Land Trusts include: Key West, Florida; Burlington, Vermont; Colorado Springs, Colorado; Albuquerque, New Mexico; Portland, Oregon; and Durham, North Carolina.

**Trust Fund ▪ Los Angeles, CA:** The City's Housing Trust Fund was created to provide resources to alleviate Los Angeles's severe affordable housing shortage. The city's 2002-03 budget included \$42 million for the first phase of the \$100,000-funding plan.

In February 2003, the LA City Council approved the Housing and Community Development Committee report recommendations to approve the following percentages for the Housing Trust Fund as general guideposts for expenditure until the guidelines are established:

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<sup>72</sup> Eschenfelder, op.cit.

- a. 60% for multifamily rental projects serving households at or below 60% of the Area Median Income (AMI).
- b. 20% for projects that create home ownership opportunities for households at or below 120% of AMI.
- c. 5% for emergency rental assistance.
- d. 10% to remain flexible with the priority going toward preservation of housing that is at risk of converting to market rate.
- e. 5% for administrative costs.

### Theme: Lease–Purchase Home Ownership Arrangement<sup>73</sup>

Under a lease purchase–arrangement, a house needing rehabilitation is purchased and repaired by a nonprofit organization or other organization. It is then leased to a lower income family or individual at an affordable rent. This family is given the first option to buy the home after an arranged period. During this entire process, the renter is putting money aside and rebuilding credit in hopes of having a down payment for the home and securing his/her own mortgage. This strategy allows families who would otherwise be unable to afford or qualify for a mortgage to become homeowners and also stay in the area. It helps local residents remain in the community since the residents of the area would be given the first option to apply for the arrangement. This could also work for new construction.

**Cleveland:** The Cleveland Housing Network (CHN) was founded in 1981 by the Famicos Foundation to renovate deteriorated housing throughout Cleveland. The foundation has helped to keep acquisition and rehab cost low. CHN receives donations of property, acquires abandoned buildings and then repairs them to meet city codes. The families are carefully screened and are usually picked from the area or an adjacent community. To date CHN has produced housing for more than 600 families, with a total property value of more than \$20 million

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<sup>73</sup> Eschenfelder, op.cit.

## Theme: Local "One-For-One Replacement" Ordinance<sup>74</sup>

**New York City:** These ordinances are modeled after the federal mandate but are used in a variety of forms at the local level. In New York City, an umbrella community organization called the Joint Planning Council won a one-for-one replacement agreement from the city which affected only their particular neighborhood on the lower east side of Manhattan. This agreement required any developer who purchases city-owned land or property and develops it for higher-end use must fund the creation of the same amount of low-income housing units in the same neighborhood.

## Theme: Rent Control<sup>75</sup>

Rent control laws restrict rent increases, either city-wide or particularly in gentrifying neighborhoods. Some allow rent increases only in certain circumstances, such as when ownership of the building is transferred. Many of the laws also limit the size of the increase.

**New York City:** Regulations in New York City restrict landlords' ability to raise rents. Last year, for example, rents could only be raised 2%. The law in New York City, though, allows landlords to raise rents higher if they've made a significant capital improvement to the building. Activists in NYC also complain that tenants whose rent is raised beyond the legal limit wait for long periods as their case is passed through the bureaucracy. The law applies only to buildings larger than three units. San Francisco also has a rent control program.

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<sup>74</sup> Eschenfelder, op.cit.

<sup>75</sup> Eschenfelder, op.cit.

## Theme: Affordable Housing

**Biltmore, Portland, OR.**<sup>76</sup> The Biltmore has 76 units of Single Room Occupancy (SRO) housing with a ground floor commercial space. Central City Concern (CCC) is remodeling and doing the seismic upgrades necessary to keep the low income housing viable for the next 60 years. This rehab will also be a historic restoration that has been supported by the Old Town History Project and the neighborhood's land use review committee.

The Portland Development Commission (PDC) acquired the Biltmore Hotel from a private owner, under the City's new Affordable Housing Preservation Ordinance. They then selected CCC's proposal to purchase, rehabilitate and manage the building. Central City Concern works to help individuals move from homelessness and poverty to lives of self-sufficiency and independence with a unique array of services and innovative community partnerships.

**The Supportive Housing for Families Program, Connecticut.** The Supportive Housing for Families Program preserves and unifies families and prevents family homelessness by providing permanent affordable housing with services to families involved with the Connecticut child welfare system. There is often an intersection between child welfare and homelessness, and a large percentage of children in foster care are there because their parents are homeless or unstably housed. The Supportive Housing for Families Program recognizes and addresses this intersection by combining the resources and expertise of two state agencies and a non-profit partner. The result is better housing and child welfare outcomes for families--as well as cost-savings to the state.

The Supportive Housing for Families Program provides permanent affordable housing coupled with supportive services to families involved with the Connecticut child welfare system. The program centers on a commitment to improving child welfare by preserving families at risk of separation, reunifying families who have been separated, preserving and renewing parent-child relationships, and preventing family homelessness. Its key components are

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<sup>76</sup> [www.centralcityconcern.org](http://www.centralcityconcern.org)

permanent housing and home-based intensive case management (ICM) aimed to help families avoid the potentially devastating effects of separation through foster placement and stay stably housed.

Placement in permanent housing is preceded by careful housing search assistance. Housing coordinators serve as a liaison between housing authorities, landlords, clients, and case managers. They work to build strong relationships with landlords and housing authorities in order to create better housing options for clients. Housing coordinators help families identify high quality apartments in safe neighborhoods. They also help the families overcome any barriers to housing such as outstanding debt. Once an apartment is acquired, the agency uses the Family Unification Program (FUP) or Section 8 Housing Choice Vouchers to subsidize housing costs.

Intensive Case Management, or ICM, is the keystone of services for the family. Case managers perform weekly home visits, working with the family to create a family care plan and becoming the single point of accountability for coordination of all appropriate services as identified by the plan. Services can include substance abuse treatment, parenting training, child care, transportation and educational and vocational training. Case managers are committed to building a relationship with the family and becoming a consistent and reliable presence in the family's life. An important element is that all case management is home-based, and case managers come to the families where they live. The program strives to provide seamless support for families to meet their self-identified needs. The case management aspect of the program lasts for approximately 12-18 months--and up to 2 years--depending on the needs of the family.

What is unique about this program and what is crucial to its success is the cross-collaboration between different state agencies and a non-profit partner. The Supportive Housing for Families Program is a partnership between the State of Connecticut Department of Children and Families, the State of Connecticut Department of Social Services and The Connection, Inc, a non-profit human service and community development agency. The two state agencies provide funding--the Department of Children and Families funds services and the Department of Social Services funds housing--while The Connection Inc. operates the program. Case management services are provided statewide by The Connection, Inc. and nine additional community based, non-profit agencies.

This collaboration provides seamless and comprehensive support for families enabling them to stay unified and access services in their own permanent housing.

**Lighthouse Youth Services, Housing Continuum, Cincinnati, OH.**<sup>77</sup> Lighthouse Youth Services, located in Cincinnati, Ohio, prevents youth in child welfare from becoming homeless and prevents young adults in the adult shelter system from remaining homeless through their Independent Living and Transitional Living Programs. In 1981, Lighthouse developed a semi-supervised scattered-site apartment model based on the philosophy that young people learn best by "doing" and that youth should have opportunities to live on their own and develop self-sufficiency skills prior to discharge from care. The agency has served over 1000 youth in its model and averages around 80 youth a day living in their own apartments.

**Beyond Shelter, Inc., Housing First Program for Homeless Families Los Angeles, California**<sup>78</sup> Beyond Shelter was founded in 1988 in response to increasing numbers of homeless families in Los Angeles and the need for a more comprehensive approach to serving them. Today, the mission of Beyond Shelter is to combat chronic poverty, welfare dependency and homelessness among families with children, through the provision of housing and social services and the promotion of systemic change. The agency's programs in Los Angeles County serve as a laboratory for the development of cutting-edge methodologies to help guide the development of both social policy and service delivery mechanisms nationwide. Beyond Shelter, Inc. has been the national leader in the development and promotion of "housing first" strategies to re-house families experiencing homelessness. Beyond Shelter provides technical assistance nationwide for communities interested in adopting a housing first approach, holds annual training conferences, and runs their own housing first program in Los Angeles, California.

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<sup>77</sup> <http://www.endhomelessness.org/best/lighthouse.htm>

<sup>78</sup> <http://www.endhomelessness.org/best/beyondshelter.htm>

**Getting Housed, Staying Housed, Chicago, Illinois**<sup>79</sup>, For those families and individuals who are already homeless or for whom homelessness cannot be prevented, the Chicago Continuum of Care is transitioning to a system-wide Housing First strategy. This approach seeks to assist persons to exit homelessness as quickly as possible by placing them in permanent housing and linking them to needed services. This approach assumes that the factors that have contributed to a household's homelessness can best be remedied once the household is housed. It also accepts that for some lifelong support may be required to prevent the reoccurrence of homelessness. The plan seeks to maximize utilization of mainstream resources.

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

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

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

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<sup>79</sup> <http://www.endhomelessness.org/best/GettingHoused.htm>

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

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

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

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

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

**St. Stephen's Housing Services, Hennepin County, Minnesota<sup>80</sup>.** St. Stephen's Housing Services is working to rapidly rehouse families and individuals with moderate to severe impediments to finding and/or maintaining housing and ensuring the supports are in place to help people at risk sustain their housing and achieve stability in housing. St. Stephen's is successfully rehousing and stabilizing those with significant impediments to regaining housing stability, including individuals and families newly recovering from a substance abuse

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<sup>80</sup> Richard Amos, St. Stephen's Human Services, 2211 Clinton Avenue South, Minneapolis, MN 55404, (612) 874-0311

addiction, recent, repeated incidents of domestic violence and those with histories of evictions, bad credit and incarceration.

St. Stephen's Housing Program works with individuals and families many would consider high-risk, including those with histories of evictions, domestic violence, incarceration and recent drug addiction. St. Stephen's provides assistance to the individual or family in their search for appropriate housing, negotiating with landlords, and providing the follow-up case management to enhance housing stability.

Efforts to reduce landlords' reluctance to enter a rental agreement with those who may appear "high risk" include:

- Offering security deposit guarantees, last month rent guarantees or co-signing leases as necessary.
- Agreeing to absorb the cost of an unsuccessful housing placement including paying for damages and eviction costs to reduce the disincentives to the landlord in accepting a "higher risk" rental candidate.
- Committing to home visits to the tenant's apartment twice monthly during the first six months that include housing inspections.
- Providing case management up to one year and linking families and individuals to needed support services available in the community.
- Offering assistance to the landlord and tenant to resolve any crisis that may threaten housing stability by engaging in mediation and advocacy.
- Providing agency references to prospective landlords.

In addition to these incentives to landlords, St. Stephen's is committed to maintaining relationships with landlords and recognizes a negative housing placement will affect the program's ability to place other clients. A strong relationship and reputation with landlords allows the agency to maintain a roster of landlords who will accept St. Stephen's tenants and enhances their advocacy to house those with severe barriers to housing. At times, St. Stephen's may provide or refer a client to transitional housing; this is primarily done to allow a client who lacks a rental history or has a criminal record to develop a stable housing history to facilitate a rapid return to permanent housing.

**Direct Access to Housing**<sup>81</sup>, San Francisco. The San Francisco Department of Public Health's (SFDPH) Direct Access to Housing (DAH) program provides permanent housing with on-site supportive services for approximately 400 formerly homeless adults, most of whom have concurrent mental health, substance use, and chronic medical conditions.

The DAH program provides 370 units of permanent supportive housing in five Single Room Occupancy (SRO) residential hotels and an additional 33 units in a licensed residential care facility ("board and care").

SFDPH acquires sites for the DAH program through a practice known as "master leasing." The main benefits of this approach include the ability to rapidly bring units on-line and the reliance on private capital for the upfront renovation costs. In addition, the renovated buildings combined with on-site services stabilize properties that have often been problematic for the surrounding neighborhood.

The key components of SFDPH's strategy include:

1. Identifying privately-owned buildings that are vacant or nearly vacant where the building's owners are interested in entering into a long-term lease with SFDPH. These are triple net leases with the owner retaining responsibility only for large capital improvements.
2. Negotiating improvements to the residential and common areas of the building prior to executing the lease. It is the owner's responsibility to deliver the building with improvements completed and in compliance with all health and safety codes. Improvements typically include build-out of supportive service and property management offices, community meeting rooms, community kitchens, and additional bathrooms. All rooms are fully furnished prior to occupancy.
3. SFDPH contracts with one or more organizations to provide on-site support services and property management. Most buildings include a collaborative of two or more entities.

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<sup>81</sup> [www.sfdph.org](http://www.sfdph.org)

# Systems

Theme: One stop, systemized services, central intake

**Kentucky NIA Center**<sup>82</sup>. The NIA Center is an economic opportunity campus whose mission is “to provide a seamless one-stop environment that builds on the strength of area residents to enhance business growth and development, to cultivate a marketable workforce and improve mobility through increased access to public transportation.” This “one stop shop” for employment, job training, transportation, business start-up and economic growth and development has assisted hundreds of working families living in an area targeted for revitalization.

All entities housed in the NIA Center address the needs of the community:

□□□Member’s First credit union addresses the lack of financial services available to low income workers. As little as \$10 is needed to open a savings account. Services available include free debt and budget counseling, free tax preparation, and access to an Individual Account Partnership.

□□□The Transit Authority of River City (TARC) operates a neighborhood travel center designed to alleviate the transportation problems of working families. The Night Owl Service provides customized transportation services to cover second- and third-shift jobs located miles away from the residents’ homes and not on regular bus routes.

33 TARC also offers Saturday hours, special fare-saver passes, and senior citizen identification cards.

□□□Career Resources, Inc. (CRI) operates a One-Stop Center in the NIA Center. The One-Stop offers a full range of employment and training services under the Workforce Investment Act. Community residents have access to the Internet, BrainGain (an electronic job matching system), and workshops that give workers the tools required for an effective job search. Occupation skills training focuses on the occupations in demand in the local labor market. To bridge the digital divide, the Digital Boost program at CRI prepares and certifies individuals in basic technology skills.

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<sup>82</sup> Anna Larson, Project Director, Kentuckian Works, at (502) 574-2900 or [anna.larson@loukymetro.org](mailto:anna.larson@loukymetro.org).

□□□To meet additional educational needs of the community, the Jefferson County Public Schools (JCPS) offer GED classes during the day and in the evening. In an effort to encourage those in need of a GED, JCPS has frequently provided GED testing free of charge.

□□□The Louisville Enterprise Group offers established small businesses consulting services, gap financing assistance, pre- and post-loan counseling and affordable office space in the NIA Center. Entrepreneurs are coached on day-to-day business operations and financial management to foster company growth.

□□□The Metro Business Resource Center is a joint venture of the Louisville/Jefferson County Metro Government, the United States Small Business Administration, the Service Corps of Retired Executives, and the Small Business Development Center. The Resource Center offers prospective small business owners on-site counseling, a business start-up library, assistance with business development plans, and financial consultation.

The funding is as varied as the organizations within the NIA Center. A mixture of private and government-funded initiatives supports all the services available to the working families who use the Center.

**Central intake**<sup>83</sup>. Finally, in areas such as Columbus/Franklin County, Ohio and Montgomery County, Maryland, the creation of a central intake system (for families in Columbus/Franklin County and for everyone in Montgomery County) has been a key mechanism in efforts to prevent homelessness. In Columbus/Franklin County, for example, families enter the system through a central intake telephone line at the YWCA, where a triage approach is used to help families avoid homelessness first and foremost. Through this program, over 400 of the 1000 families served in 2000 had their housing crisis resolved without having to enter shelter, thereby avoiding homelessness

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<sup>83</sup> <http://www.endhomelessness.org/best/prevention.htm>

## Theme: Case Management

**HomeStart, Boston, Massachusetts**<sup>84</sup>. In 1994, the Massachusetts Housing and Shelter Alliance (MHSA) developed a project to meet the housing needs of people experiencing homelessness. MHSA recognized that case managers in homeless service agencies were becoming increasingly specialized to deal with the multiple challenges many of their clients presented. When programs were taxed with high demands and high levels of complex needs, it was the housing search services that were often lost. Initially, the project relied on one grant that funded three staff positions and was housed under MHSA. By 1999, HomeStart was an independent agency consisting of 22 employees and an annual budget of \$1 million. It currently employs 28 people with an annual budget of \$1.6 million.

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

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

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<sup>84</sup> <http://www.endhomelessness.org/best/homestart.htm>

To facilitate the successful housing of clients, HomeStart staff members rely on the resources known as their "toolbox." The toolbox includes an array of resources they have developed or secured including housing subsidies and financial assistance for security deposit and first month's rent.

**Self-Sufficiency Calculator, Chicago, IL<sup>85</sup>.** The Chicago Income and Expense Calculator, created by the Mayor's Office of Workforce Development (MOWD) from a self-sufficiency standard established by Wider Opportunities for Women and Women Employed, estimates the cost of living in Chicago for 71 different family types. The Calculator simplifies the way in which self-sufficiency is determined for both individuals and case managers assisting job-seeking clients. Automating the process eliminates cumbersome paperwork and allows each client to walk away with his or her self-sufficiency status, as well as a place to start when deciding on a career path. The Chicago Income and Expense Calculator is available online through the MOWD Web site at [www.ci.chi.il.us/WorkforceDevelopment/selfsuff.html](http://www.ci.chi.il.us/WorkforceDevelopment/selfsuff.html).

**North Dakota Department of Corrections and Rehabilitation Division of Juvenile Justice<sup>86</sup>.** Incarcerated youth can fall into a continuous cycle of homelessness; if they return to the streets after their release from jail there is a high probability that they will become involved in the same lifestyle that caused their original arrest. However, state juvenile justice agencies can play a significant role in preventing youth homelessness by coordinating state activities and providing youth in custody with a viable plan for reentering society.

Effective reentry services and planning are essential to preventing homelessness among youth leaving the state juvenile corrections system. Accurate initial assessment, timely provision of treatment services and appropriate discharge planning increase the likelihood that youth will successfully reenter society. North Dakota accomplishes these tasks by coordinating state service systems and running a statewide case management program.

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<sup>85</sup> Liz Libby, Communications Director, Mayor's Office of Workforce Development, at (312) 746-7458.

<sup>86</sup> <http://www.ndaco.org/jj/default.asp>

Across North Dakota, the Division of Juvenile Services provides intensive supervision and case management to delinquent youth under their custody. DJS operates eight regional offices and coordinates a variety of treatment services and placement options for adjudicated youth. These regional offices work with juvenile courts, county social services, law enforcement, public and private human service agencies, and schools to provide individual rehabilitative programming. Each juvenile's case is assigned to a corrections specialist prior to or at the time of commitment and that worker follows the case for the duration of the court order. Every effort is made to ensure that caseloads remain manageable, with no more than twenty-five cases per specialist.

## Theme: Databases

**King County's Mental Health Information System**<sup>87</sup> is a database used for both communication and coordination purposes. King County's Mental Health System has a Mental Health Information System logging any person's use of county mental health services. This database has become a source of useful information for Seattle's homeless service providers that are also certified mental health providers such as the Downtown Emergency Service Center. Individuals who have used system services have a record in the shared database and get a rating, or tier, for their service needs. To enroll a new client, he or she must first be on or eligible for Medicaid. Then the agency serving the client will apply for a tier based on medical necessity and treatment intensity. The county will review the tier request and grant or deny the tier. Once tiered, the person can begin to receive ongoing publicly funded treatment. The Mental Health Information System serves a communication function related to service duplication. The database logs the person's tier and the agency that provides care within the mental health system; two agencies cannot serve the same individual and both receive reimbursement for the care. The database thus prevents mental health service duplication and encourages some interaction among agencies to provide the most appropriate services. For example, if an outreach worker begins to provide outreach and engagement services to a street homeless individual who already gets services from another agency, the worker will reconnect the person to the original agency to continue services. Or if the person seems to need the specific services of the agency doing outreach, the

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<sup>87</sup> Burt, op. cit.

staff will contact the other agency and ask them to stop providing services to the individual so they can begin to.

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

**The San Diego REACH Project<sup>88</sup>** (Reaching Out and Engaging to Achieve Consumer Health) makes use of an existing database to assist its clients. This program, operating under the aegis of the San Diego County Mental Health Services Department, contracts with the San Diego County Probation Department to have a probation officer assigned to work directly with the REACH team. The officer is able to access the Department of Corrections database and helps many REACH clients clear up outstanding legal issues (e.g., warrants, criminal background checks) in her role as liaison between clients and the courts.

**The Greater Los Angeles Department of Veteran Affairs<sup>89</sup>** (VAGLAHS) created a database to assist with its work with agencies in its collaborative network. Staff members developed a discharge/service history database that provides the ability to track the service-use patterns of individual veterans. The discharge/service history database logs individuals' use of services throughout the whole homeless services network. VAGLAHS program and partner agency staff members contact the VAGLAHS database coordinator to provide client data and the database coordinator also periodically contacts partner agencies to ensure that all data have been submitted. Partner agencies also contact the database coordinator to learn about a new enrollee's history of service receipt and use the information to develop an appropriate service approach. VAGLAHS staff liaisons to partner agencies also use this database to review veteran status and to ensure appropriate referral and service plans.

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<sup>88</sup> Burt, op. cit.

<sup>89</sup> Burt, et. al.

**Philadelphia's OCC<sup>90</sup>**, which was discussed above in this report's section on outreach, is a particularly strong example of a collaborative service network using an integrated database. The agencies collaborate to integrate outreach efforts so that different teams cover different areas of the city and/or different issues of immediate concern. The collaborative has created a database to log the outreach and case management contacts. Outreach workers can also access shelter and transitional housing information by linking into the database maintained by the city that tracks this information.

### Theme: Multi-Agency Special Case Teams

**Seattle's High Users of Crisis Public Services team<sup>91</sup>**. Every two weeks staff members from the Crisis Triage Unit in the Harborview Medical Center Emergency Room, the REACH project (an outreach and case management project for chronic public inebriates), the emergency room, the Sobering Center, the detoxification center, the Emergency Service Patrol (a transport system for chronic public inebriates) and other relevant service providers meet to discuss high service users. These are people who have used the Crisis Triage Unit four times in three months, of which 52 percent are homeless. Together the agencies create integrated service plans for clients that each provider commits to following. This system allows service providers to think together creatively about client needs and the types of services that would be helpful to particular individuals, focusing especially on services designed to reduce their reliance on expensive public services. Clients sign information releases so agencies can coordinate in this way. At times the Triage Unit may also involve the client, family, friends, or police representatives.

**Los Angeles, the VAGLAHS collaborative network<sup>92</sup>**. This network is another example of a multi-agency special case team. The VA has an administrative requirement that a homeless veteran is only eligible for three complete treatment episodes in residential programs. If a person requires more than three episodes in housing, then the VA is required to seek a waiver for the person. The network uses the discharge/service history database just described to see whether a person has reached his service limit. When that happens, staff members from the VAGLAHS and relevant collaborating programs, as well as the

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<sup>90</sup> Burt, et. al.

<sup>91</sup> Burt, et. al.

<sup>92</sup> Burt, et. al.

veteran, come together in a clinical case conference to develop an approach to care to meet the person's needs at that point. The group develops a service plan and integrated service approach that the participating agencies commit to following.

## Theme: Multi-Purpose Service Centers

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

**VAGLAHS's Comprehensive Homeless Access Center<sup>93</sup>.** The VAGLAHS operates the Comprehensive Homeless Access Center for homeless veterans. VAGLAHS staff realized that homeless veterans had multiple needs and designed the Access Center to co-locate primary medical care, mental health, and homeless services. The structure of the access center dramatically changed "business as usual" for VA medical services. Now, a nurse conducts a complete bio-psycho-social assessment on clients including medical, treatment, and housing needs. The nurse will also review the person's history of using VA medical and homeless services within the LA system and the larger VA network. The veteran receives a comprehensive treatment plan addressing all bio-psycho-social issues including referrals to appropriate services. Referrals to services are then prioritized according to need.

**Seattle's Dutch Shisler Sobering Support Center<sup>94</sup>.** The Sobering Support Center was built and is owned by Community Psychiatric Clinic and co-locates three connected programs collaborating to provide services for chronic public inebriates: the Sobering Support Center itself; the Emergency Service Patrol; and the REACH Project. The Sobering Support Center, funded by King County, cares for people as they sober up. Another county program, The Emergency Service Patrol, operates a van that picks up vulnerable homeless people from the streets

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<sup>93</sup> Burt et. al.

<sup>94</sup> Burt, op. cit.

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

### Theme: Service Integration and Systems of Care

Service integration projects bring together the services offered by two or more organizations or agencies to either facilitate access to service or to meet a broader array of consumer needs. Service integration projects bring the players together at the level at which services are delivered to the client. They are not specifically intended to change how the broader systems function, but rather to improve the delivery of services and client outcomes. Some citations include:

**Veterans Administration**<sup>95</sup>. One well-documented example of a successful dual-agency integration effort to facilitate access is the SSI/VA demonstration in which local SSA field offices co-located a claims analyst for SSI at four VA medical centers. The VA designated a social worker to refer potential applicants to the SSI analyst, assist in developing the claims, and obtain needed medical records for the applicants. A disability analyst at the SSA office was assigned to coordinate the applications. The result of this demonstration was that veterans at the sites with the SSI analyst were almost twice as likely to apply for benefits and receive awards. The number of applications increased, as did the total number of recipients.

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<sup>95</sup> Gale, op.cit.

**The Health, Housing and Integrated Services Networks (HHISN) sponsored in the Bay Area by CSH, and California’s Integrated Services for Homeless Adults with Mental Illness<sup>96</sup>** (A.B. 2034). These programs bring together a number of provider agencies, both public and nonprofit, to meet multiple client needs. The HHISN model is formed around a provider team connected to one or more housing sites that provide case management and specialized services, such as substance abuse treatment, health care, mental health and employment training. These teams often include nonprofit agencies and staff from local mental health or health care departments. The A.B. 2034 program has a number of different service delivery models but also focuses on “intensive, integrated outreach and community-based services.” Both these team approaches have been shown to reduce costs to the larger mainstream service system, including reduced rates of hospitalization, incarceration and use of the homeless system.

### Theme: System Integration

By far the biggest and most challenging area of improvement for mainstream services is systems integrations. Activities in this area address system barriers with particular emphasis on the issue of service fragmentation. Researchers distinguish between “service integration,” in which services are brought together at the program or client level only, and “systems integration,” in which the services systems themselves are coordinated and relationships between mainstream agencies are changed. Most researchers agree that, in order to be effective, strategies for client-level change and administrative-level change must be undertaken together. An example of best practice is provided below.

**ACCESS<sup>97</sup>**. The most widely studied systems integration experiment in the field of homelessness is the Access to Community Care and Effective Services and Supports (ACCESS) Project. A joint project of the Robert Wood Johnson Foundation and the Substance Abuse and Mental Health Services Administration (SAMHSA), the ACCESS project was designed to determine if integration initiatives implemented at the program, policy and organizational levels improved outcomes for homeless persons with serious mental illness. The ACCESS Project selected 18 sites in nine states. One site in each state was

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<sup>96</sup> Gale, op.cit.

<sup>97</sup> Gale, op. cit.

selected to be the experimental site and the other to be a comparison site. Both types of sites received outreach and case management funds. The demonstration sites also received funding specifically for systems integration. The demonstration sites undertook several different integration strategies, including:

- Interagency coalitions
- Interagency teams for service delivery (considered service integration)  
Interagency MIS and client tracking
- Cross training
- Interagency agreements and memoranda of understanding □ Pooled or joint funding
- Flexible funding
- Uniform applications, eligibility and intake assessments
- Co-location of services

In the second year of the five-year program, the project sponsors found that many of the sites were struggling to implement their system integration plans. They identified four primary obstacles:

- The project sites did not have a clear vision of what they were trying to achieve. Their integration plans were not adequately developed (not specific to resources, activities; no dedicated staff person).
- The interagency groups had too little responsibility or authority (they were advisory, not change agents; critical mainstream systems were underrepresented; members were not high enough in their own agency hierarchies to make decisions.).
- They lacked joint/shared funding.

**The Program on Chronic Mental Illness<sup>98</sup>.** This project also promoted local systems integration, through development of a Local Mental Health Authority. The study compared the function of the local systems and the results for clients early in the integration process and later in the study period. At the end of the study, measures of inter-organizational relationships showed that the systems in demonstration cities were less fragmented and more centralized, and that agencies had more contact with one another. The families of clients reported

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<sup>98</sup> Gale, op. cit.

experiencing less of a burden on them. However, while participants were found to be more likely to have a case manager and to retain that case manager throughout the study's follow-up period, there were no differences in clinical, social or quality of life outcomes. The best outcomes were reported for those who received HUD Section 8 certificates, which were not available to everyone in the program.

**In Michigan<sup>99</sup>**, the state first developed a multi-agency team eight years ago to address the needs of people with serious mental illness and substance abuse. The agencies included representatives of state programs in mental health, substance abuse and special needs housing. The group quickly resolved to pursue other common areas, including needs of homeless adults and families. The group has recently evolved to become the executive-level Interagency Collaboration Team which works to "develop strategic planning, policy and program support, cross-sector training strategies, and other initiatives associated with Michigan's commitment to 'closing the housing gap for persons who are homeless and most in need.

The primary emphasis of the Michigan work thus far has been on developing joint projects/programs to increase supportive housing, and the Interagency Collaboration Team has produced more than 500 new units already. The team's work is led by the state Housing Finance Agency, and has received significant technical assistance from CSH. The state is now working to encourage the creation of similar coordinating bodies at the local level to support the multiple service needs associated with supportive housing.

**In Philadelphia<sup>100</sup>**, the lead agency in promoting service integration is the Managing Director's Office, with strong support from the mayor. To break through the many "service silos," the city has united all critical departments under one organizational umbrella. A managing director oversees all the "operating departments," including Child Welfare, Health, Behavioral Health Care (mental health and alcohol and drug services), Adult Services (homeless and housing service, shelters, transitional housing and permanent supportive housing), Recreation, Jails and Prisons, and a number of commissions. All the directors and commissioners meet weekly. The emphasis has been on moving to

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<sup>99</sup> Gale, op. cit.

<sup>100</sup> Gale, op. cit.

performance-based outcomes, which are being incorporated into the contracts of organizations doing business with the city. As in the Massachusetts discharge model, this outcomes-based model seeks to make a shelter stay a negative outcome and housing a positive outcome, even for the nonprofit agencies that provide shelter services to the city. Developing and implementing these outcomes is still in process; however, Philadelphia has already begun to decrease its number of shelter beds by 5% annually.

**In Chicago**<sup>101</sup>, systems integration work focusing on people with mental illness, is led by the state Office of Mental Health's Bureau of Chicago Network Operations. The bureau was created in 1999 to promote systems integration among the large bureaucracies that constitute the "functional system of care" in the greater Chicago area. To facilitate both services and systems integration, the bureau formed a Mental Health Service System Planning Council with more than 50 members, including representatives from the state Mental Health and Attorney's offices; the county Department of Corrections and county hospital system; city Human Service; Health and Police departments; and consumers, advocates and community providers.

Through planning and developing relationships on the council, they have been able to implement many cross-department and cross-jurisdictional projects, including a working partnership with 72 local shelters to ensure mental health assessments and treatment are available to all shelter residents who need them. A key tool under development is a data system for extracting queries from various databases to identify people who "slosh" between jails, shelters and community psychiatric hospitals, traveling a well-worn loop. By identifying people who overlap the systems, they will be able to work together to develop intervention plans that involve multiple players. Already, Community Mental Health Centers are able to anticipate an individual's release from jail, arrange for him to receive a two-week supply of medication, and schedule appointments for housing. In addition to working on projects together, and participating in the Planning Council, commission heads come together bi-monthly for a "coffee klatch" to discuss common issues and develop collaborative problem-solving strategies.

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<sup>101</sup> Gale, op.cit.

**Adolescent Transition Groups, New Mexico Dept of Health<sup>102</sup>.** The target group is The most vulnerable youth transitioning from out-of-home care into adulthood. Typically, the youth referred have dual or multiple diagnoses including a mental health condition with substance abuse and/or developmental disorders. Building and successfully managing a systems perspective in transitioning youth from out of home care into adulthood. Rather than fix a current problem and keeping youth in the system that creates dependency, ATGs look forward to where the youth will be when they become an adult and in systems that promote independence.

**Connecticut Department of Children and Families, Housing Continuum<sup>103</sup>.** In the past several years, Connecticut revamped the service delivery to adolescents in their care. Youth work their way through a continuum of housing options, moving from highly structured, supervised living arrangements to a transitional phase where support is provided while structure and restriction is decreased. Connecticut contracts approximately 60 Independent Living Providers and is able to expand housing options within the continuum as demand increases. The program targets youth 14 and older, whose permanency goal is emancipation. At age 14, all youth are transferred to caseworkers specializing in independent living services for youth. Youth are then referred to a provider that will serve the individual housing needs of the youth. Services are categorized in the following phases.

#### Phase I: Preparation for Adult Living Group Homes

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

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<sup>102</sup> <http://www.endhomelessness.org/best/ATG.htm>

<sup>103</sup> <http://www.endhomelessness.org/best/CTyouth.htm>

## Phase II: Transitional Living Apartment Program

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

## Phase III: Community Housing Assistance Program (CHAPS)

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

## Theme: Institutional Discharge

**Philadelphia's Housing Support Center (HSC)**<sup>104</sup>. The HSC has a primary prevention focus for individuals (and families) at imminent risk of homelessness. It began operations in winter 2003, and when fully operational will bring together resources from Adult Services, Department of Human Services (child welfare), Community Behavioral Health, the County Assistance Office (cash assistance), the Philadelphia Housing Authority, and other public agencies

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<sup>104</sup> Burt, op .cit.

whose clients face challenges to housing stability. It will serve as the city's central referral point for all households needing help because they are facing or experiencing homelessness. Because Philadelphia has a homeless management information system that covers all emergency shelter and another that covers the street population, the city will be able to track whether people assisted by the HSC do indeed avoid becoming homeless.

**Psychiatric Institution Discharge Planning**<sup>105</sup>. A number of communities, including Boston and Columbus, have policies and structures in place to prevent people leaving public psychiatric facilities from becoming homeless.

**Correctional Institutions Discharge Planning**<sup>106</sup>. Boston and Los Angeles (County Sheriff's Department), and at least some other California cities have programs to prevent homelessness among mentally ill offenders leaving correctional institutions. The Los Angeles program, funded through California state revenues in the AB 2034 program, involves careful interagency coordination as part of making discharge planning work. The Program Evaluator links the client with an agency in the area where he wishes to reside after discharge. If no housing is available in the client's desired area, he is placed close by and has the option of receiving outpatient treatment in the program of his choice until housing becomes available. Once in the program, the individual may transfer between programs as the need arises. Even though the jail does not have a policy requiring housing upon release, the agencies participating in the AB 2034 program are required to locate housing and provide transportation to wherever the client will be living upon release. Checks are in place to assure that incarcerated AB 2034 clients are not discharged to the streets.

**Leaving Substance Abuse Treatment**<sup>107</sup>. In some communities, individual agencies such as the Community Psychiatric Clinic in Seattle and Aletheia House in Birmingham have created a continuum of housing options, starting with residential treatment and including transitional, permanent supportive, and affordable independent housing, because they perceived that many such clients became homeless without these options. Both programs serve people who have never been homeless as well as those who have. They offer primary prevention to the former, and secondary prevention to the latter.

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<sup>105</sup> Burt, op. cit.

<sup>106</sup> Burt, op. cit.

<sup>107</sup> Burt, op. cit.

## Theme: Funding Systems for Services

**Flexible Funds** Because myriad rules and restrictions govern how mainstream program funds can be used, it is hard for mainstream agencies to utilize these funds, even in small amounts, to meet individual client needs. One strategy to improve how mainstream services serve homeless clients is to provide them with a little “flexible funding.” Citations include:

**In Des Moines, IA**<sup>108</sup> the state Maternal and Child Health (MCH) program provides its contractors with an “empowerment fund.” This flexible fund allows the contractors to pay for housing, utilities, clothing or anything else that the program deems necessary to help a pregnant woman, or a mother of a child under the age of two, obtain the conditions necessary for health. MCH programs are evaluated based on performance measures such as lower infant mortality and higher rates of immunization. As long as the performance measures are met, the Iowa programs have great flexibility in how the empowerment funds are used.

**In Alaska**<sup>109</sup>, the Division of Mental Health and Developmental Disabilities has provided flexible service funds of up to \$2,000 per client to use for any expense needed to keep the client housed in the community.

## Theme: Technical Assistance and Support

**Shelter Partnership, Los Angeles**<sup>110</sup>, Ca is a nonprofit umbrella organization that has mobilized private and public sector resources, as well as technical information and research to end homelessness among families and individuals in Los Angeles County. Since 1985, Shelter Partnership has continued to provide a variety of support to hundreds of agencies, free of charge. Shelter Partnership also serves as a resource to public agencies, the business community, local and national media, and community members involved in the issues of

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<sup>108</sup> Gale, op. cit.

<sup>109</sup> Gale, op.cit.

<sup>110</sup> <http://www.endhomelessness.org/best/bpsp.htm>

homelessness and the creation of permanent, affordable housing.

Shelter Partnership makes information available to the public, including products of our work as well as general information on homelessness. Shelter Partnership tracks major funding sources available to agencies serving the homeless and issues regular funding alerts. Our publications include educational materials compiled by Shelter Partnership as well as studies completed since 1989 to the present. The library includes studies and reports on homelessness and housing.

Through on-going technical assistance, Shelter Partnership works to build the capacity and effectiveness of individual agencies providing short-term and transitional housing for homeless people. We also work with agencies to create permanent affordable housing with supportive services for homeless people. Toward improving capacity of an agency, we offer training and instruction in such areas as forming a nonprofit entity, working with a Board of Directors, mission and program development, and building an effective staff to carry out your mission. Toward supporting the operations of an agency, we assist in the development of funding plans, identify funding sources for programs, and provide guidance in completing specific funding applications.

**Housing America, San Fran, CA**<sup>111</sup>. Housing America has mobilized pediatricians, religious leaders, students, community-based organizations and other constituencies to end America's housing crisis. Our strategy is twofold: we build support for increased federal housing funds in key states and congressional districts, and we issue reports that both detail the worsening affordable housing shortage and offer specific solutions. Housing America provides free technical and strategic assistance and media support to local groups seeking to increase national housing funding.

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<sup>111</sup> <http://www.housingamerica.net/>

## Theme: Governance

**Community Shelter Board, Columbus, OH.**<sup>112</sup> A public-private partnership of 18 organizations, the Community Shelter Board provides more than \$6.17 million in direct financial support for homelessness prevention, shelter, supportive housing programs, and housing-related services. Working with the United Way, the City of Columbus, Franklin County, and numerous corporate and foundation partners, the Community Shelter Board has developed a holistic approach to homelessness in Columbus. The Community Shelter Board coordinates virtually all of the private and public funding for homelessness in Columbus and Franklin County. As a result of this centralized approach, the Community Shelter Board has been able to develop effective management information systems to track the utilization of homeless resources, identify the needs among those experiencing homelessness in the city and quickly move them into affordable housing with the appropriate services.

**Santa Clara County Collaboration, Santa Clara CA**<sup>113</sup>. In Santa Clara County, it was widely recognized that addressing regional needs and problems requires regional cooperation. For more than five years, collaborative efforts by housing staffs and administrators in the County have streamlined processes, kept information flowing and cut across territorial lines to facilitate joint projects. Although the County includes a wide range of jurisdictions – with San Jose the largest city in Northern California and Gilroy still primarily agricultural – there are many common interests. Staff representatives of the County's seven entitlement cities – Gilroy, Milpitas, Mountain View, Palo Alto, San Jose, Santa Clara and Sunnyvale – and the County meet at least quarterly to review issues common to the CDBG programs in the various jurisdictions. Community Planning and Development staff members from HUD's San Francisco Office attend most of these meetings, adding to the collaboration and information sharing.

To carry through on matters of common interest, the various jurisdictions remain in informal communication between the quarterly meetings. Joint efforts include sharing common information for the consolidated plan, contributing to

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<sup>112</sup> <http://www.endhomelessness.org/best/bpcsb.htm>

<sup>113</sup> <http://www.ndaco.org/jj/default.asp>

a County-wide homeless survey, collaborating on domestic violence services and housing, comparing the service quality and auditing results of groups supported by CDBG funding, creating common elements of funding applications, and addressing County-wide fair housing issues. These efforts not only help solve problems, they also reduce spending by avoiding the duplication of services. The group also has been able to share resources and knowledge to aid clients affected by the disbanding of some non-profits.

A result of the collaboration has been the development and placement of projects which meet the needs of all jurisdictions. Jointly-funded projects include a homeless reception center and shelter in San Jose, homeless youth shelters in Mountain View and Santa Clara, a children's shelter in San Jose, a single room occupancy project in Sunnyvale, apartments for the developmentally disabled in Palo Alto and Sunnyvale, senior shared housing in Sunnyvale and Mountain View, transitional housing for victims of domestic violence in Santa Clara, and family rental housing in Gilroy and Milpitas.

One of the reasons for including HUD representatives at the meetings is to communicate to HUD in Washington the unique needs of Santa Clara County, where the median income is high but housing prices and rents are astronomical. It has been emphasized that there are many who do not share in Silicon Valley's much-touted financial success, and that they are not always noticed in Washington because they generally are scattered throughout the County rather than concentrated in poverty areas.

Santa Clara County's collaborative model is similar to a three-legged stool: The supporting legs are HUD, the local jurisdictions and the non-profits which deliver services and build affordable housing. This approach has given Santa Clara County a stronger voice at HUD, and it has ensured that the County's smaller cities have the same access to funds for affordable housing as the larger urban centers.

**Indianapolis, IN Funders Collaborative.**<sup>114</sup> The Blueprint to End Homelessness developed by Indianapolis, IN proposes a "lead entity" that will focus its energies on mobilizing our community's resources to ensure that the vision becomes a reality. At the same time, our community - which will be called upon to devote considerable resources to ending homelessness - has the right to expect that

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<sup>114</sup> <http://www.endhomelessness.org/best/prevention.htm>

any lead entity will transcend the outcome of any election and will be held accountable for the implementation of the Blueprint's ambitious, and aggressive, 10-year goals. After considerable analysis – including lengthy discussions with leaders of public and private organizations, whose support will make or break the realization of the Blueprint's goals – the Coalition for Homelessness Intervention and Prevention (CHIP) is the designated lead entity. Among many other duties that are detailed later in this document, CHIP would work to form partnerships with existing agencies and programs; promote awareness of the needs of homeless and near-homeless people; increase effectiveness of service delivery; and conduct research and planning. CHIP would also: Assemble, and provide staff support to, an implementation group of city officials, housing experts, members of the philanthropic community, and other community leaders to advance the housing objectives set forth in the Blueprint. Provide staff support to a collaborative of public and private funding agencies that jointly consider funding requests related to the Blueprint's objectives. Regularly monitor data and conduct survey research to assess the community's progress toward ending homelessness. Report, on a semiannual basis, to the Indianapolis Housing Task Force – and, as requested, to any public or private body – on the status of the implementation of the Blueprint.

CHIP, as the lead entity, will provide staff support to a collaborative of public and private funders that will meet periodically to consider funding needs related to this Blueprint. The Funders' Collaborative will be one vehicle for making decisions from a more collective vision and within the larger context of the Blueprint. This Funders' Collaborative must take a proactive approach to the Blueprint strategy by issuing requests for proposals that identify both the process objectives and desired outcomes to be attained by partnerships of providers. The lead entity can assist in developing the RFPs and in helping to evaluate proposals. CHIP will provide advice and direction to the Funders' Collaborative on issues affecting homeless and near-homeless people. It also will help raise the resources necessary to meet this Blueprint's goals and explore methods for reallocating existing resources to be more cost-effective.

## Theme: Civic Leadership and Volunteerism

### **Involvement of Business/Private Sector**

Though not providers of mainstream services, business interests are definitely mainstream and are often missing from the table where homeless services are planned. Businesses, especially in downtown areas of major cities, are directly impacted by homelessness. In some communities, the business sector has become an important ally in providing homeless services, and has even had an impact on the provision of mainstream services to homeless people.

**In Washington D.C., the Downtown Business District<sup>115</sup>** responded to the large numbers of homeless people living on the streets by developing a downtown service center. As part of this effort, they requested that city staff from alcohol and drug programs be co-located to their site. Thanks to the business association's influence with the city, the mayor ensured that staff was on-site to pre-certify people for detox beds.

**In Seattle, the Downtown Business Association<sup>116</sup>**, which includes many national corporations, has assessed itself a one-cent tax Business Improvement District (BID) tax for homeless services, which it uses to support services for homeless people in the downtown area.

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<sup>115</sup> Gale, op. cit.

<sup>116</sup> Gale, op.cit.

## Theme: Research

### Method: GIS and mapping

**Vera Institute of Justice, New York**<sup>117</sup>. Researchers at Vera are using mapping techniques to determine which New York City neighborhoods produce the most homeless families and what characteristics—such as demographics or physical conditions—distinguish these neighborhoods from others. The research also includes a survey of homeless families that will increase understanding of why and how families end up homeless.

### Method: Street Counts

**Birmingham Street Counts, Birmingham, AL**<sup>118</sup>. Birmingham has done periodic counts of homeless persons complemented by a sample survey of the people counted. To provide a complete profile of the chronic homeless individuals in a community, a “street count” needs to go beyond the people on the street and include homeless individuals housed in emergency, transitional, treatment. Birmingham’s counts provide a good example of the scope necessary for a reliable count.

### Method: Movement of homeless persons into housing

**San Diego Movement of Chronically Homeless Individuals into Housing, San Diego, CA**<sup>119</sup>. San Diego’s AB 2034 program for chronically homeless individuals with mental illness enrolled 404 persons between November 1, 1999 and January 31, 2003 in permanent supportive housing. It offered people immediate housing in a variety of settings, using hotels in the early period before safe haven and PSH slots became available. At the end of this period, 253 were still enrolled and 154 had been disenrolled for various reasons (59 percent of the 154 “disenrollees” dropped out of the program and another 17 percent moved out of the REACH program area). Presumably most clients should be staying in permanent housing for a long period. If too large a percentage disenrolls, the program is having problems. Agencies can use simple length of stay in permanent housing to make some assessment of how a system is

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<sup>117</sup> [http://www.vera.org/project/project1\\_1.asp?section\\_id=6&project\\_id=68](http://www.vera.org/project/project1_1.asp?section_id=6&project_id=68)

<sup>118</sup> Burt, op. cit.

<sup>119</sup> Burt, op. cit.

working. If the typical length of stay is six to eight months in a program designed to provide years of residence, the support services may be insufficient or the program may be taking in clients who do not need that high a level of care and are moving on to independent living. However, this does not appear to be a problem for the PSH programs we visited. Far more often providers noted that turnover among clients was much lower than expected, even after years of residence. Some communities are now beginning to think about lower-intensity options for tenants who have been stabilized for several years.

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

**Columbus Shelter Board, Columbus, OH**<sup>120</sup>. In Columbus existing shelter data indicate a 7 percent decrease in the total number of clients sheltered in 2001 as compared to 1998 (note these are all homeless clients, not just those who are chronically homeless). Of the 2,959 clients sheltered in 2001, 298 had successful outcomes, meaning they exited the shelter system to either permanent or transitional housing. The average length of stay during this period of time remained relatively stable for men, while it increased by over 20 percent for women, increasing from 37 days in 1998 to 47 days in 2001. During this period of time the recidivism rate increased by 14 percentage points for men and 3 percentage points for women.

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

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<sup>120</sup> Burt, op. cit.

## Method: Reductions in Days Homeless, Hospitalized, or Incarcerated

**Reach, San Diego**<sup>121</sup>. In San Diego among the 253 formerly homeless clients currently enrolled, REACH had the following impacts, annualized to represent the 12 months before compared to the 12 months after enrollment, current enrollees have: 73 percent fewer homeless days; • 55 percent decrease in incarceration days, and 71 percent decrease in incarceration episodes; • 35 percent decrease in hospital days, and 62 percent decrease in hospitalization episodes; and 506 days of enrollment, on average, or about 1.4 years, in a program that in January 2003 had only been at full enrollment for about 2 years.

Theme: Advocacy

**Massachusetts Shelter and Housing Alliance**<sup>122</sup> . The Massachusetts Housing and Shelter Alliance (MHSA) is an advocacy group working to end homelessness at the state level. Creating and engaging in public policy deliberations at the local, state and federal levels for 15 years, MHSA has transformed an emergency- and maintenance-oriented public policy to create prevention and production initiatives and funding, including over \$100 million in state resources. MHSA has partnered with government agencies and elected officials to ensure the visibility of homelessness in budget deliberations, public policy decisions, and media coverage.

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<sup>121</sup> Burt, op. cit.

<sup>122</sup> <http://www.endhomelessness.org/best/bpmhsa.htm>

# Funding

**Affordable Housing Trust, Los Angeles, CA<sup>123</sup>.** Recognizing that Los Angeles's housing crisis poses significant challenges to the local economy, transportation infrastructure, education system, health care delivery system, and basic quality of life, Mayor James K. Hahn has committed to allocate an unprecedented \$100 million. The City's Housing Trust Fund was created to provide resources to alleviate Los Angeles's severe affordable housing shortage. The city's 2002-03 budget included \$42 million for the first phase of the Mayor's funding plan. Based on general principles, a Housing & Community Development Committee developed recommendations using three broad categories: (1) How the Trust Fund Should be Spent, (2) How the Trust Fund Should be Governed, and (3) How the Trust Fund Should be Sustained. In February 2003, the LA City Council approved the Housing and Community Development Committee report recommendations to approve the following percentages for the Housing Trust Fund as general guideposts for expenditure until the guidelines are established:

- f. 60% for multifamily rental projects serving households at or below 60% of the Area Median Income (AMI).
- g. 20% for projects that create home ownership opportunities for households at or below 120% of AMI.
- h. 5% for emergency rental assistance.
- i. 10% to remain flexible with the priority going toward preservation of housing that is at risk of converting to market rate.
- j. 5% for administrative costs.

Revenue for the Trust Fund comes from:

- New revenue from enhanced tax enforcement
- CDBG funds
- Community Redevelopment Area (CRA), Increased Housing Set Aside
- Revenue from the sale of real property
- Tobacco Settlement Funds
- Vehicle License Fee Increase

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<sup>123</sup> <http://housingcrisisla.ucla.edu/>

Also explored as funding options were the following:

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- Adopting an in-lieu fee as part of the inclusionary zoning ordinance
- Adopting a linkage fee for commercial development
- Requiring that all new coastal zone housing include housing units for low and very low income households or in-lieu fees sufficient to develop such housing
- CRA Central Business District Project Area tax revenues
- Citywide property tax growth
- Establishing/increasing and dedicating a portion of a transient occupancy tax
- Levying fees on water usage above a first-tier (life-line) base amount
- Securing stock options in exchange for Community Development Bank investments in e-commerce ventures
- Studying additional fees on luxury items
- Cable TV Franchise Fee (\$3.6 – \$18 million)
- Local general obligation bond for housing
- Parking users tax
- Increasing the redevelopment housing set-aside

### **Gas Tax / General Revenue Exchange**

**Broward County, FL<sup>124</sup>.** Broward County's Homeless Initiative Partnership (HIP).

Broward County's Homeless Initiative Partnership (HIP) Advisory Board and HIP Administration are a part of the Broward County Human Services Department. Funding for Broward's HIP and HIP programs comes from County General Revenue that has been freed up as a result of a one cent increase on each gallon of fuel. This tradeoff generates \$7.5 million for homeless services. The one cent gas tax established in 1998, and since the penny cannot be used for other than transit, Broward County government supplanted an equal amount of General Revenue and dedicated it by resolution exclusively for homeless services. The 30 cities give their usual 38% share of the penny to the county in order to have a County-wide system. This is accomplished through inter-local agreements with cities representing more than 50% of the population.

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Broward County has also used a one-time accumulation of an accrued Pay Phone Trust Fund reserve. It was collected from the jails when inmates make calls, and it generated over \$1 million in reserves over several years.

### **Food & Beverage Tax**

#### **Miami-Dade County, FL Dedicated source of funding for homeless programs<sup>125</sup>**

In 1993, local business leaders and elected officials lobbied the State legislature to allow the County to levy a one-percent food and beverage tax at all restaurants grossing more than \$400,000 a year that also had a liquor license. The tax has been collected since October, 1993 and generates revenues of approximately \$12.5 million per year.

### **Housing Levy**

#### **Seattle, WA.<sup>126</sup>**

The 2002 Seattle Housing Levy will provide up to \$86 million over a 7 year period to provide, produce, and/or preserve affordable housing in Seattle and to assist low-income tenants in Seattle.

Levy programs include:

- Rental Preservation and Production
- Homeownership
- Neighborhood Housing Opportunity Program
- Rental Assistance
- Operating and Maintenance

The 2002 Housing Levy, approved by Seattle voters in September, 2002, includes property tax levies authorized for seven years, from 2003 through 2009. The Office of Housing (OH) will administer all 2002 Seattle Housing Levy

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[http://www.co.miami-dade.fl.us/homeless/homeless\\_main\\_page.htm](http://www.co.miami-dade.fl.us/homeless/homeless_main_page.htm)

<sup>126</sup> City of Seattle, Office of Housing, 700 Fifth Avenue - #5700, PO Box 94725  
Seattle, WA 98124-4725, Tel: (206) 684-0721 • Fax: (206) 233-7117  
Email: [Seattle.Housing@seattle.gov](mailto:Seattle.Housing@seattle.gov) <http://www.cityofseattle.net/housing/Levy.htm>

programs with the exception of the Rental Assistance program, which will be administered by the Human Services Department.

An Ordinance passed by City Council in June 2002, adopted an Affordable Housing Financing Plan (“AHFP”) that placed the levy proposition on the September ballot and directed the Office of Housing (OH) to prepare an Administrative and Financial (A&F) Plan covering all Levy programs beginning in 2003.

→ The Plan must be approved by City Council and updated every two years.

→ The Plan was developed by OH with the assistance of working groups that included nonprofit group representatives (including Seattle Housing Authority) and other community members.

→ It was reviewed, revised and approved by the 1995 Housing Levy Oversight Committee.

The 2002 Ordinance requires A&F Plans to include:

- Criteria for evaluating and selecting projects;
- Guidelines for loans or grants;
- Requirements for project borrowers;
- Progress and performance reports on ongoing projects and for each Levy program (this section to be included in future plans);
- Program reviews to ensure that levy funds are used for their stated purposes; and
- Financial budgets for each levy program.
- The A & F Plan may include such other information as the Mayor or Housing Director may deem appropriate or the City Council may request.

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## Linkage Fees<sup>127</sup>

A linkage fee ordinance can be used as a complement to an inclusionary housing ordinance. Linkage fees are a way for local governments to collect monies from non-residential developments and/or market rate residential developments to be placed in a housing trust fund for others to use in building affordable housing. Linkage fees are a recognition that commercial, industrial, and upper end residential construction all increase the need for employment of low wage workers who will be in need of affordable housing within the community. The development of land for employment-generating activities creates the need for housing those employees. Even residential development creates the need for jobs, such as housekeeping and lawn maintenance. Both nonresidential development and market rate housing development take up land that might otherwise be used to provide affordable housing. The linkage fee is not a tax; it is a regulatory fee akin to an impact fee.

### How Linkage Fees Are Calculated

Generally, a linkage fee is collected as a certain monetary amount multiplied by the square footage permitted. For example, the fee might be \$3.00 per square foot of nonresidential construction. The amount a local government charges per square foot in its linkage ordinance is best determined by a local or regional economic and demographic study that takes into account the local market conditions. The calculation can be rather complicated. A sample fee equation is as follows:

Fee = Employees x Cost Unit of Development

Employees per unit of development is the number of targeted employees per some measure of development, probably 1,000 square feet.

Cost is the economic cost of providing a new housing unit; that is, the cost of production less the present value which could be supported by the income of a low- or moderate-income household.

Winter Park, Florida, has successfully adopted a linkage fee ordinance. Appendix 4 offers a model

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<sup>127</sup> The Affordable Housing Study Commission Final Report 2001 (July).

linkage fee ordinance based on Winter Park's that can be a starting point for local governments in developing their own ordinance.

**Bay Area Smart Growth Fund**<sup>128</sup>, a \$65 million private equity fund formed in 2001 to invest in commercial and residential real estate projects in 46 low- and moderate-income neighborhoods in the nine-county "Bay Area" of Northern California. Sponsored by the Bay Area Council in association with the Bay Area Alliance for Sustainable Development and the Community Capital Investment Initiative, the Fund is managed by Pacific Coast Capital Partners. As of summer 2004, the Fund had invested \$32.6 million in several transactions including the redevelopment of 14.2 acres of the Oakland Airport industrial corridor, the acquisition and rehabilitation of 100 single-family homes in Alameda and Contra Costa counties for low- and moderate-income residents, infill housing development in the city of Richmond, and the acquisition and redevelopment of a 182,000 square foot community shopping center in Marin City.

**California Community Foundation Land Trust**<sup>129</sup> is a demonstration project, which would buy the land and provide a ground lease at three percent per year to homebuyers. Because the homebuyers would not have to finance the land, they could take out a smaller ten-year or 15- year mortgage, rather than a 30-year mortgage and still afford the payments. As a result, the homeowner would build up substantial equity through debt reduction.

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<sup>129</sup> Norie Harrower, Community Foundation Land Trust CEO, California Community Foundation, 445 S. Figueroa Street, Suite 3400, Los Angeles, CA 90071, tel (213) 413-4130 ext. 267, e-mail: [nharrower@ccf-la.org](mailto:nharrower@ccf-la.org).