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

Strategies for Improving Homeless People's Access to Mainstream Benefits and Services

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Prepared for:

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PREFACE

In 2000, HUD, in recognition that any solution to homelessness must emphasize housing, targeted its McKinney-Vento Act homeless competitive programs towards housing activities. This policy decision presumed that mainstream programs such as Medicaid, TANF and General Assistance could pick up the slack produced by the change. This study examines how seven communities sought to improve homeless people's access to mainstream services following this shift away from funding services through the Supportive Housing Program (SHP). By examining the different organizations used and activities undertaken by communities to maximize homeless people's access to mainstream benefits and services, this study provides communities with models and strategies that they can use. It also highlights the limits of what even the most resourceful of communities can do to enhance service and benefit access by homeless families and individuals.

Responses to HUD's Policy Shift

Of the seven study communities (Albany/Albany County, NY; Albuquerque, NM; Metropolitan Denver, CO; Miami-Dade County, FL; Norfolk, VA; Portland, ME; and Pittsburgh/Allegheny County, PA), six shifted their balance of homeless housing and service funding from HUD substantially in response to the Department's greater emphasis on housing. Four of the seven communities more than doubled their receipt of housing resources (capital and, mostly, rent subsidies) from the SHP between 2001 and 2007. SHP service funding, however, either increased much less than housing resources over the same time period, or declined. Some communities were able to find additional resources to support new services or to substitute for lost funding, but others have been forced either to cut back or to forego new services.

Improving Access to Mainstream Services

The study identifies three groups of barriers to access and three categories of mechanisms communities could use to reduce these barriers.

Structural barriers are obstacles that prevent an eligible person from getting available benefits, such as where programs are located, how they are organized, or what they require of applicants. In each site, structural barriers represented both a significant frustration and a primary target of mechanisms for increased access. Homeless individuals and families face unique structural obstacles because, by definition or circumstance, they do not have the ready means of communication, transportation, regular address, and documentation that most mainstream programs require. **Smoothing mechanisms** reduce structural barriers and address problems at the street level. Such mechanisms include providing transportation; conducting outreach to the streets, feeding programs, shelters, and other homeless facilities; co-locating mainstream eligibility workers in homeless assistance programs; creating "one-stop" intake centers for homeless people; providing multilingual services; and improving communications among homeless

assistance workers and mainstream agency eligibility workers. Denver's Road Home program focused on organizing all existing outreach programs, expanding some along the way. It pays for 20 outreach workers, including two in the police department. It also facilitates relations of the outreach teams with mainstream agencies. Chronic homelessness was down 36 percent in the program's first three years.

Capacity barriers result from the inadequacy of available resources; funding may be finite or capped. While harder to reduce than structural barriers, most study communities managed to acquire new resources (usually state funds) to expand capacity for at least one mainstream benefit or service. Capacity barriers are often addressed through **expanding mechanisms**, which involve increasing overall capacity via the commitment of additional resources, including raising funds from state or local sources or allocating other federal funding. Miami-Dade County's Homeless Trust began in 1993, when the county imposed a tax on food and beverages served in many restaurants and bars to provide resources to address homelessness. The Trust manages the tax funds generated as well as all other public homelessness resources, centralizing the county's homelessness organizing structure.

Eligibility barriers are program rules that establish the criteria for who may receive the benefit as well as time limits on receipt. Many eligibility restrictions are embedded in federal policy and cannot easily be influenced at the local level. **Changing mechanisms** alter eligibility but not overall capacity. This could involve, for example, establishing a priority for homeless households within local rent subsidy programs. The city housing authority in Pittsburgh, through the flexibility it had from the Moving to Work demonstration program, adopted a felony rehabilitation clause to allow ex-offenders access to federal rent subsidies and public housing if they could demonstrate rehabilitation.

While smoothing mechanisms were the most common approach used by communities to overcome barriers, the study communities were able to change eligibility and/or expand capacity for non-entitlement services through significant new commitments of local resources, along with occasional use of state resources.

Improvements in Homeless People's Receipt of Benefits

Using 2007 Annual Performance Report data from the four study communities for which it was available, the study finds evidence that people exiting HUD-funded programs were likely to be connected to mainstream benefits at rates for 2007 that exceeded national rates for that year.

- The highest rates of enrollment were for food stamps—40 percent or more in three communities, compared to the national average of 25 percent. This high rate reflects that basic eligibility is broadest for food stamps, but also suggests that many barriers to access have been reduced through structural mechanisms.
- In the two communities that had General Assistance programs, participation rates at program exit were 18 and 22 percent, compared to the national average of 6 percent.

- SSI/SSDI access rates varied highly at the four sites, as did access to TANF. Rates of Medicaid enrollment did not differ from national rates.

The study also examined data from the Substance Abuse and Mental Health Services Administration (SAMHSA) Homeless Families study, to gain additional information on homeless families' receipt of mainstream benefits and services over time. The SAMHSA study families had high rates of participation in Medicaid, food stamps, and TANF.

Understanding the Role of Central Organizing Structures

The communities in the study who took the most effective steps in overcoming obstacles to benefit access had a strong central organization focused on improving the access of homeless households to mainstream services. This structure enables communication and collaboration to create a coordinated community response. The study concludes that more strongly organized communities have: 1) thought through and put in place a range of mechanisms to improve access; 2) made sure those mechanisms covered the whole community; 3) made more of an impact on how mainstream agencies do business; and 4) significantly increased the degree of coordination and collaboration among homeless assistance providers, among mainstream agencies, and between the two groups.

In addition to developing effective, inclusive, and creative organizing structures, communities should look for mechanisms to improve access that show evidence of effectiveness in other communities. This study provides a range of creative mechanisms that they can consider.

ACKNOWLEDGEMENTS

Many people offered their time and expertise to assist us in carrying out this project and completing this report. Most importantly, Paul Dornan and Marina Myhre at the U.S. Department of Housing and Urban Development provided extensive guidance throughout the planning and implementation phases, and assisted in the development of this report through their thoughtful review of its earlier versions.

The information in this report is drawn from the experience and knowledge of the front-line staff, supervisors, administrators, and local officials we interviewed at each of the seven study sites. With 20 to 50 interviewees per community, there is not space to thank them individually here. Their names may be found in the community descriptions in Appendix A.

The study community site visits would not have been possible without the involvement of our primary local contacts. Each community's contacts helped us identify the aspects of their communities on which we should focus our attention, worked with us to determine the individuals and agencies we needed to visit in their community, facilitated the visits themselves, responded to our requests for clarification following the site visits, and carefully reviewed our site-visit write-ups, ensuring that the information we used for the report accurately reflects the communities and their service systems. Our primary contacts are:

- **Miami** - David Raymond of the Miami-Dade County Homeless Trust
- **Denver** - Jamie Van Leeuwen of Denver's Road Home and Jerene Peterson of the Denver Department of Human Services
- **Pittsburgh** - Michael Lindsay and Reginald Young, both of the Allegheny County Department of Human Services
- **Albuquerque** - Lisa LaBrecque of the New Mexico Coalition to End Homelessness
- **Albany** - Linda Glassman, formerly of CARES, and Linda Doyle of the Albany County Department of Social Services
- **Norfolk** - Katie Kitchin, formerly of the Norfolk Office to End Homelessness
- **Portland** - Robert Duranleau of the Portland Health and Human Services Department and Jon Bradley of Preble Street

The analysis reported in Chapter 4 is based upon data collected in a SAMHSA-sponsored study of homeless families; principal investigators for the individual projects were Linda Frisman (CT), James Galloway (NC), John Hornik (NY), Gary Morse (MO), JoAnn Sacks (PA), Judith Samuels (NY), Michael Shafer (AZ), and Linda Weinreb (MA).

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EXECUTIVE SUMMARY

The U.S. Department of Housing and Urban Development (HUD) has been funding transitional housing, permanent supportive housing, and related supportive services projects for homeless people since 1988, under the authority granted by the Stewart B. McKinney Homeless Assistance Act of 1987 and its subsequent modifications. When HUD began funding these projects under its Supportive Housing Program (SHP) as competitive grants, and later (starting in 1996) through the Continuum of Care (CoC) process, it gave applicants discretion to use HUD homeless funds for whatever mix of eligible activities they preferred. As a result, by 2000, nearly 60 percent of HUD homeless funds were being used by communities for services such as daycare and drug treatment, while the remaining funds were used for housing.

HUD is the only federal agency that provides resources to develop and run permanent supportive housing. In contrast, many federal agencies provide the resources to deliver services. In 2000, facing a situation in which most of HUD's SHP funds were committed to renewals of existing projects, and much of that funding going to services, little money was available for new projects and the SHP had little flexibility to create new housing. Yet it was important that communities continue to create new housing, in order to make progress toward the goal of ending homelessness, and HUD funds were the obvious resource to make that happen. Understanding this situation, Congress directed HUD to use more of its funds to create and sustain permanent supportive housing. In response, HUD created incentives in the Continuum of Care competition to encourage communities to use more of its funds for housing and less for services. It was argued that the services no longer covered by SHP funds could be funded instead by increasing the participation of program tenants in mainstream services.

Today (2009), about 66 percent of HUD competitive SHP funding goes to housing and about 33 percent goes to services, which are concentrated more on case management and other core services that help keep people in housing, and less on activities that are the province of other federal agencies. This shift and increased appropriations freed HUD to commit its resources to create over 40,000 new permanent supportive housing units since the new policy took effect.

The Core Study Questions

The questions that arise following HUD's dramatic shift in resource allocation are: *have* communities been able to compensate for the loss of supportive services funding for homeless programs? If yes, how have they done it? This study was conducted to gain answers to these questions.

The expectation was that mainstream public agencies at the local level—welfare offices, Social Security offices, mental health and substance abuse agencies, employment and training agencies, and the like—would be the most likely source of funding to compensate for the services funding lost through HUD's policy shift. Replacement services funding might come through grants or contracts from local public agencies to

homeless assistance providers, but difficulties obtaining such contracts and their historic unreliability from year to year were among the reasons that homeless assistance providers looked to HUD for services funding in the first place. A more likely source of services funding is linked directly to homeless clients or formerly homeless permanent supportive housing (PSH) tenants, through their eligibility for benefits and services (e.g., Temporary Assistance for Needy Families [TANF], Supplemental Security Income [SSI], Medicaid, veterans' services).

If mainstream benefits and services are to be the source that pays for services to homeless people in supportive housing projects, it is essential that homeless people are able to get to the relevant public offices and to complete applications that will be successful. Potential problems arise at this point; much evidence indicates that poor people in general and homeless people in particular face many barriers to receipt of mainstream benefits and services. This study was undertaken to see whether, and how, communities mobilized in light of HUD's policy shift to improve homeless people's access to mainstream benefits. Specific study aims included:

- Understanding the full range of barriers to homeless people's access to mainstream benefits, and developing useful classifications of barriers.

- Documenting the types of mechanisms that communities have developed to overcome barriers and maximize access to and receipt of mainstream benefits and services by homeless families and individuals, including communitywide organizing (broad response) and specific mechanisms (focused response).

- Identifying the effects of local realities and the practices of local homeless providers and mainstream benefit/services representatives on improved access.

- Seeing if communities could produce evidence that their efforts to increase access have been successful.

- Seeing if communities have been able to compensate for the loss of funding for services following from HUD's shift in priorities for Supportive Housing Program funds toward housing-related activities, by finding service funding from other sources.

The Issue of Access to Public Benefits

Enrollment in mainstream public programs is rarely easy; over the past several decades, hundreds of studies have documented the fact that many people eligible for a particular benefit do not sign up for or receive it. Regardless of the benefit—whether it is TANF, the major federal-state welfare program for families; SSI, which supplies cash income for poor disabled people; food stamps; Medicaid; or behavioral health services—studies find numerous barriers that keep eligible people from applying and from ultimately receiving the benefit if they do apply.

Some barriers to receipt of public benefits and services occur at the front door of public service agencies. Staff of local public agencies make policy-related decisions that affect access, often informally. In a seminal work, Lipsky (1980) argued that "policy implementation in the end comes down to the people who actually implement it." He coined the term "street level bureaucrats" to characterize the frontline staff of public agencies—police, firemen, teachers, eligibility and case workers, and others—who interact directly with the people who want to use an agency's programs and services. He pointed out that their interpretation of policy, as well as their attitudes and behavior toward applicants, may determine whether individuals do or do not receive the benefits and services to which they are entitled. Communities that are serious about increasing the proportion of homeless people who receive mainstream benefits must examine the ways that frontline workers interact with potential clients, and do what it takes to improve those interactions until they are no longer barriers.

In addition to the issues posed by frontline workers in public agencies, many studies have noted other barriers to benefit receipt. These include ignorance of the benefit altogether, that one might be eligible for it, or how to apply; inability to get to the application office or to get there when it is open; the complexity of the application process; requirements for extensive documentation; language barriers; and stigma, to name a few barriers that attach to individuals. When homelessness is added to the barriers experienced by low-income people in general, the process of completing a successful application for mainstream benefits can be daunting. Added to individual-level barriers are barriers arising from an inadequate supply of the benefit or service—a nearly universal circumstance for any benefit or service that is not an entitlement.[1]

Approach

The study goals were addressed primarily through qualitative inquiry, conducting site visits, and analyzing responses to interviews with multiple key informants in each of seven study communities (Exhibit 1). The seven communities were selected through a multi-stage process. We assembled a list of communities that we thought were making significant efforts to increase access, conducted screening interviews, and made the final selections. The most significant criteria for final selection were a communitywide approach to improving access rather than the work of a single agency, however impressive, and the presence of some interesting mechanisms designed to increase homeless people's access to mainstream benefits and services. In addition, we made an effort to select communities that: 1) had the possibility of being able to provide some evidence that their access mechanisms were working to improve benefit receipt; 2)

[1] Entitlement programs are those that must serve everyone who is eligible, even if that means that costs increase. Entitlement programs examined in this study include food stamps, Medicaid, Medicare, SSI/Social Security Disability Income (SSDI), General Assistance, and pensions and disability benefits for veterans. Other programs examined in the study enroll new people only as long as their funding allocation lasts; these include TANF; health care; mental health and substance abuse treatment and services; federal, state, and local rent subsidies and public housing, employment and training, and health and behavioral health care for veterans.

provided geographic balance; 3) included some large, medium, and small communities; and 4) had not been included in previous HUD studies.

Exhibit 1: Cities Selected for Site Visits

Large Cities	Medium-sized Cities	Small Cities
Denver, Colorado Miami-Dade County, Florida	Pittsburgh/Allegheny County, Pennsylvania Albuquerque, New Mexico	Portland, Maine Norfolk, Virginia Albany and Albany County, New York

Two-person teams spent two to four days visiting each study community. During these visits the team conducted individual and group interviews with one or more key leaders among providers of housing plans and programs in the community; providers of mainstream benefits and services; providers of services to homeless persons; and relevant federal, state, and local governmental officials. Additional data were gathered through document reviews and follow-up telephone calls to key informants to clarify any issues or discrepancies from site visit notes.

The site visits were supplemented with analysis of existing quantitative data from the Substance Abuse and Mental Health Services Administration (SAMHSA) Homeless Families study and from local and national data on people leaving HUD-funded programs as reported to HUD on those programs' Annual Performance Reports (APRs).

Responses to HUD's Policy Shift

Before commissioning this study, HUD already knew the extent to which each of the country's Continuums of Care had shifted its funding requests toward housing. Exhibit 2 shows how the seven communities in this study changed in response to HUD's placement of greater emphasis on having Continuums of Care use SHP resources for housing rather than services. For each community, the proportion of funds allocated to housing and services for the year 2001 and the year 2007 is shown (third panel), followed by the change in funding for each category as a proportion of 2001 dollars (fourth panel).

Four of the seven communities more than doubled their receipt of housing resources (capital and, mostly, rent subsidies) from the SHP, and one community (Pittsburgh) came close to tripling it, reflecting the increased resources available through the SHP thanks to larger congressional appropriations targeted toward permanent supportive housing as well as their own success in winning those resources through annual applications to HUD. Albany and Albuquerque also experienced substantial increases in SHP housing resources (60 and 37 percent, respectively). Only Norfolk remained essentially static in its SHP housing-related funding.

Exhibit 2: Changes in Allocation of U.S. Department of Housing and Urban Development Funding to Housing and Services

Community	Funds Allocated to Housing and Services (in millions)				% Housing Funds		% Change in Funding	
	2001		2007					
	Housing	Services	Housing	Services	2001	2007	Housing	Services
Albany	1.06	0.80	1.70	0.64	57%	72%	+60%	-19%
Albuquerque	2.35	1.06	3.22	1.27	69%	72%	+37%	+19%
Metropolitan Denver	4.19	2.91	7.39	2.76	59%	73%	+176%	-5%
Miami-Dade Co.	6.96	7.00	13.62	10.33	50%	56%	+187%	+48%
Norfolk	1.66	0.78	1.67	0.76	68%	69%	+1%	-3%
Portland	0.83	0.56	1.73	0.86	60%	67%	+207%	+54%
Pittsburgh/All. Co.	3.58	7.65	10.67	3.55	32%	75%	+289%	-54%

The same is clearly not true for SHP services funding, as shown in the last column of Exhibit 2. Services funding either increased considerably less than housing resources as a proportion of all SHP funding, or actually declined. Some declines were very small (3 and 5 percent for Norfolk and Denver, respectively), but Albany received 19 percent less services funding from SHP in 2007 as it did in 2001, and Pittsburgh received less than half the services funding in 2007 as it did in 2001. In the case of Pittsburgh, this change appears to be linked to the very low proportion of its SHP funds that were going to housing in 2001, and the very dramatic shift that occurred between that year and 2007—the largest shift of any study community, from 32 to 75 percent (third panel of Exhibit 2).

Discussions with community leaders during site visits of how the change in HUD policy affected their decisions yielded the following (Chapter 8 provides more detail):

- Some communities sought and were able to find additional resources to support new services (for example, Denver) or to substitute for the lost services funding (for example, Pittsburgh, which was able to replace at least some behavioral funding through government and foundation support).

- Some communities could not find additional resources and have been forced either to cut back or to forgo needed new services.

- Some communities have not changed their allocation of SHP funds between housing and services. Some were already devoting a high proportion of their HUD request to housing (Norfolk, Albuquerque), some were willing to accept the risk of a reduction in funding in the Super Notice of Funding Availability (SuperNOFA) process, and some relabeled basic services such as housing stabilization as operations funding.

Thus the shift in HUD policy made little effective difference in some communities, while in others, a convergence of the HUD policy shift, perceived dependence on HUD funding, and local circumstances appears to have led to a perceptible increase in efforts to maximize mainstream benefit access.

Major Findings

Findings fall into four areas:

1. We identified three categories of barriers to access.

2. We identified three categories of mechanisms to reduce or eliminate barriers.

3. We gathered available information that shows the success of study communities in helping homeless people access benefits and services, and supplemented it with new findings from the SAMHSA Homeless Families study.

4. We explored the nature and activities of centralized organizational structures in study communities and the role they play in increasing homeless people's access to mainstream benefits and services.

Categorizing Barriers to Access

Once all barriers were listed and described, we were able to group them into three broad categories—structural, capacity, and eligibility.

Structural barriers come into play when benefits are available and a person is eligible for them, but various obstacles nevertheless prevent the person from getting the benefits. They may relate to where mainstream programs are located, how they are organized, or what they require of applicants. They include barriers posed by mainstream agency locations that are remote or inconvenient, and also by limited days and hours that offices are open; the sometimes negative atmosphere of the application office, the way staff treat applicants, stigma, and other environment matters; the complexity and length of benefit applications that pose significant cognitive demands; requirements for identification and documentation; the complexity of maintaining enrollment; staff knowledge of systems and processes, or lack of it; and the problems that arise when a person needs assistance from more than one agency (system interaction problems) (see Chapter 4 for more detail).

For structural barriers, the problem of access lies outside the program's basic eligibility rules and capacity, falling, rather, within the domain of its implementation and structure. Structural barriers afford perhaps the greatest opportunity for increasing access to mainstream benefits without the difficult tasks of changing eligibility criteria or increasing revenues. For these reasons, they are generally more politically palatable and have the potential for informal, timely solutions. Structural barriers, however, can also be the most pervasive, restrictive, and hidden barriers a community may face. Indeed, it is often hard to gain information on the extent of

these barriers because they inherently reduce contact and communication between a program and its potential clients. In every site visited, structural barriers represented both a significant frustration for delivering benefits and a primary target of mechanisms for increased access. They were the type of barrier most commonly addressed by local efforts to increase access.

Capacity barriers are those posed by the inadequacy of available resources to meet the need of all people who are eligible for a benefit or service. Funding is finite, or capped, and people get the benefit or service only as long as the money lasts. Mental health and substance abuse services and treatment are often funded in this way, as are rent subsidies, whether federal, state, or local. Alternatively, the benefit may not exist at all in some communities. For example, many communities and states do not offer General Assistance—welfare for poor single adults and families that do not qualify for TANF. Capacity barriers are much more difficult than structural barriers for communities to reduce, because doing so usually requires commitment of new resources. Nevertheless, most study communities managed to acquire new resources to expand capacity for at least one mainstream benefit or service (see Chapter 5 for more detail).

Eligibility barriers are those set by program rules that establish the criteria for who may receive the benefit and who may not. They include income level (must have well below poverty-level income to qualify for most benefit programs), household type (TANF is only for households with children), receipt of other benefits (Medicaid is only available to households that receive TANF or SSI, unless a state or locality has a supplemental program that is funded entirely with state dollars), age (being 65 or older qualifies a person for Medicare), disability (which must be of a certain severity and duration to qualify for SSI or SSDI), and criminal history (HUD denies housing subsidies to people with a drug-related felony conviction) (see Chapter 6 for more detail).

In addition, some benefits have time limits on receipt, either for one's lifetime (60 months for TANF) or for a single spell of benefit receipt. Some General Assistance programs limit receipt to six or nine months in a year. Food stamps limits receipt for people who are able bodied and without dependents to three months out of every three years unless they are working or involved in work-related activity—although the American Recovery and Reinvestment Act of 2009 has recently given states the option to waive these requirements for most people until October 1, 2010 and in areas of high unemployment even after that date.

Eligibility restrictions for the major benefits of food stamps, Medicaid, and SSI are embedded in federal policy. Such barriers are not easily influenced at the local level, so it is not surprising that we found very few examples of mechanisms for increasing access that succeeded in changing or expanding eligibility criteria, as evidenced by the limited number of relevant mechanisms observed in the study communities.

Categorizing Mechanisms to Overcome Barriers

As part of planning for site visits, we tentatively divided the types of activities that communities could use to overcome barriers into three categories—smoothing, changing, and expanding. **Smoothing mechanisms**, we thought, would be those that worked to reduce the structural barriers limiting homeless people's access to mainstream benefits, but that did not involve changes in eligibility or capacity. **Changing mechanisms** would be those that altered the eligibility of homeless people for a particular program without changing the overall capacity of the program. An example would be a health clinic that set aside particular days or hours to serve homeless people, or a rent subsidy program that established a priority for homeless households. **Expanding mechanisms** were expected to be those that added resources so more qualified people could get a benefit or service, or so that previously ineligible people could get the expanded service. In short, we expected we would see a one-to-one association of type of mechanism with type of barrier that needed to be eliminated.

Once we had the information collected during site visits, we revisited our classification of mechanisms. We found the categories to be largely appropriate. We also found, however, that one mechanism often addressed many barriers, and often for many benefits at once. For instance, a sophisticated outreach network with appropriate follow-up helps to overcome transportation issues, doubts about eligibility, friendliness and respect from caseworkers, application complexity, staff knowledge of multiple programs, and even system integration issues, while promoting access to most mainstream benefits. A single point of access intake center accomplishes many of the same things, although not transportation issues. In addition, we found that it was not always easy to draw the line between changing and expanding mechanisms, because something that changed eligibility for homeless people represented a true expansion of benefits available to them, even though it did not mean that the availability of the benefit had expanded overall. We had to refine the definitions of "changing" and "expanding" to specify that "expanding" had to involve an increase in the *overall* availability of a benefit or service, not just an increase for homeless people gained by giving homeless people priority for a benefit with the consequence that someone else would not get it. Chapters 4, 5, and 6 describe the many specific mechanisms that fall into each category.

Mechanisms Used by Study Communities to Increase Access to Mainstream Programs

Smoothing mechanisms address the problems of street level barriers to mainstream access directly, by making it easier for homeless people to know what they are eligible for and how to apply; and by improving the knowledge, skills, and interactions of homeless assistance case workers and intake workers in mainstream benefits offices. Thanks to these mechanisms, homeless people are more likely to get *to* a mainstream agency and to get *through* the application process successfully.

Smoothing mechanisms developed by study communities include providing transportation; doing outreach (including highly organized communitywide

collaborative outreach with follow-up); co-locating mainstream eligibility workers in homeless assistance programs; creating "one-stop" intake centers for homeless people where representatives of many mainstream agencies are present to offer help in applying for benefits; situating mainstream offices conveniently; providing "quick question" lines at benefit offices; providing telephone lines to services that can connect to translators for up to 40 languages; providing access to computers that let applicants fill in their own data; training homeless assistance caseworkers in mainstream application procedures, including SSI/SSDI Outreach, Access, and Recovery (SOAR) training; establishing good communications among homeless assistance workers and mainstream agency eligibility workers; and developing strategies for "pending" applications and "suspending" benefit receipt for people in institutions so their benefits will be available to them immediately upon discharge; among other strategies.

Changing mechanisms include modifications of restrictions on eligibility for housing subsidies for ex-offenders, and establishing "homeless priorities" for health care, mental health care, and housing subsidies.

Expanding mechanisms all involve the commitment of additional resources, which study communities did for health care, mental health care, substance abuse treatment, case work and other supportive services in permanent supportive housing, and housing itself, through raising funds from local sources and allocating Community Development Block Grant (CDBG) or Home Investment Partnership (HOME) funding to create housing opportunities for homeless households.

After identifying the various mechanisms that study communities use to overcome the array of barriers that restrict homeless people's access to mainstream benefits and services, we used this information to assess which programs were the most frequent targets of local efforts. Exhibit 3 shows what communities are doing about *each* benefit, as well as what mechanisms they use, making it possible to see which benefits are subject to widespread efforts to improve access and which ones are less likely to be included. Exhibit 3 also provides a quick overview of the type of mechanism (smoothing, changing, or expanding) that study communities are most likely to use to improve access (second column), and the issues that arise for particular benefits and services as communities try to put effective mechanisms in place (third column).

We divide the mainstream programs into entitlements and other programs. Entitlements, shown in the top panel of Exhibit 3, are "guaranteed," in the sense that if one meets the eligibility criteria the program is required to provide the benefit, regardless of how many people are eligible or how much it costs. With the exception of General Assistance, the entitlement programs examined in this study are all federal, including food stamps, Medicaid, Medicare, General Assistance, and disability benefits and pensions for veterans. Other benefits and services, shown in the second panel of Exhibit 3, are not entitlements. They operate with fixed budgets and usually do not have enough resources to serve all eligible people.

One can see in Exhibit 3 that most study communities have created at least some access mechanisms for the major federal entitlement programs, and those that have General Assistance also work to improve access to that benefit. One can also see that smoothing mechanisms are by far the most common type, with no community succeeding in changing eligibility criteria for these programs, and only two communities achieving some program expansion using state or local resources.

With respect to services that are not entitlements, including TANF, smoothing mechanisms are still the most common approach. But at least one study community, and often more, has been able to *change eligibility* and/or *expand capacity* for each type except TANF and health and behavioral health care specifically for veterans. These expansions represent significant new commitments of local resources, along with occasional use of state resources. The more organized the study community and the stronger its central organizing structure, the more likely it is to have been able to expand capacity for at least one nonentitlement service.

Documenting Improvements in Homeless People's Receipt of Benefits

Evidence in study communities regarding connections to mainstream services and benefits is generally incomplete, with the best information coming from the Annual Performance Reports that programs receiving HUD funding must file. This information describes receipt of income from mainstream benefits at program entry and program exit for people leaving transitional and permanent supportive housing programs. Four study communities (Miami, Norfolk, Pittsburgh, and Portland) were able to supply these APR data, for 2007. The Office of Special Needs Assistance Programs, which manages the SHP, provided us with data reflecting national averages for similar programs for 2007. We compare the data from study communities to these national averages to assess whether the communities' activities designed to improve access lead to higher than national average receipt of public benefits by homeless people (Chapter 2 provides details).

We found evidence that people exiting HUD-funded programs in the four study communities were likely to be connected to income sources (SSI/SSDI, TANF, General Assistance, food stamps, and employment) at rates for 2007 that exceed national rates for that year for people leaving similar programs. Among these benefits, the highest rates of enrollment were for food stamps—40 percent or more in three communities, compared to the national average of 25 percent for people leaving similar programs. The four study communities reported very different rates of SSI and SSDI receipt. Two communities reported 16 and 19 percent receiving SSI compared to the national average of 11 percent, but two others were somewhat lower than the national average. One community reported that 11 percent of program leavers were receiving SSDI, compared to the national average of 5 percent; the remaining communities reported SSDI rates only slightly higher than the national average or, in one instance, somewhat below the average. General Assistance is not available in two communities, but in the two that have General

Exhibit 3: Summary of Findings Related to Specific Benefits and Services

Benefit or Service	Smoothing, Changing, or Expanding Mechanisms in Study Communities	Issues
Entitlements (no cap on how many people can receive if eligible)		
Food stamps	SMOOTHING—**Denver, Miami, Portland, Norfolk, Albany, Pittsburgh** (through simplified applications, waiver of face-to-face interview requirements, expedited access, outreach, outstationing, "pending" applications, and suspending rather than terminating benefits during institutional stays)	Cannot change eligibility; set at federal level. Can smooth application procedures and facilitate acquisition of needed documentation. Recent federal policy is pushing streamlined procedures that increase access
Medicaid	SMOOTHING—**Miami** (children, through Temporary Assistance for Needy Families [TANF] office, mentally ill offenders through Supplemental Security Income/Social Security Disability Income [SSI/SSDI] Outreach, Access, and, and Recovery [SOAR]); **Portland** (specialized SSI staff, consolidated application); **Denver** (consolidated application, outreach, benefit suspension for institutionalized persons); **Norfolk** (Homeless Action Response Team); **Albany** (outreach at hospitals); **Pittsburgh** (consolidated application, rapid enrollment in medical assistance managed care program) EXPANDING—**Portland** (MaineCare noncategorical eligibility); **Albany** (all General Assistance [GA] recipients eligible for state-funded Medicaid)	Cannot change eligibility for basic program; set at federal level. Can smooth application procedures and acquisition of needed documentation. Some states set up additional eligibility categories and pay for coverage entirely with state dollars. Among study communities, Maine and New York do this.
Medicare	No study community specifically mentioned trying to improve access to Medicare, but SOAR and other mechanisms to improve SSI access do the same for SSDI if it is relevant, so these mechanisms will also increase access to Medicare for anyone eligible for SSDI.	Depends on eligibility for SSDI, which most homeless people will not have the employment history to qualify for, or on age (65 and older).
SSI/SSDI	SMOOTHING—**Denver, Miami, Portland, Norfolk, Albany, Pittsburgh** (through SOAR or specialized staff in public or homeless agencies, including significant cooperation that has been developed with local Social Security Administration offices)	Issues same as Medicaid. SOAR and other mechanisms make a big difference for speed and success of SSI applications.
General Assistance	SMOOTHING—**Portland, Pittsburgh** EXPANDING—**Denver** (increased motel vouchers using General Assistance funds)	Many states do not have General Assistance; for those that do, eligibility thresholds and benefit levels are very low.
Veterans' disability benefits	SMOOTHING—**Denver, Miami, Portland, Norfolk, Albany, Pittsburgh**	Need honorable or general discharge, length of service, documentation is an issue, vets of older wars losing priority to newer vets.
Veterans' pension	SMOOTHING—**Denver, Miami, Portland, Norfolk, Albany, Pittsburgh**	

Exhibit 3: Summary of Findings Related to Specific Benefits and Services

Benefit or Service	Smoothing, Changing, or Expanding Mechanisms in Study Communities	Issues
Other Benefits and Services (resources usually not sufficient to serve all eligible people)		
TANF	SMOOTHING—**Portland, Denver, Norfolk, Pittsburgh** (consolidated applications, language lines, computerized search for documentation)	Eligibility, length of receipt, requirements for participation, and sanctioning policy are set at state level, with little local flexibility to modify.
Health care	SMOOTHING—**All** (Health Care for the Homeless [HCH]), **Miami** (post-shelter linkage); **Denver** (priority at clinic, mobile unit); **Pittsburgh** and **Albuquerque** (co-location) EXPANDING—**Miami** (Homeless Trust purchase of health services), **Portland** (MaineCare for noncategoricals); **Denver** (new medical respite program)	State or local jurisdictions must commit resources; of study communities, only Portland (Maine) has expanded Medicaid eligibility through state-only funding.
Mental health services other than through Medicaid	SMOOTHING--**Miami** (purchase of services); **Norfolk** (Projects for Assistance in Transition from Homelessness [PATH] and Assertive Community Treatment [ACT] teams); **Albany** (single point of access, co-location); **Pittsburgh** (case management, provider coordination, co-location); **Albuquerque** (co-location) EXPANDING—**Miami** (Homeless Trust purchase of services, state and federal grants, county funds); **Denver** (new ACT team); **Pittsburgh** (new funds for behavioral health managed care entity)	Funding falls extremely short of need in all study communities.
Substance abuse treatment other than through Medicaid	SMOOTHING--**Denver** (PATH, Benefit Acquisition and Retention, and Homeless Outreach teams); **Albany** (single point of access); **Pittsburgh** (provider coordination) EXPANDING—**Portland** (HCH expansion, provider specialization); **Albuquerque** (new city funding for Sobering Center/single point of entry for substance abuse services)	Funding falls extremely short of need in all study communities.
Federal rent subsidies or public housing	SMOOTHING—**Portland, Denver, Norfolk** CHANGING—**Pittsburgh** (changed Moving to Work felony rehabilitation clause systemwide); **Albuquerque** (adjusted felony rules for one program's clients)	Far too few subsidies, waiting lists are extensive or closed, not all give priority to homeless households.
State/local rent subsidies	EXPANDING—**Miami** (for ex-offenders with mental illness); **Denver** (Road Home funds); **Portland** (access to state subsidies); **Albany** (two local housing trusts); **Pittsburgh** (Local Housing Options Team); **Albuquerque** (city funds to support housing first program)	Shows strong local commitment, but still too few.
Use of Community Development Block Grant	CHANGING/EXPANDING—**Denver, Norfolk, Pittsburgh**, **Portland** (similar resources from state housing authority/housing finance agency)	Rare nationally, so having four out of seven study communities allocating

Exhibit 3: Summary of Findings Related to Specific Benefits and Services

Benefit or Service	Smoothing, Changing, or Expanding Mechanisms in Study Communities	Issues
and Home Investment Partnership for homeless-related housing		resources from these U.S. Department of Housing and Urban Development block grants to homeless-related residential programs reflects the consequences of high-level executive leadership on ending homelessness.
Employment and training	SMOOTHING—**Denver, Norfolk** CHANGING--**Albuquerque** (Vocational Rehabilitation resources for women with criminal histories) EXPANDING—**Pittsburgh** (Homeless Children's Education Fund)	Federal performance standards may discourage some One-Stops from serving people with disabilities; pressure for people to be work-ready.
U.S. Department of Veterans Affairs (VA) health/ behavioral health care	SMOOTHING—**Denver, Miami, Portland, Norfolk, Albany, Pittsburgh**	Same as for VA cash benefits.

Assistance, participation rates at program exit were 19 and 22 percent compared to the national average of 6 percent. TANF receipt ranges from 1 to 23 percent in the four study communities with data, compared to the national average of 8 percent.

The higher rates of enrollment in food stamps reflect the reality that basic eligibility is broadest for food stamps, and also the fact that many barriers to access have been reduced through structural mechanisms (for example, outreach, waiver of face-to-face meetings) described in Chapter 4. Variation in access to SSI/SSDI reflects the high barriers to access that are more likely to have been addressed, at least in part, by whether communities have trained staff in the SOAR model. We may speculate that variations in rates of access to TANF may reflect the extent to which communities have adopted mechanisms (for example, outreach) to overcome the barriers to this program, but they are equally likely to reflect the differential restrictiveness of TANF eligibility and application rules set by states. Across all programs, smaller communities, Norfolk and Portland, have much higher participation rates than the larger communities, Miami and Pittsburgh.

Rates of enrollment in Medicaid in the four study communities do not differ from national rates for people in similar programs. Within the four study communities these also vary widely, ranging from 4 to 24 percent at exit from HUD programs. Again, Norfolk and Portland have the higher rates. No data are available on rates of enrollment in services such as primary health, mental health, or addictions care, or in life skills development or employment supports.

Data from the SAMHSA Homeless Families study, reviewed in Chapter 7, indicate generally high rates of participation for study families in Medicaid and food stamps (consistently above 70 percent) and TANF (between 44 and 63 percent), with much lower participation in other programs.[2] Patterns of participation for all three of these welfare programs, plus mental health and substance abuse services, were highest at the 3-month follow-up and then dropped off by 15 months after baseline, suggesting the influence of program help to get benefits that operated during the initial months after first program contact. Additional influences on later participation rates may include loss of eligibility (for example, for TANF, families may have exhausted their months of eligibility), new episodes of homelessness that resulted in benefit termination, and stabilizing to the point of not needing benefits any more. Some benefits that take longer to access showed a different pattern, however, increasing steadily over the course of the study. These included SSI and SSDI and housing and child care subsidies, all of which probably required assistance from case managers to access, but which have extended periods of application processing or wait listing. The only program characteristic that made a

[2] These enrollment rates for SAMHSA Homeless Families participants are substantially higher than the rates for the same programs reported by the communities in the present study. Reasons include the fact that all SAMHSA participants were family households, and thus likely to be eligible for TANF; that enrollment in food stamps and Medicaid is usually done at the same time as TANF intake; and that average monthly TANF caseloads were 25 percent higher in 2000, when recruitment for the Homeless Families study was occurring, than in 2007.

difference to the probability of benefit receipt was case load size, with smaller case loads generally resulting in clients being more likely to receive benefits.

Understanding the Role of Central Organizing Structures

An important reason for selecting the communities included in this study was that each has developed a 10 Year Plan (10YP) to end homelessness (one has a 5 Year Plan) and has some type of communitywide organizing structure with the responsibility to carry it out. Increasing access to mainstream benefits is part of all these plans. As has been found in previous HUD studies, of community efforts to end chronic homelessness (Burt et al. 2004) and prevent homelessness (Burt et al. 2006), a strong central organizing structure focused on a particular goal, which in the case of the present study is increasing access, is key to achieving communitywide, systemwide effects. We consider the structures working to end homelessness to be potentially the most important "mechanism" in study communities for increasing homeless people's access to benefits, if the community chooses to use them for this purpose. These structures have the capacity to identify barriers to access and may choose to generate ways to reduce these barriers if they consider doing so a priority.

Study communities differ considerably, however, in the scope and authority of their organizing structure, the extent to which it has taken on this challenge, and the resources it has at its disposal for increasing access. For the reader to fully appreciate the mechanisms that communities have developed to overcome structural, capacity, and eligibility barriers, it is essential to understand the role of community organizing structures and how specific mechanisms fit into the overall picture of the ways these seven communities address the homelessness in their midst.

Five study communities have strong central organizing structures that identify gaps and take steps to fill them, including gaps in homeless people's access to mainstream benefits and services. Two have strong mayoral support (Denver and Norfolk), one has an independent funding stream (Miami-Dade County), another (Denver) does major fundraising from the private community, two have been their community's primary focus of planning and action to end homelessness for more than 15 years (Miami and Portland), and three benefit from major involvement of the public agency that controls core public benefits (Denver, Norfolk, and Portland). Albany has a working alliance among its homeless coalition and two county government agencies that has generated significantly more access mechanisms than neighboring counties, despite the absence of the types of political support found in Denver and Norfolk. Finally, Albuquerque does not have the benefit of a strong central structure, but provider efforts over the years have gone some way toward improving access to mainstream services for their own clients through various arrangements with public agencies.

Brief examples will demonstrate the ways that central organizing structures have applied themselves to the challenge of increasing homeless people's access to benefits by orchestrating multiple, coordinated, communitywide activities designed to reach that end (Chapter 3 provides more detail on these examples, plus others from all study communities):

- Denver's Road Home began in 2005. It is housed in the Denver mayor's office and is charged with implementing Denver's 10YP. It has raised substantial resources to fully fund the plan. Helping homeless people with disabilities to move into housing is central to the plan, so substantial resources have gone into creating permanent supportive housing units. To get the right people into those units, Denver's Road Home realized it would have to connect with long-time homeless people and help them get benefits that would make it possible for them to support themselves in housing. Denver's Road Home therefore set out to organize all the existing outreach programs in town. It did so, expanding some along the way. It pays for 20 outreach workers including two in the police department. It pays for a coordinator and for a dispatcher, who provides a central contact point for members of the public who are seeking help for a homeless person. It facilitates relations of the outreach teams with mainstream agencies. Some of the results, over the plan's first three years, include helping at least 2,000 people to access public benefits and treatment services, as well as creating over 1,200 units of permanent supportive housing. Chronic homelessness was down 36 percent in Denver's Road Home's first three years.

- The Homeless Trust (HT) is Miami-Dade County's organizing structure. The HT came into being in 1993, at the same time that the county began taxing itself to provide resources to address homelessness through a tax on food and beverages served in many restaurants and bars. The HT manages the resources generated by that tax as well as all other public resources devoted to addressing homelessness. The HT created two Homeless Assistance Centers that provide many direct services (for example, health care) as well as connections to most mainstream benefits through co-location of mainstream agency staff. The HT also funds three outreach teams that coordinate to cover the whole county and to help connect people to benefits and services. After identifying lack of documentation as a major issue in homeless people's inability to obtain benefits, it decided to fund a document retrieval service for driver's licenses, birth certificates, and other documentation. A major, multi-year project to divert homeless people with mental illness from being arrested and jailed, and provide them with housing and appropriate services, is also orchestrated through the HT.

- Portland's Emergency Services Assessment Committee (ESAC) has been that community's central organizing structure since the mid-1980s. When faced with the need to shift HUD resources from services to housing, ESAC took steps to see that people connected to mainstream benefits to replace the lost services funding. It set up trainings in which all major benefits agencies teach caseworkers in homeless service agencies about the benefits they offer and how to apply. Mainstream benefits workers at many Portland agencies say that since the trainings began, the applications they receive are more accurate and more complete, with fewer applications from clearly ineligible people. ESAC also began pushing homeless assistance providers to increase the proportion of their clients who receive benefits, and monitor performance as part of the process of

ranking proposals for continuation funding through the Continuum of Care process.

Effective community organizing structures in study communities take the multi-year view of improving mainstream access. They set goals, identify gaps in existing service offerings or approaches that would get in the way of meeting goals, develop strategies to fill gaps and meet goals, assess their progress, and alter course if needed. Most have deliberately set out to increase the proportion of homeless people in their community who receive mainstream benefits, recognizing that gaining access often is not easy for homeless people, and setting up mechanisms to facilitate not just access but approved applications and continued benefit receipt. Their experience and sometimes formal documentation tells them that many more homeless people are probably eligible for an array of benefits than are currently receiving them, so their goal is "more." To assemble the resources to put facilitating mechanisms in place and to build community support, a number of them go to great lengths to explain their goals, strategies, and progress to their communities in the expectation that the communities will respond with both strategic and financial support.

A reasonable conclusion we can draw from site visit findings is that the more strongly organized communities are the ones that have: 1) thought through and put in place a range of mechanisms to improve access; 2) made sure those mechanisms covered the whole community; 3) made more of an impact on how mainstream agencies do business; and 4) significantly increased the degree of coordination and collaboration among homeless assistance providers, among mainstream agencies, and between the two groups. A single case worker in one homeless assistance program can develop a good relationship with a single intake worker in one mainstream benefit agency—this happens all the time, in most communities around the country. But these relationships die when staff change, and do not create any *systematic* change that will survive when personnel change. To get that level of change, at the system level, requires the intimate involvement of the type of centralized organizing structure at work in most study communities.

Implications

Ending homelessness will not occur without housing opportunities for individuals and families who are now homeless. However, often housing alone is not sufficient. There must also be supports, particularly mainstream benefits and services. Without these supports, some individuals and families will not move successfully into permanent housing, nor will they be able to retain that housing. While HUD's primary mission as an agency is to assure access to housing, it has also recognized a need to assure availability of supportive services. Those supports are more likely to be available under the following conditions:

- First, whether or not a community has a 10YP, it will need an organizational structure for addressing changes in the policies and practices of homeless assistance programs and public agencies so that access to benefits continues and improves. A community organizing structure that focuses primarily on deciding

how to allocate HUD funds, such as a narrowly focused Continuum of Care committee, does not usually address issues of access to mainstream benefits, let alone develop mechanisms appropriate to improving access. Community organizing structures that are more effective for this purpose will embody the following characteristics: they take a perspective covering many years; they set goals that are broadly accepted by the larger community, but work to bring the larger community along toward the goals that will end homelessness; they identify unmet needs; they apply creativity and perseverance to the task of evolving strategies to fill gaps in existing service offerings or approaches; they tend to have strong political support; they assemble information about what works and what does not work and apply that knowledge to improve things; and they pay serious attention to building, maintaining, and expanding community support for their efforts.

- Second, communities should look for mechanisms to improve access that show some evidence of effectiveness in other communities. This report has described many mechanisms that demonstrate the creativity and commitment of communities to ending homelessness. There is no shortage of appropriate ideas.

- Third, communities should make far greater efforts to assure that the promise of the Homeless Management Information System (HMIS) is fulfilled. In the seven study communities, HMIS do not appear to be structured in ways that give coordinators and program managers essential information in a timely manner. Although they nominally cover emergency shelter programs, they do not require enough information to document service receipt at first contact with the homeless assistance system, nor do they record what happens thereafter. As a result, communities have no way to systematically determine how well they are doing with respect to assuring access to mainstream benefits and services and where there are gaps that need to be addressed.

Over the past decade, to assure the availability of resources to create new permanent supportive housing, HUD has promoted a policy in which it encourages communities to reduce their allocation of HUD funds to services in favor of expanding their use to develop housing and provide operating funds for new and existing units. This has left some study communities relatively unaffected, but for others it has created difficult choices with respect to funding existing service commitments or needs for new services. Given legislative directives and its own departmental priorities, HUD is not at present free to return to a policy that offers greater flexibility. Rather than continue with the current situation, in which the U.S. Department of Health and Human Services (HHS) has continued to grapple with mechanisms to assure access to its benefits and services for homeless people, it might be better for Congress to augment the resources of the McKinney-Vento Act to support certain well-defined core services. These funds could be administered by HHS with the explicit directive that they be offered to communities in an integrated manner through HUD's current Continuum of Care application process, or given to HUD to integrate into that application process for its transitional and permanent supportive housing grants. Either arrangement would greatly simplify the lives of

homeless service providers as well as greatly benefit homeless individuals and families. The trade-off for communities would be that they would be expected to adopt both an organizational structure and new mechanisms that assure greater access to mainstream benefits and services, as well as the capacity through HMIS to effectively evaluate their efforts. HUD could provide incentives to communities to plan the introduction of such mechanisms and fund structures and services that support this direction.

CHAPTER 1: INTRODUCTION

Homelessness continues to have an enduring presence in American society. Despite more than two decades of federal effort, statewide planning, and local initiatives, an estimated 1.6 million unaccompanied individuals and persons in family households use homeless shelters or transitional housing in one year (*2007 Annual Homeless Assessment Report*, U.S. Department of Housing and Urban Development [HUD] 2008).

On one night at the end of January 2007, communities throughout the United States counted about 672,000 homeless people, of whom about 58 percent were sheltered and 42 percent unsheltered. Sixty-three percent were individuals and 37 percent were persons in families. About 18 percent of the total point-in-time homeless population met the U.S. Department of Housing and Urban Development definition of chronic homelessness (HUD 2008).

The structural issues that underlie the persistence of homelessness, as well as the heterogeneity of the homeless population, defy simple solutions. Poverty, an ever-increasing squeeze on the availability of housing affordable to very low-income people, low-wage jobs, inadequate primary and behavioral health care, and drastically reduced state mental health systems are just a few of the underlying economic and social factors that, singly and in combination, contribute to homelessness in America.

The demographic characteristics of homeless people vary widely. The largest group, 67 percent, consists of single adults (the majority of them men), including those who have physical disabilities, psychiatric disabilities, substance abuse problems, and/or are veterans (Burt, Aron, and Lee, 2001;Burt et al. 1999). Families, defined as one or more adults and at least one dependent child, make up about 37 percent of the homeless population at any one point in time; 23 percent are children and 11 percent adults (Burt et al. 1999). This is consistent with more recent data from the 2007 point-in-time count, also showing that 37 percent of the homeless population was persons in families, of whom 38 percent are adults and 62 percent are children (HUD 2008). Unaccompanied or runaway youth (who are often trauma survivors and/or gay/lesbian/bisexual/transgendered), as well as young adults aging out of foster care, also contribute to the homeless population, are not included in the National Survey of Homeless Assistance Provider and Clients or Annual Homeless Assessment Report estimates, and have proved notoriously difficult to enumerate.

Differences are also seen in the length of time and patterns of homelessness that people experience, ranging from those who have one brief, often situational, episode; others who cycle through multiple periods of homelessness; and those with long-term, sustained histories of homelessness (HUD 2007). The literature shows that, based on factors including demographic characteristics, histories of chronic health conditions, psychiatric disabilities, substance use disorders, and other physical disabilities, and the nature and extent of their history of homelessness, the type, extent, and duration of service needs of different groups of homeless people varies widely. A family that experiences a brief

episode of homelessness following the loss of a job will require a different set of services to regain housing stability than will a single adult with a history of substance abuse and psychiatric disability who has been homeless for several years.

In attempting to address some of the fundamental causes of homelessness, as well as the wide-ranging needs for housing and services for those who are homeless, the federal government has responded by funding a range of programs through a number of agencies. This has resulted in a fragmented service system that is often difficult for states, municipalities, service providers, and individuals in need to navigate (Government Accountability Office [GAO] 1999a; GAO 2002; U.S. Department of Health and Human Services [HHS] 2007a). Changes in HUD policy over the past decade have resulted in more of its McKinney-Vento funding being targeted to the housing component of supportive housing (capital, rent subsidy, other operations expenses), with an emphasis on permanent, rather than transitional housing programs. Fewer HUD dollars are being spent on the supportive services attached to these programs, services that help people move from homelessness and keep them housed.

These policy shifts began during a period when the emphasis across federal agencies was on encouraging coordination among systems and integrating mainstream services to better meet the needs of people who are homeless, in the belief that the efficiencies realized would expand access to basic services and supports as well as strengthen the social safety net. In more recent years, the focus in federal policy and practice has shifted from working to manage homelessness toward preventing and ending homelessness (U.S. Department of Health and Human Services 2003). These policy shifts increase the urgency of ensuring that all available funding is used efficiently, effectively, and in a coordinated manner to meet the multiple service needs of people who are homeless, have recently exited homelessness, or are at risk of becoming homeless.

Existing Research: Access to Mainstream Services and Benefits for Homeless Populations

In gradually shifting its funding priorities away from supportive services and toward the housing components of supportive housing programs, HUD acted on the assumption that existing federal and state human service and entitlement programs for those in poverty could, and rightly should, be accessible to homeless people to meet many of their needs. As reports from government agencies (Government Accountability Office, 1999a; U.S. Department of Health and Human Services, 2003; U.S. Department of Health and Human Services, 2007a) and private foundations (Charles and Helen Schwab Foundation, 2003) illustrate, the amount of federal funding available within mainstream programs dwarfs the resources committed to targeted homeless services. The array of existing mainstream benefits and services has been categorized and enumerated in different ways by researchers, federal agencies, and other interested parties. The Government Accountability Office (GAO, 1999a) defined the term as "publicly funded programs that provide housing, food, health care, transportation, and job training designed to help low-income individuals achieve or retain their economic independence and self-sufficiency." The Schwab Foundation's report, *Holes in the Safety Net: Mainstream Systems and*

Homelessness (2003), described mainstream services as "publicly-funded programs that provide services, housing and income supports to poor persons whether they are homeless or not. They include programs providing welfare, health care, mental health care, substance abuse treatment, and veterans' assistance."

What Programs Exist to Meet Basic Needs?

While the definitions offered in the literature vary, it seems reasonable to state that mainstream benefits and services consist of a wide variety of publicly funded services, programs, and entitlements for low-income people that address basic needs, including, but not limited to, income and employment, housing, food and nutrition, health and behavioral health services, child welfare, and transportation. The Substance Abuse and Mental Health Administration (SAMHSA) of the U.S. Department of Health and Human Services (2003) provides examples of mainstream services and benefits, including income support programs such as Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI); supplemental food programs such as food stamps and Women, Infants, and Children; health insurance programs such as Medicaid, Medicare, and any state and local equivalents; health services such as Community Health Centers, Federally Qualified Health Centers, county hospitals and clinics; public mental health and substance abuse services; Workforce Investment Act programs that provide supports for employment; and housing subsidy programs such as public housing, Housing Choice Vouchers (formerly, Section 8 vouchers), and their state and local equivalents where these exist.

In reports responding to congressional inquiries about the ability of homeless people to access mainstream federal programs, the GAO (1999a; 2000) identified 50 programs administered by 8 federal agencies that could provide assistance to homeless individuals and families. Of these programs, 16 are targeted specifically to homeless people, although eligibility for some programs is limited to specific subgroups such as veterans or children. The remaining 34 federal programs include those available generally to low-income people, as well as some designed for groups with special needs, such as people with disabilities or people with HIV/AIDS. The GAO (1999a) stated that "while this broader group may include homeless people, information on the number served is generally not available."

To What Extent Do Homeless People Access Mainstream Services?

Because eligibility for mainstream benefits and services is determined by factors other than homelessness (such as income, age, or disability status), few mainstream programs are required to collect information about the housing status of enrollees either at intake or on an ongoing basis. This, as the GAO report just cited implies, makes it difficult, if not impossible, to get accurate national data about the extent to which homeless families and individuals receive mainstream services. Up-to-date national comprehensive information is not readily available, but the 1996 National Survey of Homeless Assistance Providers and Clients revealed that about half of homeless families received Aid to Families with Dependent Children (AFDC, the precursor of TANF) and about 11 percent of all homeless adults received SSI. There are also local and regional studies of homelessness

(for example, Burt 2007; Hill and Kauff, 2001; Meschede et al. 2004) that report receipt of some benefits; studies focused on access to a particular mainstream benefit (for example, Burt and Anderson, 2006; Eiken and Galantowicz, 2004; Post 2001; Rosen, Hoey, and Steed, 2001); a report specifically focused on identified problems with homeless access to mainstream services (Charles and Helen Schwab Foundation 2003); and existing federal data sources (for example, HHS 2007a; HUD 2007), suggesting that homeless people tend to receive mainstream benefits at rates lower than do other people in poverty.

What Factors Impede Access?

As Burt and colleagues' 2002 evaluation of HUD's Continuum of Care (CoC) approach points out, the obstacles homeless people may encounter in trying to access mainstream services include often unspoken attitudinal barriers, logistical problems, and lack of sufficient funding: "Mainstream services often prefer not to serve homeless clients, often are not readily accessible to homeless people, and usually do not have enough resources to serve their non-homeless target populations." Wireman (2007), a formerly homeless man now working as a mental health services administrator, describes barriers such as the rudeness, disrespect, even disdain, that homeless people often face from mainstream service providers. Persons who are homeless face the same barriers to access for both benefits and services as do other low-income people, with one significant exception. Where services (for example, health, behavioral health) are involved, lack of capacity too often places an upper limit on the numbers of persons who can be served in a community. Agencies often opt to serve those who are easiest for their staff to understand and work with—a reality that frequently puts homeless people at the end of the line. Wireman concludes with his belief that, in principle, benefits must be made available to everyone who meets the eligibility criteria.

The report *Holes in the Safety Net* (Charles and Helen Schwab Foundation, 2003) found that some barriers to access individuals face may be inherent in the condition of homelessness. For example, difficulty completing applications because of lack of identification and other documentation; lack of a telephone and mailing address; lack of transportation; higher likelihood of poor health, physical or psychiatric disability, substance abuse problems, or criminal history; competing priorities such as obtaining food and other basic necessities; and a lack of social support. In a study describing barriers to public services encountered by people with psychiatric disabilities, the Bazelon Center (1995) identified obstacles that could easily affect homeless people with or without disabilities, including negative reactions from staff; ignorance of the existence or location of services; difficulty sitting for long periods in waiting rooms or difficulty keeping appointments; and a lack of assistance in completing confusing, complicated application forms. Returning veterans, newly released jail and prison inmates, and people recently discharged from psychiatric facilities, substance abuse treatment facilities, and other institutions face particular obstacles in getting access to housing and mainstream services. For example, individuals with past felony offenses are denied access to certain federal sources of housing subsidies, and people are too frequently discharged from psychiatric facilities without access to permanent housing.

The Schwab Foundation report (2003) and other studies (for example, Burt 2007; Burt and Anderson, 2006; Meschede et al. 2004) identify a number of formidable systemic obstructions at the federal level, including the fragmentation of mainstream services funded and delivered by separate agencies that may rarely communicate. The GAO (1999a, 2000) charts and describes the confusing array of the 50 often similar-sounding federal programs that could serve homeless people. The disparate eligibility requirements and service parameters would be difficult for even an experienced service provider to navigate, let alone a person who is homeless with few resources. The lack of mandated data collection on the housing status of mainstream service clients, as well as the challenges many localities face in implementing HUD's Homeless Management Information System (HMIS), are also cited as barriers to reducing fragmentation and identifying shared clients (HHS 2007a).

Program fragmentation negatively affects service access at the community level because of the lack of standardized application forms, processes, documentation requirements, and time frames for receiving services, as well as the need for applicants to travel to multiple locations. Service delivery can also be hindered, as homeless clients are shuttled among multiple agencies that attempt to deal with each of their issues or problems in isolation. Other identified barriers include mainstream providers' perception of inadequate resources, a lack of experience working with homeless persons, few incentives for mainstream programs to serve people who are homeless, and a lack of accountability, illustrated by the fact that few mainstream programs are required to report their clients' housing status. In addition, homeless service providers, who could potentially facilitate access, may be unfamiliar with the range of services potentially available to their clients, or with the often confusing eligibility requirements and application processes required to access mainstream benefits. For families in particular, the potential involvement of multiple systems in meeting their own needs and those of their children (for example, schools, health and behavioral health, child welfare, social services) often requires coordination and integration that do not exist among the systems in many communities.

Mechanisms and Strategies to Facilitate Access

In 1999, the GAO identified a number of steps that federal agencies had taken to address the systemic obstacles to homeless people's access to mainstream benefits. In 2001, the HHS and HUD secretaries began an interagency collaboration to make HHS-funded mainstream services more easily available to homeless people in HUD housing. This led to enhanced cooperation among HUD, HHS, and the U.S. Department of Veterans Affairs (VA) to tackle issues of chronic homelessness, and ultimately to 21 demonstration projects whose main goal was to develop integrated housing and services at the local level. Five additional demonstration projects supported by coordinated funding from HUD, HHS, and the U.S. Department of Labor (DOL) sought to integrate employment services and supports into the mix.

In 2002, the long-dormant U.S. Interagency Council on Homelessness (USICH) was reactivated and charged with coordinating the federal response to homelessness across 20 departments and agencies. USICH also works to create partnerships at every level of

government and with the private sector, with the goal of reducing and ending chronic homelessness across the country, a goal endorsed by then-President George W. Bush in 2003.

In 2003, an HHS workgroup released an ambitious plan, *Ending Chronic Homelessness: Strategies for Action*, which proposed a number of strategies to improve access to mainstream benefits, including strengthening outreach and engagement activities, simplifying application procedures, improving the eligibility review process, increasing the flexibility of funding streams, and developing incentives for mainstream providers to serve people who are homeless. Among the activities aimed at increasing access to mainstream services that grew from this plan was FirstStep, a computer-assisted tool for case managers and outreach workers to streamline access to mainstream benefits for homeless clients (http://www.cms.hhs.gov/apps/firststep/index.html), created through the collaborative efforts of several federal agencies.

In addition, between 2001 and 2007, 56 states and territories participated in Homeless Policy Academies, initiatives designed by a coalition of five federal agencies to help states promote collaboration, build partnerships, and expand service capacity through planning, education, and technical assistance (HHS 2007b). Evaluators of the Homeless Policy Academy Initiative (HHS 2007a) described innovative ways in which Policy Academy states used multi-agency collaboration to address the challenge of improving homeless people's access to mainstream benefits and services. Among the successful approaches identified were creating local housing trust funds; developing "one-stops" or "multi-service centers" where homeless people can easily access an array of services; implementing Housing First approaches; and using the SSI/Social Security Disability Income (SSDI) Outreach, Access, and Recovery (SOAR) process initiated in 2005 by SAMHSA of HHS to significantly increase the number of homeless people with psychiatric disabilities receiving SSI/SSDI. SOAR has shown positive initial results in substantially increasing the approval rate of applications for SSI/SSDI from homeless people, and in streamlining the application process and lowering the application response time for this group (Dennis et al. 2007).

In addition to the changes that federal agencies have been working on, since the early 2000s, states and localities have developed an assortment of their own strategies to address some of the barriers that limit homeless people's access to mainstream services. These efforts complement HUD's Continuum of Care approach, which was created in 1994 and implemented throughout the country in 1996 to promote local level coordination in the distribution of HUD's McKinney-Vento Act funds (Burt et al. 2002). Reports in the literature have documented initial positive outcomes from many of these promising initiatives, and have also shown how much work remains to be done if improved access to mainstream services is to become standard practice across the country (Burt and Anderson, 2006; Burt, Pearson, and Montgomery, 2007; Camasso et al. 2004; Dennis et al. 2007; Eiken and Galantowicz, 2004; HHS 2007a; HHS 2007b).

Assuring that Policy Changes Get to the Streets

Policy changes made at the federal level, such as those just described, do not automatically become "business as usual" in the thousands of communities where homeless people actually live and apply for benefits. In a seminal work, Lipsky (1980) argued that "policy implementation in the end comes down to the people who actually implement it." He coined the term "street level bureaucrats" to characterize police, firemen, teachers, and others who interact directly with the people who are receiving services. He pointed out that their interpretation of policy may determine whether individuals do or do not receive services to which they are entitled. He also identified various influences on their policy decisions, including the need to meet targets or to ration services. Lipsky's concept applies to the intake and assessment workers in the numerous bureaucracies upon whom homeless individuals and families must depend for access to benefits and services. Case workers in homeless assistance programs and the eligibility determination staff in public agencies offering mainstream benefits and services are "street level bureaucrats" in Lipsky's terms.

In the decades since Lipsky published, and for at least a decade earlier, evaluators and policy researchers have conducted hundreds of studies to determine the effects of one or another new federal or state policy. To truly determine the existence and nature of such effects, researchers knew they had to get down to the street level and examine how frontline workers—those who work with potential beneficiaries and service recipients face-to-face—interpret and use the policy change, including whether they have even heard of it. Studies of this nature have been conducted repeatedly with respect to most of the mainstream benefits and services pertinent to the present study, including AFDC/TANF, Medicaid, food stamps, Supplemental Security Income, mental health and addictions treatment and services, and employment services. Until the late 1990s, these studies did not focus specifically on access for homeless people, but the issues encountered were largely the same, with the exceptions noted above. Since homelessness became a national issue, some studies have included homeless-specific barriers in their inquiries. The truth emerging from all of these studies is also the same—if the street level people do not change their behaviors, and often their attitudes, policy changes made on high will not be translated into changes at the street level.

The same studies that examined implementation of federal and state policy changes also found many instances in which street level behaviors *did* change, and they documented the processes that facilitate those changes. Across many years and many different types of mainstream benefits, the processes for changing street level access were often similar. The present study adds the challenges associated with being homeless to the basic challenges of applying for and succeeding in qualifying for mainstream benefits. Lipsky pushes us to pay attention, not only to the policy as it is articulated in statute and regulation, but also to how it is interpreted and implemented by the staff of local offices who must make the everyday decisions about how best to conduct their program. Our approach focuses on mechanisms that facilitate access for homeless people.

Staff at every level of local agencies make policy-related decisions, often informally. To facilitate access for homeless people, frontline staff in homeless assistance programs and mainstream agencies may work together, without the explicit agreement of middle management and agency directors, to alter their behavior and their attitudes to smooth the path to benefit receipt. We found a lot of this type of informal smoothing activity in study communities, reducing previously existing barriers to benefit receipt that were common practice before people from different agencies started talking with each other. Street level behavior change may also come about as the result of explicit policy changes made locally by middle management or agency directors, or through implementing the plans made by communitywide groups intent on ending homelessness. For such changes to happen, the people making decisions at higher levels must take pains to assure that frontline workers understand the reasons for the changes, and have the tools and the supports to make the changes work.

For the present study, "street level" refers to the activities undertaken by frontline workers who interact directly with clients. Decisions and implementation activities of local managers and agency directors occupy a middle ground that, to be effective, has to make sure that the message and the means to implement changes successfully are understood and accepted by street level workers. National and state level policy changes are always transmitted and translated by these local actors; whether a policy made at the top has a chance of being implemented in accord with legislative or regulatory intent depends on those actors. This study sought to document how seven communities changed the nature of street level interactions with the goal of increasing homeless people's access to mainstream benefits and services.

Research Questions

Based on the existing research and the above observations about barriers to access, a number of questions regarding homeless people's access to mainstream services emerge. The major goals of this study are to address the following questions:

1. What kinds of mechanisms have been adopted by one or more communities to maximize homeless families' and individuals' access to mainstream benefits and services? Can we document approaches that smooth, expand, or change access to mainstream services?

2. What independent effect do local realities and practices of local homeless providers and mainstream benefit/services representatives have on homeless individuals' and families' access to mainstream benefits and services? Can we explain the variation in homeless people's access to mainstream services in the selected communities, considering both factors that are to some degree under the control of the community or program, and those that are not?

3. How has the shift in HUD McKinney-Vento Act policy toward increased funding for housing-related activities vs. services worked itself out in mainstream benefit/service access among homeless people at the local/street levels? Can we describe homeless people's current access to mainstream services in the selected

communities and how that differs from access to parallel services that were provided through HUD funding prior to the policy change?

The study goals were primarily addressed through qualitative inquiry—the systematic analysis of primary interviews with multiple key informants in each community. This inquiry was supplemented with analysis of existing quantitative data from the SAMHSA Homeless Families study and from local HMIS or other relevant databases.

Study Parameters

To address the research questions above, it is necessary to establish definitions of the key concepts that have informed our planning for this study. In this section we describe the populations, mainstream benefits and services, barriers to access, and mechanisms for overcoming them that are under study.

Populations

The populations under study are single homeless adults and homeless families. For both populations we sought to distinguish between access to mainstream benefits and services for those who also have disabilities and those who do not.

Mainstream Benefits and Services

When requesting information on benefit and service access, we organized our interviews primarily according to benefit provider, or to the office or agency receiving and processing applications for the benefit. This strategy is also reflected in the discussion of barriers and mechanisms in later chapters of this report.

- Benefits administered by the local social services office include General Assistance (GA), TANF, food stamps, Medicaid, and any local or state-funded health insurance.

- Social Security Administration benefits include SSI, SSDI, and Medicare.

- Department of Veterans Affairs benefits and services include disability benefits; pension; and health, mental health, and substance abuse care.

- Local mental health and substance abuse provider services include general mental health, substance abuse, and supportive services administered by state and local mental health authorities.

- Housing authority benefits include housing supported by Section 8, 202, and 811 funding, as well as public housing. Subsidies from other sources such as Community Development Block Grant (CDBG) and Home Investment Partnership (HOME) Program funding may come through public housing authorities or community and economic development departments.

- Workforce Investment Board services include employment and training.

- We also investigated access to primary care and dental services, HIV/AIDS-related services, and education; administration of these services varied considerably from community to community.

Exhibit 1.1 shows the specific mainstream benefits and services that homeless persons might need/get and that are the focus of the study. This includes all federal benefits. Services (for example, health, behavioral health care) are structured differently by the different states and are represented here as major classes. These are not exhaustive; for example, child care was not included.

Exhibit 1.1: Sources and Types of Benefits and Services Studied

Sources	Specific Benefits and Services
Welfare benefits	o General Assistance (if there is such a state or local program) o TANF o Food stamps o Medicaid o Any state/locally funded indigent health insurance o Child care
Social Security Office	o SSI o SSDI o Medicare
Veterans' Affairs	o Veterans' disability benefits o Veterans' pension o VA health, mental health, substance abuse, other types of care
Behavioral health care	o Mental health care and supportive services o Substance abuse treatment and supportive services o Trauma/Post Traumatic Stress Disorder counseling/treatment
Housing Authority, Housing and Community Development Agency, Other housing source	o Sections 8, 202, 811 o Public housing o Subsidies/housing from CDBG, HOME, other sources
Employment	o Employment and training
Other	o Health o HIV/AIDS o Education

Barriers

Based on findings from site visits, we identified three groups of barriers communities encounter, each of which contains a number of subclasses or categories.

- *Eligibility barriers* include challenges related to would-be recipients' approval for benefits and services that are otherwise accessible. Homeless people often encounter difficulty accessing services because they fail to meet criteria related to housing status, family size, criminal history, mental health and substance abuse diagnoses,

location/residency, insurance status, credit history, or other categorical requirements. Each of these difficulties constitutes a category of eligibility barriers.

- *Structural barriers* encompass the problems homeless people encounter when attempting to access benefits and services for which they are eligible, and that are theoretically available. Categories of barriers in this class include those related to transportation, discrimination and negative environments at application offices, demands of the application process, identification and documentation requirements, demands of maintaining enrollment, insufficient staff knowledge of the system and application process, and system interaction breakdown.

- Finally, *capacity barriers* are fundamental problems with the availability of benefits and services. These include delayed availability resulting from waiting lists and application processes, as well as lack of availability resulting from complete absence, insufficient supply, or insufficient value of benefits and services.

Mechanisms

Mechanisms are strategies used to reduce or eliminate the impact of barriers, thereby facilitating access to benefits and services. Mechanisms vary considerably in scope and impact. In some cases mechanisms are systemwide. In others, they are housed primarily within the community's organizing entity, or may be practices of one or more provider agencies. Some mechanisms may target barriers encountered by particular groups of homeless people, such as families with small children or single adults with histories of criminal justice involvement. Other mechanisms are designed to provide universal relief to barriers encountered by most homeless people seeking benefits and services.

Before going into the field, we developed a framework that contained three types of mechanisms, which we refined further as we gathered information from study communities:

- *Smoothing mechanisms* are intended to make it easier to apply or to promote application acceptance. For example, outreach is a smoothing mechanism because it is often used to facilitate engagement and initiate the application process with people who would have difficulty coming in to a benefits office. Smoothing mechanisms do not address eligibility policy or increase the supply of benefits and services.

- *Changing mechanisms* involve actual changes in policies or practices regarding eligibility for benefits and services. For example, some communities have developed mechanisms to allow people with histories of felonies access to public housing and subsidies, provided that they offer evidence of rehabilitation. This is a changing mechanism, in that standard eligibility policies preclude public housing access among people with these histories. Strategies that give priority in service or benefit receipt to homeless people are also changing mechanisms—they do not increase overall resources, but they do increase homeless people's access to what exists.

- While neither smoothing nor changing mechanisms address the overall availability of benefits, services and the resources to support them, *expanding mechanisms* do just that. This class of mechanisms increases the supply of supportive services and benefits available to homeless people, usually by increasing funding or securing new funding for services and benefits.

The classification system we employed to investigate mechanisms is different but not entirely independent from the system we applied to barriers. Eligibility barriers will most often be addressed by changing mechanisms, although in some cases smoothing and even expanding mechanisms may be applied to difficulties related to eligibility. Similarly, the majority of mechanisms intended to address structural barriers will fall in the smoothing class; capacity barriers are most readily addressed by expanding mechanisms, but may in some cases be addressed by changing mechanisms.

Study Components

The study included two main components:

1. Case studies of seven communities through a range of methods, including site visits, telephone interviews, and document reviews; and

2. Reanalysis of a multi-site longitudinal data base on homeless families.

Each of these components is briefly described below.

Community Case Studies

Seven U.S. communities (listed in Exhibit 1.2) were selected for case studies of their service systems, with a particular focus on strategies in place for facilitating the access of homeless individuals and/or families to one or more mainstream services. Communities were selected through a multi-step process. First, study team members nominated communities they believed had one or more access features based on first hand knowledge from prior studies or knowledge from the literature. The researchers considered communities of different sizes, and ones that would provide geographic spread. They purposely excluded communities that had been the central focus of other studies and for which information was available in study reports or notes. Second, to reduce the list of potential communities, they gathered descriptive information about each community through screening calls to individuals central to administering the system of services for persons who are homeless.

The most significant criterion for final selection was the presence of some interesting mechanisms to smooth, expand, or change homeless people's access to mainstream benefits and services. In addition, an effort was made to select communities that had the possibility of being able to provide some evidence that their access mechanisms were working to improve benefit receipt.

Exhibit 1.2: Cities Selected for Site Visits

Large Cities	Medium-sized Cities	Small Cities
Denver, CO Miami-Dade County, FL	Pittsburgh and Allegheny County, PA Albuquerque, NM	Albany and Albany County, NY Norfolk, VA Portland, ME

A two-person team conducted a two to four day site visit to each study community. During these visits, the team conducted individual and group interviews with one or more key leaders among providers of housing plans and programs in the community; housing providers; providers of mainstream benefits and services; providers of services to homeless persons; and relevant federal, state, and local governmental officials. Additional data were gathered through document reviews and follow up telephone calls to key informants to clarify any issues or discrepancies from site visit notes.

The site visit protocol included questions concerning homeless people's access to benefits and services; factors that impede access to the services; specific mechanisms and strategies for improving or facilitating access; and the nature of any overarching, communitywide strategies or organizing structures that promoted mechanisms for increasing access.

Review of Mechanisms Available in Additional Communities

Because funding for the present study limited us to visiting only seven communities, we decided to mine our existing records from other communities for additional mechanisms to overcome barriers to access to mainstream benefits and services. We reviewed field notes from prior HUD-sponsored community studies by the Urban Institute under the direction of Martha Burt and from SAMHSA-sponsored State Projects for Assistance in Transition from Homelessness visits undertaken by AHP under the direction of Ann Denton. We have incorporated examples of mechanisms in this study from both sources where they were distinctly different from mechanisms identified in the main study communities. These are shown as exhibits in Chapters 4 to 6. References for the sources of these examples are included in the exhibits.

Secondary Analysis of SAMHSA-funded Homeless Families Study

The SAMHSA-funded Homeless Families Study was conducted in eight communities and completed in 2006. Data collection began in the fall of 2000 and continued through 2003. Seven of the communities offer data on access to mainstream services for over 1,400 homeless families (single mothers with children) who received either targeted services intervention or services as usual. These seven communities are Albany, New York; Saint Louis, Missouri; Tucson, Arizona; Wake County, North Carolina; Westchester County, New York; Worcester, Massachusetts; and a group of Connecticut cities consisting of Bridgeport, New Haven, and Hartford.

Mothers in all families screened positive for mental health and/or substance abuse conditions. For the present study, the Homeless Families Study sample was further limited to families who entered the study in a literally homeless situation (not doubled up

or at imminent risk of homelessness), per the HUD homeless definition. The remaining sample is 1,110. Analyses included receipt of a range of benefits and services at study intake (baseline) and changes in access from baseline to 3 months and 15 months later. Factors that predict access to each major type of benefit or service were also examined. Additional analyses were conducted with subgroups of families meeting a clinical level of need on mental health, trauma, and substance abuse indicators to assess their access to services, especially those relating to the need condition.

Frameworks for Understanding Community Approaches to Changing Access

One result of coordinated federal activity, as well as organizations' long-term advocacy efforts, has been the development of almost 300 10 Year Plans (10YPs) to end homelessness, designed by jurisdictions across the country. Coordinating, linking, and integrating local service systems to improve homeless access to mainstream services and also to prevent people from becoming homeless as they leave mainstream institutions are prominent features of many of these plans (USICH 2007). Many communities with plans have begun implementing them, and some that have been willing to commit new resources and support effective coordination mechanisms have made substantial progress.

Improving homeless people's access to mainstream benefits and services may be accomplished as simply as by establishing communication between a case worker in one agency and a benefits worker in another agency, or as complexly as by making major simultaneous changes in the policies and practices of several agencies. If a homeless person's need is simple—such as for a security deposit—one agency will be able to handle it without needing to coordinate with another agency. If the needs are complex, however, as they usually are with single adults or families that have lengthy histories of homelessness, rendering assistance will likely require the effective interaction of several agencies and systems to get them the benefits and services they need. To provide this assistance, most communities find they need to make some changes in the direction of integrating *services* at least, and often integrating *systems* as well. As Burt (2007) and Burt and Spellman (2007) point out, the key to successfully addressing and eliminating homelessness lies in substantive system change at the community level, which is only possible to the extent that all entities involved work in concert to eliminate access barriers and create seamless local service systems.

From years of studying how communities organize themselves to meet the needs of households with many issues, researchers have developed a number of frameworks for talking about the types of change that occur, the types of arrangements that result, and indicators that things have really changed. We use two such frameworks in this study to help the reader understand what study communities have accomplished. The first framework—the "four Cs"—describes levels of services or systems integration and can also be used to characterize the extent to which a community has changed its approach to assuring access. The second framework provides indicators of system change. Both are described in detail in Burt and Spellman (2007); we summarize here, and return to these frameworks in Chapter 8 after presenting study findings.

The Four Cs

Four levels of interaction—**communication**, **coordination, collaboration**, and **coordinated community response—**may be used to characterize the ways that programs and agencies interact for the purpose of addressing the needs of individual clients and of whole groups of people. They may also be used to track a community's progress from a situation in which none of the important parties even communicates, up to a point in which all relevant agencies and some or all of their levels (line worker, manager, CEO) accept a new goal such as ending homelessness, efficiently and effectively develop and administer new resources, and/or work at a level of services integration best suited to resolving the situation of homelessness for the largest number of people in the shortest period of time. The framework also recognizes the possibility of regression from one stage to previous ones if prevailing factors work against integration.

- The level of **communication** exists when people in different agencies are talking to each other and sharing information in a friendly, helpful way. This is the first, most necessary, step in developing effective ways to end homelessness. Communication must inform participants what their counterparts in other agencies do, the resources they have available to them, and the types of services they can offer. Communication may happen between frontline workers (for example, a mental health worker and a housing developer), middle level workers, and/or among agency leadership. It may occur among these personnel in two systems, three systems, and so on up to all the systems in a community. In many communities, the parties who need to work together to create a coordinated system to end homelessness have not reached even this first stage. Everyone operates in isolation in hostile interactions that do not advance understanding or assistance for homeless people or the possibilities of preventing homelessness. Even when people know each other and sit on the same committees and task forces, they still may not communicate enough to share an understanding of the role each *could* play in ending homelessness. This latter situation is *the norm* in most communities—people know each other but have not really gotten down to the hard work of listening to and hearing each other.

- The level of **coordination** exists when staff from different agencies work together on a case-by-case basis and may even do cross-training to appreciate each other's roles and responsibilities. Again, coordination or cooperation may happen between frontline workers, middle level workers, and/or involve policy commitments for whole agencies by agency leadership. It may occur among these personnel in two systems, three systems, and so on up to all the systems in a jurisdiction.

  Coordination may also be *services integration*. Multi-agency teams that help get appropriate services to specific individuals are examples of coordination, as are multi-service centers where a homeless person can connect with many different agencies but there is no overall case coordination. However, at this stage, no significant changes have occurred in what services each agency offers or how it does business. Coordination does *not* involve major changes in eligibility,

procedures, or priorities of any cooperating agency. It merely means they agree not to get in each other's way and agree to offer the services they have available when it is appropriate to do so, albeit sometimes in new locations or through new mechanisms such as a multi-agency team. It does not entail any significant rethinking of agency goals or approaches.

- The level of **collaboration** adds the element of joint analysis, planning, and accommodation to the base of communication and coordination, toward the end of *systems integration*. Collaborative arrangements include joint work to develop shared goals, followed by protocols for each agency that let each agency do its work in a way that complements and supports the work done by another agency. Collaboration may occur between two or more agencies or systems, and usually does involve system change to varying degrees.

  Collaboration cannot happen without the commitment of the powers-that-be. In this respect it differs from communication and coordination. If agency leadership is not on board, supporting and enforcing adherence to new policies and protocols, then collaboration is not taking place. Because collaboration entails *organizational commitments*, not just personal ones, when the people who have developed personal connections across agencies leave their position, others will be assigned to take their place. They will be charged with a similar expectation to pursue a coordinated response and will receive whatever training and orientation is needed to make this happen.

- The level of **coordinated community response** expands from collaboration among two or three agencies to encompass all of the essential agencies in communitywide collaboration with the long-range goal of ending homelessness. This is system change and integration, going beyond collaboration in several directions. Because it involves all the essential agencies, it is able to provide integrated services—which for purposes of this study means that major barriers to service access are being dealt with and reduced or removed. It has a functioning feedback mechanism such as a regular meeting to address bottlenecks and develop appropriate interventions or smooth bureaucratic pathways, as well as an ongoing mechanism for thinking about what comes next, asking what needs to be done, how best to accomplish it, and, finally, what needs to change for the goals to be accomplished.

As we present study findings throughout this report, the reader will encounter many examples of changes made by study communities to increase homeless people's access to mainstream benefits and services that involve increased and improved communication at a minimum, increased coordination, and occasionally examples of long-term collaborations and structures approaching a coordinated community response. A community's commitment to increasing access might be measured by its progression through one or more levels in this four Cs framework, such as from nothing to communication, from communication to coordination, and from coordination to collaboration.

Indicators of System Change

A different framework, articulated in *Laying a New Foundation* (Greiff, Proscio, and Wilkins, 2003, p7), identifies five signs by which one can recognize system change when it is complete, or nearly complete. In the case of increased access that is the focus of this study, one would want to see clear evidence of change in mechanisms that improve access in all five of the following areas:

- A change in *power:* There are designated positions—people with formal authority—responsible for the new activity (not just committed or skillful individuals who happen to care about it).

- A change in *money*: Routine funding is earmarked for the new activity in a new way—or, failing that, there is a pattern of recurring special funding on which most actors in the system can rely.

- A change in *habits*: Participants in a system interact with each other to carry out the new activity as part of their normal routine—not just in response to a special initiative, demonstration, or project. If top level authorities have to "command" such interactions to take place, then the system has not absorbed them, and thus has not yet changed.

- A change in *technology* or *skills*: There is a growing cadre of skilled practitioners at most or all levels in the delivery chain, practicing methods that were not previously common or considered desirable. These practitioners are now expert in the skills that the new system demands and have set a standard for effective delivery of the new system's intended results.

- A change in *ideas* or *values*: There is a new definition of performance or success, and often a new understanding of the people to be served and the problem to be solved (that is, new goals). The new definition and understanding are commonly held among most or all actors in the system, such that they are no longer in great dispute.

As with the four Cs, we will see numerous examples throughout this report of changes in each of these areas—commitments of new money, strong support from new mayors and department heads, new assessment tools, computerized or telephone access, cross-trained workers in different departments, and so on. We return to both frameworks in Chapter 8, where we use them to organize and understand the findings from site visits to study communities.

The Seven Communities under Study

Included here are very brief descriptions of the seven study communities. Appendix A provides longer summaries of each community and lists of the individuals interviewed. The communities are ordered by population size, from largest to smallest.

Miami, Florida

Two primary mechanisms drove our initial interest in Miami: the Miami-Dade County Homeless Trust and the county's food and beverage tax (FBT). Created in 1993, the Homeless Trust is the hub of the community's homeless services system. In addition to developing and implementing the community's Homeless Plan, advising the County Board of Commissioners on matters related to homelessness, and serving as convener and administrator of the Continuum of Care, the Trust is charged with administering the proceeds of the FBT and other resources flowing into the community to address homelessness. The FBT adds a 1 percent tax to all transactions in restaurants with a liquor license that gross $400,000 or more a year. In its most recently completed fiscal year, the Trust had a budget of about $40 million, with $12 million derived from the FBT, $20 million from HUD, and the balance from state and private resources. To date, Homeless Trust accomplishments include increasing the number of emergency, transitional, and permanent supportive housing beds by 769, 1,815 and 2,072, respectively, and reducing the number of homeless people on the streets from roughly 8,000 to 1,347. The majority of the community's benefit- or service-specific mechanisms may be attributed at least in part to Trust planning and coordination efforts, along with the resources provided by the FBT.

Brief History

Twenty years ago, the Miami-Dade County community had a much larger and much more visible homeless population. Estimates of the exact size of the population in the late 1980s and early 1990s vary, but many are in the range of 8,000, roughly seven to eight times the number of emergency beds available in the community at the time, according to the community's Homeless Plan. There were large encampments in parks and under highways, and homeless people were often arrested for eating and sleeping in public places (National Coalition for the Homeless, n.d.), actions that ultimately led to a class action lawsuit that was decided in favor of the homeless plaintiffs.

Around this same time, the County created a Task Force on Homelessness. The Task Force made a number of recommendations, including creating the FBT and the public-private partnership of the Homeless Trust to administer the money and run the entire county's response to homelessness. An independent board of directors sets policy and works with Homeless Trust staff to carry out strategies and plans. The state legislature passed a law enabling Florida counties to establish tax mechanisms such as the FBT to create dedicated funding streams for local homeless services.

The immediate goal of the Homeless Plan and the Homeless Trust was to reduce street homelessness through the Homeless Assistance Centers (HACs) and transitional housing beds. Two HACs were developed and, in the years since, over 70,000 people have used their services. The Homeless Trust began a shift to *ending* chronic or street homelessness through permanent supportive housing (PSH) in 1997, but moved more completely to that orientation in 2004, with a plan to create and complete 100 new PSH units each year. Through this shift, however, the Homeless Plan has continued to provide the central

vision for the community's efforts. Miami-Dade County's 2006 10 Year Plan to End Homelessness is considered an update to, rather than a replacement of, the Homeless Plan.

In the late 1990s, then-governor Jeb Bush established a state level homeless task force and charged it with developing a statewide plan to end homelessness, in line with the federal push on state and local governments from the Interagency Council on Homelessness. The resulting statewide plan contains many recommendations that coincide with strategies Miami-Dade County pursues. With the authority of statewide recommendations behind them, county advocates have been quite successful at securing state funding for relevant Miami-Dade County programs.

Denver, Colorado

The existence of a central organizing structure, Denver's Road Home (DRH), within the mayor's office, strongly influenced our selection of Denver as a study community. Over the last three years, Denver has garnered national attention for its 10 Year Plan to End Homelessness and unique system of support for homeless services. Led primarily by Mayor Hickenlooper and the Denver's Road Home office, a series of committees addresses the issues and goals enumerated in Denver's 10YP, using a highly coordinated and goals-driven approach. With both local public and private support, but very little state support in terms of resources, Denver provides an example of targeted resource allocation with a special emphasis on mainstream benefits for homeless people. The city has taken on significant responsibilities surrounding the elimination of homelessness while also bringing in more private service providers, including those that are faith-based, and raising a substantial amount of private funding.

Brief History

Prior to 2004, the Metro Denver Homeless Initiative ran the Continuum of Care, which included Denver and the six surrounding counties, while the Colorado Coalition for the Homeless, a nonprofit agency, operated the majority of the city's homeless services. With the election of Mayor John Hickenlooper, however, community members and members of the City Council saw an opportunity to expand local government's role in homeless services.

In 2004, the mayor gathered a group of 43 representatives from local government, nonprofits, philanthropic organizations, and the homeless population to form the Denver Commission to End Homelessness, with the charge to create and publish the city's original 10 Year Plan to End Homelessness. The Commission split into seven subcommittees with specific tasks, which took commentary from approximately 350 community members and blended it to define a set of goals for Denver's homeless system. In 2005, Mayor Hickenlooper released Denver's 10 Year Plan to End Homelessness, titled *Denver's Road Home*. Since the 10YP's passage, the subcommittees have met to discuss issues and to bring recommendations before the broader Commission. In May 2007, the Commission approved an update, or "status report," of the 10YP, which adjusted goals and reported on the plan's overall progress.

The 10YP also established the Denver's Road Home office within the mayor's office, consisting of four staff located at the Department of Human Services who cover housing, mainstream benefits, employment, and programs. The office's Director is a mayoral appointee; however, the position is funded solely by foundation resources. DRH is charged with implementing Denver's 10YP by raising and distributing homeless funds in partnership with the Mile High United Way—Denver's fiscal agent for the 10YP.

Denver's 10YP heavily emphasizes shared responsibility for funding. The Denver Commission to End Homelessness estimated the plan would cost $46.1 million to fully implement, and charged the 13-member Committee on Fundraising, part of the mayor's Homeless Commission and led by the Director of DRH, with raising the needed funds. The mayor came up with a strategy to make the funding effort a community process with heavy community support. "He wanted to have everyone invest." The goal has been to get 50 percent public, 25 percent corporate, 25 percent private funding. According to interviewees, the mayor successfully lobbied for foundation support, asking for an expansion of what they were already giving. Foundations agreed, with the understanding that as the city rolled out the initiative they would wean off foundation and corporate dollars.

Pittsburgh/Allegheny County, Pennsylvania

County-level integration and cooperation made Allegheny County an attractive candidate for study inclusion. The Allegheny County Department of Human Services (DHS) serves as the Pittsburgh/McKeesport/Penn Hills/Allegheny County Continuum of Care lead. Homeless services are situated within the Office of Community Services (OCS), one of five DHS program offices. Having multiple program offices under one county agency provides the ability to review overlap among offices and allocate resources as needed, and facilitates a highly coordinated, communitywide effort. For example, although OCS is the bureau responsible for homeless services, other DHS offices experience a need for housing, and most play a significant role in the system serving people who are homeless. DHS is a key member of the Allegheny County Homeless Advisory Board, formerly the Allegheny County Homeless Alliance. Established in 2003, the Advisory Board is the public-private partnership responsible for overseeing the CoC and the community's 10YP. The Advisory Board's membership also includes other Allegheny County government entities; Pittsburgh, McKeesport, and Penn Hills government entities; a wide range of mainstream and homeless services provider organizations; and local foundations. An unusually strong community of major, private foundations exists in Pittsburgh, and has played a significant role in Allegheny County's homeless service system. In addition to generally providing additional funding streams, foundation money supports projects that would be difficult to fund through public money.

Brief History

The current configuration of DHS developed out of a mid 1990s effort to streamline Allegheny County government. As part of this initiative, in 1997 the County consolidated six former departments, including the Department of Child Welfare, under the umbrella

of the newly formed DHS. The recently appointed Director of Child Welfare, Mark Cherna, was named as the DHS Director, and has held this position ever since. As he was appointed at such a formative point in DHS history, Mr. Cherna had a unique opportunity to put the department together. Department members consider this situation to be a factor in the department's subsequent success, along with the consistent leadership that Mr. Cherna has provided in the years since the redesign. Mr. Cherna was able to retain the selection committee that had been assembled to conduct the search for a new Child Welfare Director (his previous position), and to use this group as a sort of "kitchen cabinet" as he assumed his new position. The foundation community also was a key player in backing Mr. Cherna's decision to consolidate the departments, and their support helped to avoid wrangling among agencies. The redesign was driven by the needs of children and families, but OCS was able to establish homelessness as a priority area for the new department.

The community developed its CoC in the early days of HUD's adoption of the approach. It has proven highly beneficial in terms of drawing down both HUD and, more recently, behavioral health funding. The department's structure is credited with some of that success, as is the highly engaged provider community.

Driven largely by the Advisory Board, Allegheny County's 10YP was released in July, 2005. The Advisory Board has been making significant progress in moving some portions of the 10YP forward, and DHS has worked to keep the Board invigorated by recruiting new members regularly from other parts of the community (for example, safety, university).

The 2000 HUD policy shift (increased funding for housing-related activities vs. services under the McKinney-Vento Act) was a major turning point in the community. DHS worked with this requirement through a combination of creative cost and funding shifting, foundation support, and adjustment to resource loss. The department's unified structure was a major factor in its ability to shift costs and funds internally in the department. The foundation community was able to supply $3 million for three years to help with the shift; the funds were evenly split between services and capital.

Albuquerque, New Mexico

The primary mechanism that drove our interest in Albuquerque was its history of working together as a community to create real opportunities for people to exit homelessness. The use of the housing first approach and the incorporation of homeless service provider agencies as "outposts" of the mainstream service delivery system were intriguing.

Brief History

The New Mexico Coalition to End Homelessness (NMCEH) was founded in the year 2000 by a group of nonprofit agencies and the New Mexico Mortgage Finance Authority. This statewide coalition coordinates the efforts of the member provider agencies to end homelessness and manages the Continuum of Care process as noted below. The Coalition

has both individual and agency members. Members elect the Board of Directors annually and the Board oversees the operations of the Coalition. The Albuquerque community is represented by four NMCEH Board members.

Albany, New York

Provider cooperation is cited as the hallmark strength of the Albany system serving homeless people. The Albany Continuum of Care serves all of Albany County, with the City of Albany being both the population center of the community and the center of the homeless and mainstream services systems. As the organizing entity for Albany's CoC, the Albany County Coalition on Homelessness (ACCH) has played, and continues to play, a central role in fostering and maintaining cooperation. Interviewees described ACCH as being helpful in identifying problems and solutions on a communitywide basis.

New York is a relatively generous state with respect to benefits and services, as evidenced by, among other things, liberal Medicaid benefits, a relatively extensive public mental health system, and Supplemental Security Income benefits for people with certain disabilities. General Assistance cash benefits are offered in New York and have historically been greater than those provided by most other GA-offering states. State generosity promotes many of the Albany programs described in this section, and in Appendix A.

Brief History

ACCH was initially convened in 1996. Since that time, staff support for ACCH has been provided by CARES, Inc., a local organization dedicated to serving people with HIV/AIDS. ACCH membership includes representatives of Albany County and City government offices, homeless and mainstream service provider organizations, community groups, faith-based organizations, and currently and formerly homeless people. Members may be appointed or invited, or may volunteer to join. ACCH meets on a monthly basis, with the primary goals of coordinating the community's resources and identifying and remedying needs or gaps in the systems serving homeless people.

In 2004, a number of ACCH members became interested in developing a 10 Year Plan to End Homelessness within the community. These efforts were endorsed by the County Executive and the Albany mayor, and an advisory group was convened in November, 2004. From the start, the group's goals included addressing the needs of homeless families and homeless/runaway youth, as well as homeless single adults. Working committees on the needs of each of these subpopulations were formed shortly after the advisory group was convened. The plan development process also included a series of focus groups with homeless adults, families, and youth, and a half-day conference involving all committee members and other community members. The 10YP was finalized in October, 2005.

Norfolk, Virginia

Norfolk's Homeless Action Response Team (HART) and the City's Office to End Homelessness (OEH) provided the initial reasoning for our community visit. Since the creation of HART in 2004, Norfolk has received national attention as a model for homeless services intake mechanisms. The HART team primarily serves homeless families that are documented residents of Norfolk, providing links to mainstream benefits, services, and housing; it also serves homeless singles coming into the Department of Human Services, although only families are mandated to enter the system through HART. A year after HART's start, Norfolk set up the Office to End Homelessness to ensure timely and sound implementation of the city's 10YP. The Office provides a link from the mayor's office to the broader homeless system, guaranteeing both a central contact and continued involvement from the city's executive branch.

Brief History

In early 2004, Mayor Paul Fraim and the Norfolk City Council announced the creation of the Commission to End Homelessness, a 26-member group made up of both public and private partners. The initial purpose of the group was to deliberate and produce a "Blueprint," or Norfolk's 10 Year Plan to end homelessness. Using local stakeholders and the Norfolk Homeless Advisory Committee—a group that, in December 2003, put out a report on the gaps in Norfolk's homeless system—the draft identified 19 areas of the Norfolk homeless system that needed to be developed, centering around case management, employment and support, and housing strategies.

In accordance with the plan, Mayor Fraim established the Office to End Homelessness in May 2005 and appointed its Director, Katie Kitchin. OEH was and is in charge of ensuring best practices and the implementation of the 10YP. It is widely regarded as *the* link from the various homeless initiatives to the mayor's office. In addition to her role at OEH, Ms. Kitchin also serves as an executive member of the Homeless Consortium Board – the oversight committee for the City's Continuum of Care.

In 2007 there was a critical reduction in available resources for homeless services distributed by DHS and HART resulting from the state's more restrictive interpretation of the Comprehensive Service Act (CSA). The CSA law, passed in the early 1990s, allowed pooling of state agency funds, subject to a local match requirement (set at 25 percent for Norfolk) to support family preservation and prevention of foster care and other out of home placements. Previously, DHS made extensive use of CSA funds to prevent and end homelessness, following the rationale that homelessness leads to family dissolution and increased foster care placement for children. Because of Norfolk's large and unexpected usage, the state mandated that all cases using CSA funds go before a review board (the Norfolk Interagency Consortium) with strict new interpretations on what the funds could be used for. Norfolk was the most liberal and generous jurisdiction in the state in making use of CSA funds, spending close to $600,000 at HART in 2006; at the time of this study, HART has received far less for 2008.

Portland, Maine

The primary mechanism that drove our initial interest in Portland was the Continuum of Care that has long been established there. The Emergency Shelter Assessment Committee (ESAC), a structure of the CoC, dates back to the early days of awareness that homelessness was here to stay, not just a blip caused by the 1981–82 recession. Early in the 1980s the city of Portland and the United Way formed a task force to examine the growing phenomenon of homeless families and develop ideas for how to address it. One task force recommendation was for a permanent body to address homeless-related concerns; ESAC was formed in response to this recommendation. ESAC was charged with developing approaches to dealing with homelessness in the community, focusing initially on family homelessness but ultimately broadening its purpose to include all homelessness.

ESAC focuses specifically on issues that pertain to Portland's homeless population. ESAC also establishes standards of care and performance at shelters and reviews shelters against these standards on a regular basis. It is able to anticipate issues, troubleshoot barriers and roadblocks, strategize for the smoothest way to introduce new practices, and create subcommittees to address particular planning issues. The group looks at program utilization statistics every month, discusses changes, and, if there appear to be problems, tries to figure out what to do.

In 1996, when HUD started the CoC approach for applying for federal Supportive Housing Program funding, the Portland City Council designated ESAC to serve as the governing entity for the city's CoC Homeless Assistance Grant Program. As part of the annual CoC planning and prioritizing process, which ESAC organizes every year, ESAC established a CoC Priorities Committee that reviews project performance and quality and assigns priority scores to applications being proposed for the city's Super Notice of Funding Availability submission. The Priorities Committee reviews each HUD grantee to make sure it is fulfilling the terms of its proposal and grant. Any provider that is seriously out of compliance risks getting a low priority score and thus potentially not getting HUD funding for the coming year. ESAC controls the membership of the Priorities Committee to make sure that members charged with establishing priority scores have no conflicts of interest with service providers submitting proposals.

Brief History

For a long time, Portland went its own way in dealing with homelessness, while the rest of its county (Cumberland) was not part of its plans. The players in neighboring York County knew the players from Cumberland County and interacted in state level activities, but there was no official coordination with homeless-related activities. In 2006, as part of statewide organizing around homelessness, Cumberland and York Counties were asked to work together as one of three Regional Homeless Councils. This Region I Council was the last of the three to get organized because Portland was already organized, being its own CoC, with an array of plans for where it wanted its system to go and how it wanted to use available resources and new ones as they came along or could be raised. The HHS

Director for Region I helped bring the two counties together beginning in June 2005. After a steering committee came up with plans and a decision-making structure that satisfied the concerns of both counties, the Region I Council was formed. It has responsibility for planning and also for prioritizing the use of state homeless resources within its two counties. ESAC focuses specifically on issues that pertain to Portland's homeless population.

Most of the Portland-specific structures and programs existed before the Region I Council started. Some predate the 1987 McKinney Act, but they and the Portland governance structure now participate in the regional process and are benefiting from it. In addition to changes in ESAC, a good example of the benefits of regionalizing is the new position devoted to homelessness prevention for families in crisis in the small towns in Cumberland County outside of Portland, which is supported by the first ever money that the county has committed to a homeless-related function. By connecting families to mainstream resources that help to keep them in their homes, the person in this new position helps families remain in their communities and prevents them from having to move to Portland to get assistance.

Report Structure

The remainder of this report is organized into seven chapters as follows:

Chapter 2 presents data for 2007 available from four study communities and the nation as a whole on receipt of mainstream benefits and services at entry and exit from programs supported by HUD's Supportive Housing Program in the office of Special Needs Assistance Programs. Program types include transitional housing, permanent supportive housing, and supportive services only programs.

Chapter 3 discusses study communities' organizing strategies, focusing on the organizing structures of the communities' systems serving homeless people and the specific advantages realized by these structures.

Chapters 4, 5, and 6 explore barriers to benefit and services access and the mechanisms the communities have developed to address these barriers. Chapters are organized first by barrier classification, presented in the order of the types we found most to least frequently: Chapter 4 covers structural barriers, Chapter 5 covers capacity barriers, and Chapter 6 covers eligibility barriers. Within each chapter, content is organized first according to barrier categories. Within each barrier category, content is organized according to the types of mechanisms (smoothing, changing, and expanding) used to overcome the barriers. The discussion of each mechanism includes a description of the mechanism, a review of its development, and, whenever possible, documentation of its effect.

Chapter 7 examines special problems of access, using findings from the SAMHSA Homeless Families dataset.

Chapter 8 presents a summary of findings, conclusions, and implications.

Appendixes. These sections are as follows:

- Descriptions of each community.
- Lists of persons interviewed.
- The interview protocols that we employed.

In designing this report, we wanted to present different "views" of the findings. Although most chapters focus the view by the types of barriers and mechanisms, in this chapter (just above) and in Appendix A we provide a view by community. We also know that certain mechanisms for overcoming access to barriers are relevant to more than one barrier. As a result, a certain amount of redundancy in organizing and writing the report creeps in. We have tried to reduce this redundancy by only presenting the full description of the mechanism in a single chapter; however, if it is relevant to a barrier in one or more other chapters, it is briefly noted there with a reference to the location of the complete description.

CHAPTER 2: EVIDENCE THAT COMMUNITIES CAN CONNECT CLIENTS TO MAINSTREAM BENEFITS

Communities for this study were selected because they had developed structures to help homeless people gain access to mainstream benefits and services. Chapters 4, 5, and 6 describe the many mechanisms operating in these communities to smooth the way or expand the opportunities for receipt of public benefits. Before delving into the details of how these communities facilitate access, it is useful to show that, overall, their approaches work.

Documenting that the mechanisms work is not so easy, however. Most communities do not collect and report data on receipt of benefits and services in ways that would best describe the impact of their efforts to increase access, and the communities in this study are no exception. Ideally, one would want to track people as they first connect to the homeless system and follow them through until they are stably housed, either in the community or within the system itself in permanent supportive housing. One would want to know what income sources they had when they first connected, and also what services (for example, housing stabilization, case management, mental health or substance abuse treatment) they might be receiving. Thereafter one would want to know when they applied for and started receiving various cash and in kind benefits (for example, Supplemental Security Income, Medicaid, food stamps) and, likewise, whether and for how long they received various supportive services. Unfortunately, none of the communities in this study, and probably few if any in the country as a whole, collect this information.

The only data available from study communities come from Questions 11C and 11D of Annual Performance Reports (APRs) that Miami, Norfolk, Pittsburgh/Allegheny County, and Portland were able to provide.[3] These APRs report information for all projects in a Continuum of Care (CoC) that receive funding through the U.S. Department of Housing and Urban Development's (HUD) Supportive Housing Program (SHP). For the purpose of this study, APRs leave a lot to be desired as a source of documentation:

- Because communities only do APRs for projects funded through the Supportive Housing Program, most APRs pertain to transitional (TH) and permanent supportive housing (PSH) program clients, since these are the types of programs funded through this source. Further, they are not available for programs funded completely with non-SHP funds, which in some study communities comprise a substantial number of programs and units.

- APRs rarely pertain to the programs and activities focused on the moment when people *enter* the homeless assistance system—central

[3] The Denver Road Home office was not able to supply APR data, but did provide evidence of increased access to mainstream benefits from a special study of homeless people placed in PSH. These data are presented in Chapter 3, in the section on the impact of Denver Road Home activities.

intake units, emergency shelters, day centers, and other centralized access points. But in this study the entry points are the main locus of action in connecting people to mainstream benefits. If the entry points are doing their jobs, most people will never become clients of transitional and permanent supportive housing programs. The mechanisms established for the entry points will hook them up with appropriate benefits and services and people will return to the community, and to housing.

- Because APRs mostly do not cover the types of programs offering these mechanisms, and most communities do not track the data one would need to document how well these entry points are doing their jobs, this study cannot report on their success in linking people to mainstream benefits. Supportive Services Only (SSO) grants are sometimes the exception; some systems use these grants to cover clients as they move through the entire range of program offerings within a CoC. One community in this study was able to provide documentation for a grant of this type.

- APRs track only *income* sources, Medicaid, and food stamps. They do not track receipt of mental health or addictions treatment and related services, education or employment-related services, or other services to which it is difficult to attach a dollar value, but which may make a big difference for clients receiving them.

- APRs report information that HUD grantees collect about client income sources at program entry *and program exit*. As a consequence, APR data misses a good bit of information that is vital to this study—(1) no data on client receipt of various supportive services is reported, and (2) no income source data is collected on people who are still in residence at the end of the reporting period. For PSH programs, that would be most of the people—on average, the approximately 80 to 85 percent of tenants who remain in housing each year. Data on current PSH residents are available from a community that was not otherwise in this study, and is used later in this chapter to show the difference in levels of benefit receipt for current PSH residents compared to those who left.

Having described all the inadequacies of APR data, it remains the case that APR data are what is available, and, therefore, data from APRs are what this chapter reports. Several more caveats are important to note before presenting the APR data. First, different communities have different mixes of projects on which they must provide an APR, and different types of projects serve different numbers of people for different lengths of time, giving them more or less opportunity to connect their clients to benefits and services.

Second, one might expect that TH clients need different things than PSH tenants, so the benefits and services to which they might be connected would differ. These differences in

client needs will almost certainly affect the benefits and services to which programs help clients apply. Most of the data reported below come from all the APRs submitted by a community combined, and thus mask the influence of the program types that dominate in a particular community.

Third, circumstances change in communities in ways that may affect the ability of community mechanisms to link people to services, even when they are doing the same thing that succeeded only a year earlier. For instance, when a state that offered a state-only Medicaid program for people with disabilities eliminates that option due to severe budget problems, case workers will be less successful at getting people onto Medicaid, despite their best efforts.

Finally, communities differ in the rules that govern what might otherwise seem to be similar benefits. For example, states differ dramatically in the maximum income a family may have and still qualify for the Temporary Assistance for Needy Families program (TANF), as well as in the level of the cash benefit that TANF provides. A lower proportion of families will qualify for TANF in Florida and New Mexico than in New York, Maine, or Pennsylvania, independent of the skills and dedication of case workers trying to link families to benefits. A community that has a General Assistance (GA) program will clearly have more clients on General Assistance than a community without this benefit. It is also true that some communities with General Assistance are working to get people *off* General Assistance and onto Supplemental Security Income (SSI), so a reduction in the proportion of people on General Assistance would be a positive outcome in such a case, assuming it is balanced by an increase in people receiving SSI.

APR Results for Four Study Communities

This section reports APR data on sources of income for persons exiting programs in study communities, and in some cases compares it to receipt of similar income sources at program entry.[4] Income sources are the major ones reported in APR Questions 11C (entry) and 11D (exit)—SSI and Social Security Disability Income (SSDI), General Assistance, TANF, Medicaid, food stamps, and employment income. Also reported is the proportion of people with no financial resources at entry and again at exit.

HUD's Special Needs Assistance Program (SNAP) provided data from Questions 11C and 11D from APRs for the 2007 reporting year by all SNAP-funded programs in the country. The remaining exhibits show data from the four study communities that were able to provide similar information and compare them to the relevant data from the combined APRs for the nation as a whole.

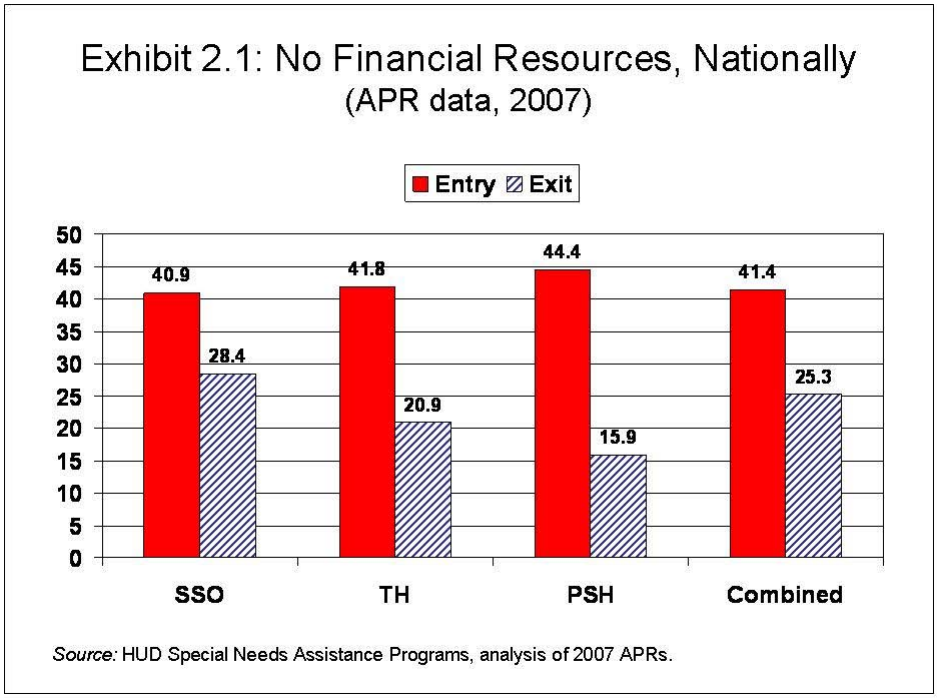
Change in the proportion of people with no financial resources is reported first, as this is the best single indicator of the ability of communities to link homeless people to at least

[4] Note that this comparison is between entry into the program reporting the data, not into the homeless system as a whole. Thus, the differences reported, if any, occurred while the person was in a TH, PSH, or SSO program and do not represent the performance of the community's whole spectrum of mechanisms to connect people to benefits and services.

one income source. Thereafter, exhibits show SSI and SSDI receipt followed by General Assistance, TANF, Medicaid, and food stamps. The section ends with reports of changes in income from employment and the implications of these APR data for improving homeless people's access to mainstream benefits.

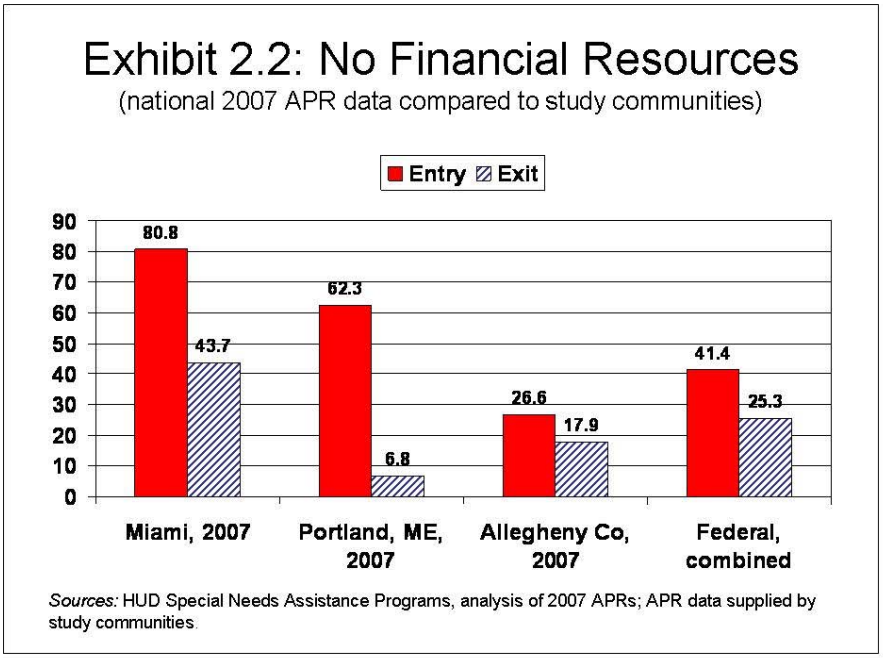
No Financial Resources

For people who have left programs covered by APRs, information is provided on the proportion of clients who had no financial resources at entry and at exit. Exhibit 2.1 presents the SNAPs data from all SHP-funded programs. These data show, first, a very consistent proportion of people entering all types of SHP programs who do not have any financial resources—between 41 and 44 percent. They also show change in the proportion of people with no financial resources from program entry to program exit for the 2007 reporting year, separately for each type of SHP grant and then for all SHP grants combined. A reduction in this proportion between program entry and program exit is a positive outcome.



Nationally, people leaving SHP-funded programs in 2007 were more likely to have at least one source of income than when they entered the program, as Exhibit 2.1 shows. Seventy-five percent had some income source, compared to 59 percent at program entry, representing a decline of 16.1 percentage points and 39 percent in the number of people with no financial resources. SSO programs reduced the proportion without financial resources by 12.5 percentage points, from about 41 to about 28 percent or about one-third (30 percent) of those without resources at entry. Comparable figures for transitional housing programs are 20.9 percentage points and a reduction of one-half (50 percent reduction), while for permanent supportive housing programs they are 28.5 percentage points and a reduction of about two-thirds (64 percent).

When the combined national outcomes are compared to 2007 data from study communities (Exhibit 2.2), it is clear that the three communities that were able to supply these data—Miami, Portland, and Allegheny County—are in very different situations when it comes to the financial resource situation of the people who come to the homeless services system. More than four in five homeless people approaching the Miami system have no resources, compared to about three in five in Portland, two in five nationally, and about one in four in Allegheny County. This puts Allegheny County's homeless population using SHP-funded programs at about the same resource level *at entry* as SHP clients nationally are *at exit* (26.6 versus 25.3 percent). Allegheny County homeless assistance programs are able to reduce that proportion by about 9 percentage points, or 33 percent. The homeless assistance system in Miami faces the biggest challenge, and meets it with a reduction of 37.1 percentage points, or 46 percent. Portland shows the largest proportional reductions of all, reducing the number of people with no financial resources by 55.5 percentage points or 89 percent.



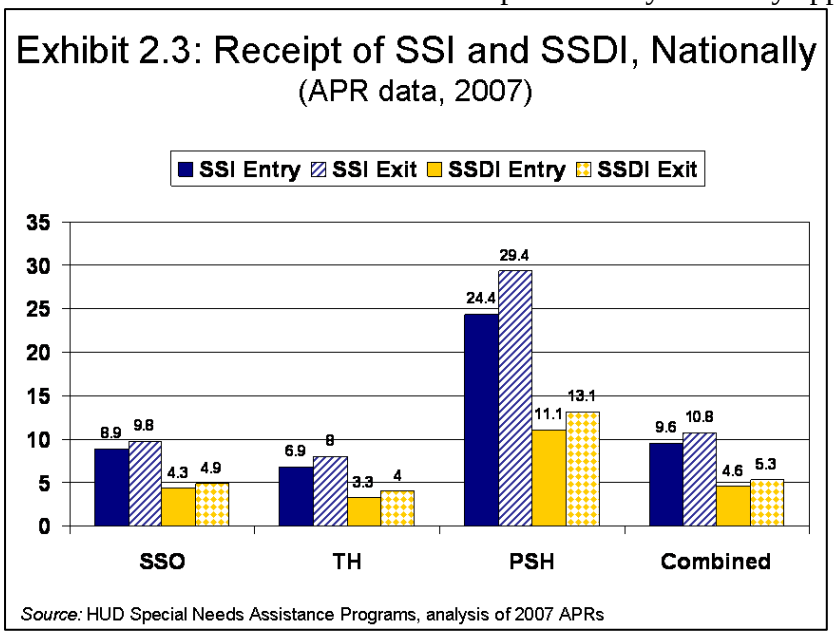
SSI and SSDI Receipt

Eligibility for SSI and SSDI depends on age or disability, but for homeless people, who generally would not qualify by being 65 or older, disability is the major issue. The federal Social Security Administration controls access to these benefits, which are highly coveted because they provide a monthly cash benefit and also categorical eligibility for Medicaid (SSI) or Medicare (SSDI), on which many communities rely to cover some of the costs of supportive services. One would expect receipt of these benefits to be highest among tenants in PSH programs. TH programs may also work to get some of their clients onto SSI or SSDI if staff realize that particular clients' disabilities are such that they are not likely to achieve the self-sufficiency goals of most TH clients.

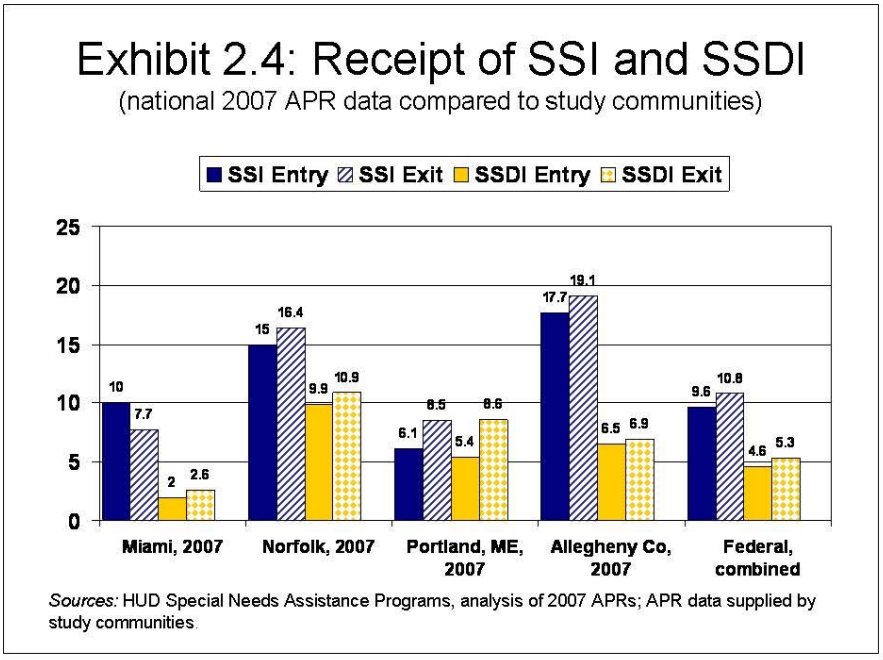
People Still Residing in PSH Look Different

A survey of all Washington, DC PSH projects indicates that 46 percent of *current* tenants have SSI and 13 percent have SSDI.

The concentration of SSI and SSDI receipt nationally is readily apparent in Exhibit 2.3.



Almost one fourth (24 percent) of PSH tenants already have SSI and 11 percent have SSDI when they move into PSH. When they leave PSH, 29 and 13 percent have SSI and SSDI, respectively. The data for Norfolk and Allegheny County (Exhibit 2.4) make clear that clients in these two communities are substantially more likely than SHP-funded program clients nationally to have SSI, SSDI, or both at exit. It also looks as if clients in Portland are less likely than the national average to leave with SSI, but more likely to leave with SSDI, and Miami clients are lower on both than national averages (Exhibit 2.4).



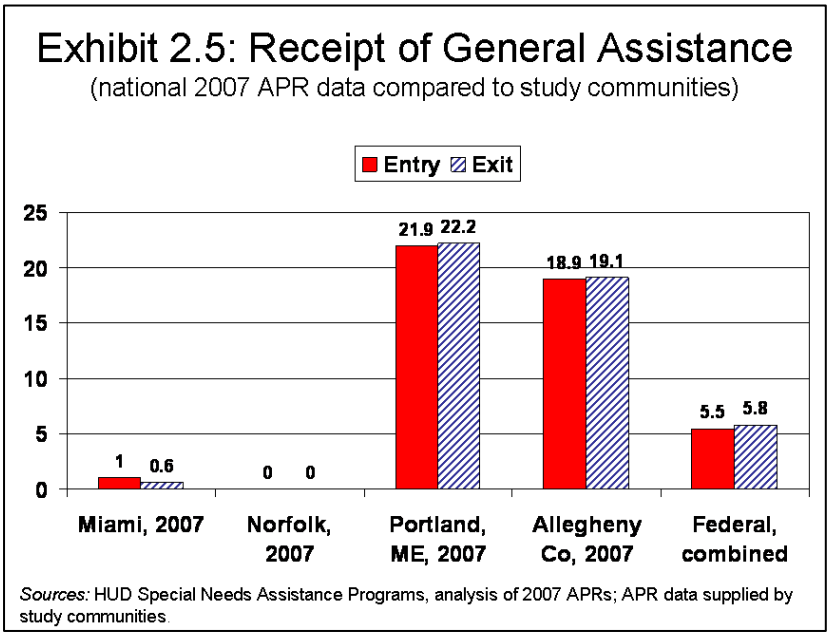
These apparent results serve as one example of the problems associated with the APR's reliance on the status of *exiting* clients for its income data, as very different numbers of people may leave SHP-funded programs from year to year, and their circumstances may be quite different as well. For example, in Portland, the proportion of people exiting SHP-funded programs with SSI in 2004, 2005, and 2006 is substantially higher than was true for 2007 (18, 13, and 15 percent, respectively, compared to 8.5 percent for 2007). In Miami, also, performance in 2006 and 2008 was better than in 2007,

with 9.2 percent of SHP-funded program leavers having SSI in 2006 and 10 percent having it in 2008, putting Miami very close to the national average.

As noted early in this chapter, for benefits such as SSI, SSDI, and Medicaid, at least, the APR focus on *exiters* is likely to paint an inaccurate picture of the connection to benefits of current residents. Data available from a survey of all Washington, DC PSH projects (not just those with SHP funding) indicates that 46 percent of current tenants have SSI and 13 percent have SSDI. That is more than twice the level for exiters in any study community, and close to twice the level nationally for PSH programs only. The odds are that many communities are doing a better job than is reflected on APRs of connecting their most vulnerable homeless people—those who need and receive PSH—to benefits.

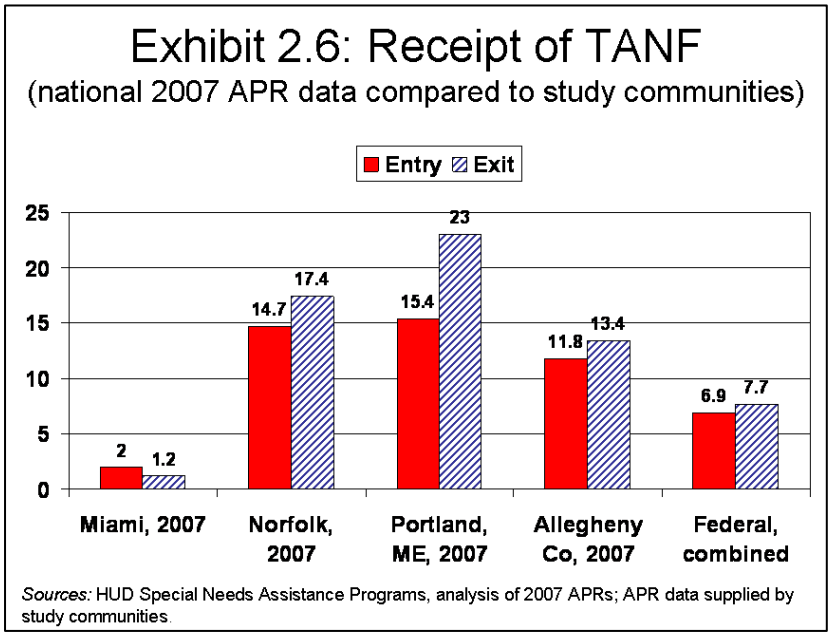
General Assistance

Not all study communities have General Assistance—a fact that is clearly responsible for the major differences among study communities apparent in Exhibit 2.5. On average nationally, 5.5 percent of people leaving SHP-funded programs had GA when they entered the program, and only marginally more (5.8 percent) had it when they left. But in communities that do have General Assistance (Portland and Allegheny County, among study communities), homeless people are quite likely to receive it. About one in five people leaving SHP-funded programs in Portland and Allegheny County had received help from GA, which is about five times the national average. GA is another benefit that can vary greatly among exiters from one year to the next. Portland data from 2004, 2005, and 2006 reflect this variability; in those years, respectively, 36, 33, and 53 percent of program leavers were linked to GA, compared to only 22 percent in 2007. It is beyond the scope of this study to determine the reasons accounting for these fluctuations, but it is important to note that they occur.



TANF

TANF eligibility is restricted to households with children and with incomes below an eligibility limit determined by each state. For a family of three in 2007, that limit was less than $300 in Florida, more than $1000 in Maine and Virginia, and $600–799 in Pennsylvania. So the proportion of a community's homeless population that could potentially be linked to TANF depends at least on the proportion of family households, which varies from community to community, and on household income. In reality, it will also vary depending on each household's prior history with TANF (how many months it has already received TANF benefits, whether it has been sanctioned, and several other factors outside the control of homeless assistance programs).

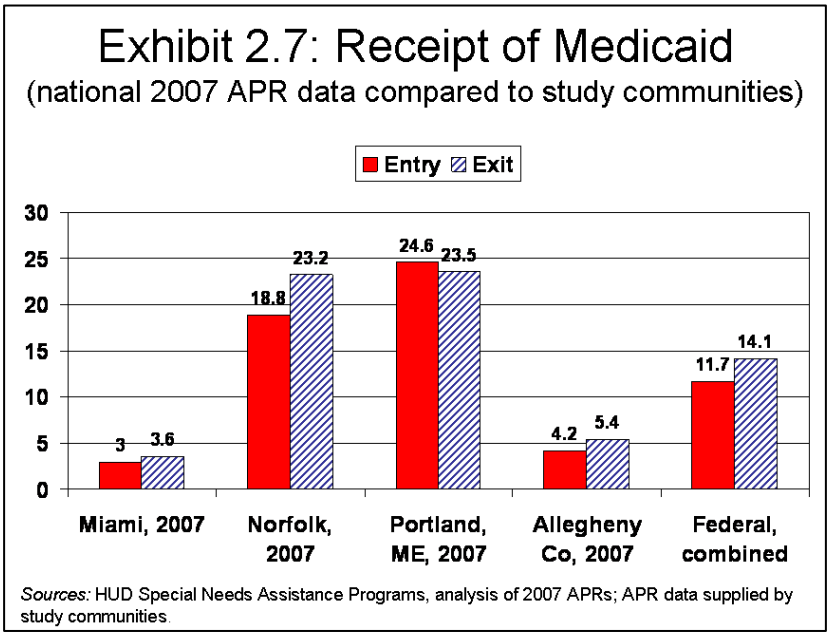


Given how low Florida's income cutoff is for TANF, it is not surprising to see that homeless assistance programs in Miami have little luck linking clients to it, as Exhibit 2.6 shows. Portland and Allegheny County are more successful, having TANF programs with considerably more flexibility than Florida's. Both considerably exceed the national average for families leaving SHP-funded programs in 2007, Allegheny County by almost double, and Portland by a factor of three. In Allegheny County, most of the households receiving TANF at SHP program exit were already recipients when they entered these programs. From the very small change in the national statistics, that is probably also the case in most other communities.

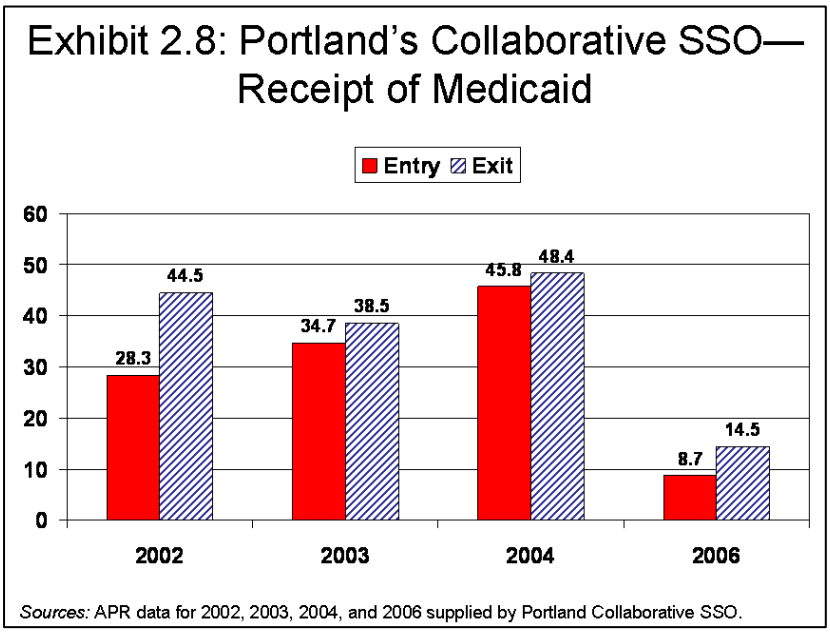
Medicaid

Access to health care is vital for anyone, but for homeless people it often means having the supports that make it possible to stay in housing, where they are able to address a range of health, mental health, and other issues. Unfortunately, Medicaid is also a very restrictive program, being limited by federal law to people who are also recipients of TANF or SSI. Some states and even localities have created their own health insurance program for indigent people, and often link its administration to the same offices that administer Medicaid.

The number of Medicaid beneficiaries at exit from SHP-funded programs in 2007 is shown in Exhibit 2.7. The national average is quite low—only one in every seven or eight people. Medicaid receipt is even lower in most study communities. Norfolk and Portland are the obvious exceptions to this picture, with 24.4 and 24.6 percent of people, respectively, leaving SHP programs in 2007 still receiving Medicaid.



Because Portland supplied APRs for a number of years and separately for several programs, it is also possible to see, in Exhibit 2.8, that this is not a unique occurrence for Portland. Rather, it is actually a fairly low level of achievement for that community's SSO Collaborative compared to the earlier years of this decade. Portland's SSO Collaborative provides case management and linkages to clients of most of Portland's provider agencies, starting as people approach the system and continuing until they are no longer homeless or are placed in TH or PSH.



As can be seen in Exhibit 2.8, during the years 2002, 2003, and 2004, many people already had Medicaid (Mainecare) when they first approached the SSO Collaborative, but the Collaborative was instrumental in assisting even more to get this benefit, especially in 2002. By 2006, access to Mainecare had plummeted because Maine cut off eligibility for people without a categorical basis (TANF or SSI) for getting the benefit, known locally as the "non-cats," for people who were not categorically eligible. In earlier years, the state was able to offer a state-only

version of Mainecare that offered limited benefits to disabled people, and Portland homeless assistance providers took full advantage of the opportunity, as having these benefits meant that Mainecare would cover some of the costs of supportive services in PSH. Since its nadir in 2006, Maine has periodically, and briefly, opened enrollment in Mainecare for noncategorical disabled people, resulting in an increase from 2006's low of 14.5 percent of exiters to 2007's 23.5 percent.

Food Stamps

The Food Stamp Program (now the Supplemental Nutrition Assistance Program) is this country's most nearly universal safety net program. Eligibility depends solely on income, it is an entirely federal program and thus offers the same benefits to the same people in every state, and its benefit level is higher the lower a household's income—in other words, it fills an income gap rather than providing the same fixed amount to all eligible people. If they do nothing else, homeless assistance providers should be able to link their clients to food stamps. The program has been simplifying its application and recertification procedures for a number of years, so access has never been easier for people who qualify.[5]

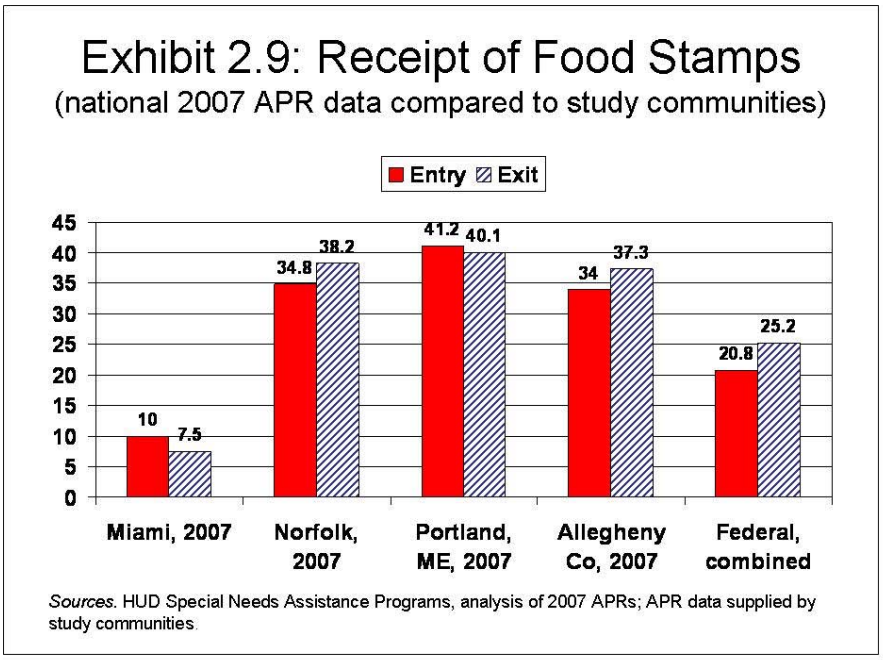


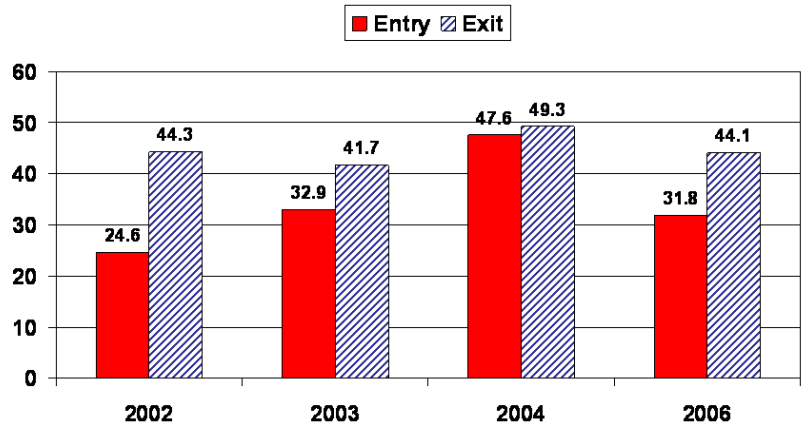
Exhibit 2.9 shows that nationally, about one in five people in SHP-funded programs already have food stamps when they enter, and one in four have them when they exit. Norfolk, Portland, and Allegheny County exceed that national average by quite a bit, with 40 percent of exiters in Norfolk, 41 percent in Portland, and 37 percent in Allegheny County being food stamp recipients.

Once again, the Portland SSO Collaborative provides an example over a number of years of one program's ability to help its clients access this important public benefit. At least 40 percent of Collaborative clients had food stamps at program exit from 2002 through 2006

[5] Of course, these changes in Food Stamp Program procedures do not make access certain, as many chapters of this report make clear. But many chapters also describe a variety of mechanisms that increase access, whether they are undertaken by homeless agencies, welfare agencies, or the two working together.

(shown in Exhibit 2.10), as well as in 2007 (Exhibit 2.9). In some years, reaching this level of benefit receipt was more of a challenge than in others. In 2002, only one in four clients had food stamps at program entry, which the Collaborative was able to increase to 44 percent at exit. Conversely, program entrants in 2004 were already at a very high level of food stamp receipt (48 percent) and the Collaborative added barely 1 percent to that level by the time people left the program.

Exhibit 2.10: Portland's Collaborative SSO—Receipt of Food Stamps

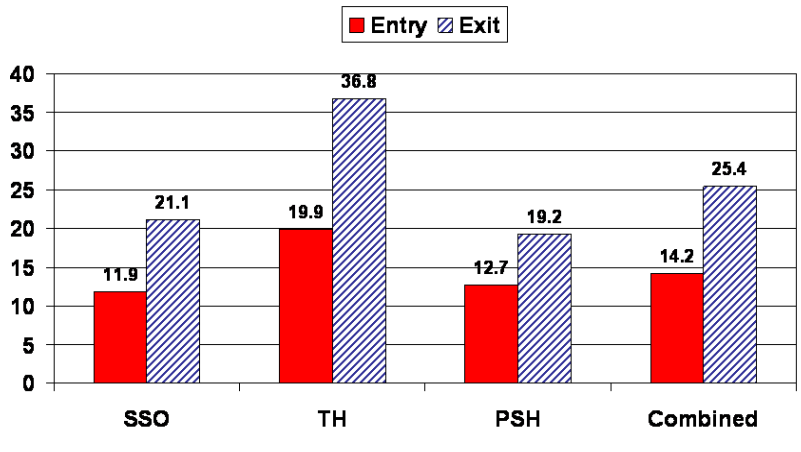


Sources: APR data for 2002, 2003, 2004, and 2006 supplied by Portland Collaborative SSO.

Income from Employment

Finally, we look at income from employment. Technically speaking, employment is not a mainstream benefit or service, although assistance to qualify for, find, and keep employment may be such a service if people are able to connect through a local One-Stop career center supported by the U.S. Department of Labor. Employment is, however, one of HUD's three overarching goals for the Supportive Housing Program and APR questions 11C and 11D measure it. Community scores on annual CoC applications to HUD depend in part on how successful the community is in helping clients find and keep employment, so communities are highly motivated to keep this number as high as possible. Communities whose SHP-funded programs lean heavily toward SSO and TH programs, which emphasize employment more than do PSH programs, are likely to report higher levels of employment than those with a major commitment to PSH.

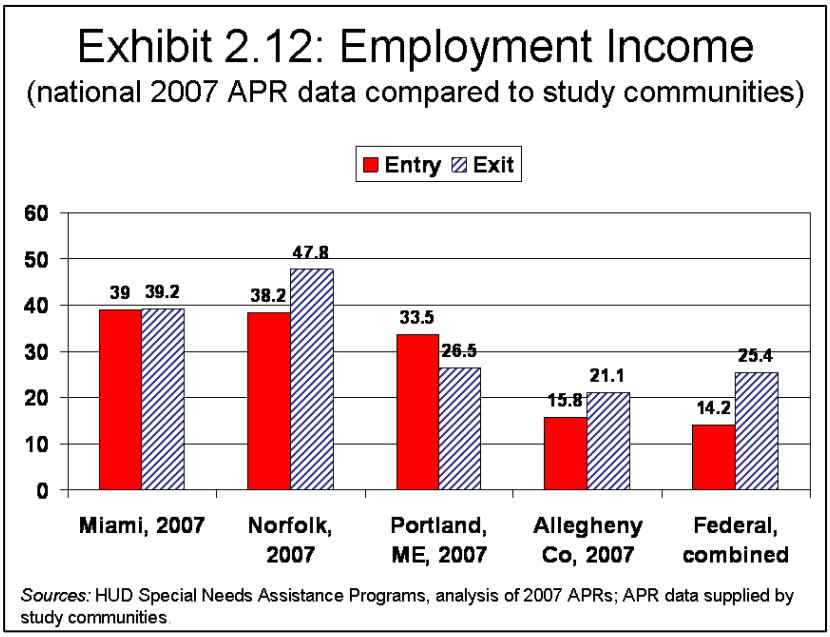
Exhibit 2.11: Employment Income, Nationally
(APR data, 2007)



Source: HUD Special Needs Assistance Programs, analysis of 2007 APRs

Nationally, 25 percent of people leaving SHP-funded programs in 2007 had income from employment at exit—up from 14 percent at program entry (Exhibit 2.11). Employment rates at exit were considerably higher for TH program leavers (37 percent) than they were for SSO and PSH leavers (19–21 percent).

Some study communities report employment rates at program exit for 2007 that are quite close to national averages (Exhibit 2.12). Miami and Norfolk are exceptions, reporting considerably higher rates of income from employment at SHP-funded program exit than happens nationally or for other study communities. The relatively low availability of GA, TANF, Medicaid, and food stamps for Miami's homeless people is balanced by the level of employment that program clients are able to achieve.



Implications

Compared to national averages for 2007 APR data, study communities mostly do better at helping homeless people access mainstream services. This ability covers quite a number of diverse mainstream programs, including SSI, SSDI, TANF, food stamps, and Medicaid. Even though the data for documenting improved access are not the best for this purpose, clients of homeless assistance programs in study communities appear to have more success in obtaining important public benefits.

CHAPTER 3: COMMUNITY STRUCTURES FOR PROMOTING MAINSTREAM ACCESS

We began this study knowing that homeless people often have trouble gaining access to mainstream benefits, for reasons ranging from not knowing they were eligible or where or how to apply through encountering complex application procedures that demand information they cannot provide. We assumed that in most communities we would find some arrangements that make it easier for homeless people to sign up for benefits. Usually these arrangements are worked out among one or two case workers at a particular homeless service provider and one or two intake workers at a public agency responsible for a mainstream benefit such as food stamps or Medicaid. Although fairly common, such arrangements are personal—when staff turn over they have to be forged all over again. They usually are not systematic enough to affect the level of benefit receipt for significant numbers of homeless people throughout a whole community. In terms of the 4 Cs described in Chapter 1, these personal relationships function at the level of *communication*. They rarely extend beyond a connection of one homeless assistance provider to one public agency, and not infrequently are limited to specific case workers in those agencies.

We expected that getting beyond this level of personal arrangements and into access mechanisms that reach the levels of *coordination* or *collaboration* would take commitment, strategy development, and organization. Therefore we looked for communities to include in this study that appeared to have strong centralized leadership that has taken on the challenge of increasing the proportion of homeless people who could be successfully linked to mainstream benefits. Not every community in the study fully meets this criterion, because we also wanted diversity in geographic location and community size, as well as wanting to include "new" communities—those that had not previously been included in U.S. Department of Housing and Urban Development (HUD) studies. The final group of seven communities includes several with strong central organizing structures and one or two with significantly less communitywide commitment to increasing mainstream access. This range in the nature of organizing structures gives us the opportunity to observe what such structures can accomplish by way of promoting coordinated and collaborative access mechanisms, and what can be accomplished when they are less powerful or less active.

Each community in this study has some type of communitywide organizing structure. These structures have the capacity to identify barriers that prevent homeless people from accessing benefits and services from mainstream public programs. Through these structures, communities could choose to generate ways to reduce these barriers if they considered doing so a priority. The communities differ considerably, however, in the scope and authority of their organizing structure, the extent to which it has taken on this challenge, and the resources it has at its disposal for increasing access. For the reader to fully appreciate the mechanisms that communities have developed to overcome structural, capacity, and eligibility barriers (described in Chapters 4, 5, and 6, respectively), it is essential to understand the role of community organizing structures

and how specific mechanisms fit into the overall picture of the ways these seven communities address the homelessness in their midst.

The Organizing Structures

Five of the communities included in this study have strong central organizing structures that identify gaps and take steps to fill them, including gaps in homeless people's access to mainstream benefits and services. Two have strong mayoral support (Denver and Norfolk), one has an independent funding stream (Miami-Dade County), another (Denver) does major fundraising from the private community, two have been their community's primary focus of planning and action to ending homelessness for more than 15 years (Miami and Portland), and three have major involvement of the public agency that controls core public benefits (Denver, Norfolk, and Portland). Albany has a working alliance among its homeless coalition and two county government agencies that has generated significantly more access mechanisms than neighboring counties, despite the absence of the types of political support found in Denver and Norfolk. Finally, Albuquerque does not have the benefit of a strong central structure, but provider efforts over the years have gone some way toward improving access to mainstream services for their own clients through various arrangements with public agencies.

Exhibit 3.1 provides an overview of these structures for the seven communities. The first column shows the community and the year in which the primary organizing structure began. Each of these communities has a 10 Year Plan to end homelessness (10YP); the year each 10YP was released appears in the first column also. The longest standing organizing structure is Portland's Emergency Shelter Assessment Committee, which dates from the mid-1980s, followed by Miami's Homeless Trust, which was established by county ordinance in 1993. Portland and Miami came rather late to the 10 Year Plan movement, but both communities already had plans that had guided their activities for at least a decade and a half. The Albany County Coalition on Homelessness also got organized more than a decade ago; organizing structures in the remaining four communities date from 2000 through 2004.

These seven communities do not put equal weight on their 10YPs, even though they each have one. In Miami the 10YP augmented a long-standing Homeless Plan that did not initially focus on permanent supportive housing or ending chronic homelessness, but which had shifted to incorporate that emphasis before the local 10YP was developed. Portland does not have a 10YP of its own but participates in Maine's statewide plan, into which it had significant input. It has locally developed plans that have long guided the continuing development of its homeless system. Denver and Norfolk developed 10YPs as part of a new mayor's significant emphasis on ending homelessness. In these two communities, the 10YP is a critical blueprint for the organizing structures, both housed in the mayor's office and both enjoying considerable leverage to pursue the plan with vigor. Pittsburgh, Albany, and Albuquerque have multi-year plans but they are not as central to day-to-day activities as these plans are in Denver and Norfolk.

Exhibit 3.1: Key Features of Study Communities that Facilitate Homeless People's Access to Mainstream Services

Community	Organizing Entity	Implementing Entity	Role of Local Elected Officials	Role of Mainstream Agencies	Role of Service Providers	Change in Level of Resources
Miami (since 1993; 10 Year Plan [10YP] in 2004 as add-on to Homeless Plan)	Homeless Trust (HT)	Homeless Trust	Five of 27 HT Board members either are or represent local elected officials; elected law enforcement and mayors have strongly supported the Criminal Mental Health Project; HT advises County Board of Commissioners on homeless matters	Recently signed Memorandum of Agreement to increase connections with homeless system; much co-location; strong involvement of criminal justice agencies; schools and Department of Children and Families have representatives on HT Board	Main access mechanisms run through providers—Citrus for outreach and jail connections, Camillus for families, Community Partnership for the Homeless for the Homeless Assistance Centers	Local dedicated tax, increased state funding, especially for Criminal Mental Health Project
Denver (since 2000; 10YP since 2005—established Denver's Road Home)	Denver Commission to End Homelessnes s/ Denver's Road Home (DRH)	Denver's Road Home and the Commission's seven committees	Strong commitment of mayor and City Council	Strong Dpt. Of Human Services (DHS) involvement; DRH is housed in and works integrally with Denver DHS	Many new and expanded programs under Denver's Road Home to increase access as well as other goals	Major fundraising focus—$46 million for first four years, on target; 50% public, 25% corporate, 25% private
Pittsburgh (DHS reorganized in 1997; Advisory Board since 2003; 10YP since 2005)	Allegheny County Homeless Advisory Board—public-private partnership	Department of Human Services and, through its contracts, service providers	Not directly involved	DHS is the locus of most activity to increase access; funding flexibility to fill gaps identified by Advisory Board	Work closely with DHS to implement strategies that DHS funds	Have refocused existing money, generated new grant funds from the U.S. Department of Housing and Urban Development and the Substance Abuse and Mental Health Services Administration for targeted services

Exhibit 3.1: Key Features of Study Communities that Facilitate Homeless People's Access to Mainstream Services

Community	Organizing Entity	Implementing Entity	Role of Local Elected Officials	Role of Mainstream Agencies	Role of Service Providers	Change in Level of Resources
Portland (since 1987; no local 10YP, statewide since 2008 but were earlier plans)	Emergency Shelter Assessment Committee (ESAC)	ESAC's Mainstream Resources and Priorities Committees	Not directly involved, but supportive	Do trainings, establish point person, co-locate staff, provide leadership through ESAC membership	Highly collaborative, host co-located staff, extend trainings internally	Small increase in health resources, bridge housing resources
Norfolk (since 2004; 10YP since 2005)	Mayor's Office to End Homelessness (OEH); Norfolk Homeless Consortium	OEH; Homeless Action and Response Team (HART), Consortium	Strong mayoral commitment	HART is housed in DHS, which promotes mainstream access for families and some singles, and connects to other agencies	Support HART and efforts to end/ prevent family homelessness, but less integrated with other 10YP goals	Creative use of state funds for family preservation, some use of federal block grant funds, but have faced significant cuts
Albany (since 1996; 10YP since 2005)	Albany County Coalition on Homelessness (ACCH)	Split—co-location, Single Point of Access for mental health services	Endorsed 10YP development; supportive through Dpt. of Social Services (DSS)	Participate in ACCH; Dpt. of Mental Health leads Single Point of Access for mental health services	Participate in ACCH	NY has General Assistance; DSS has put resources into prevention and Housing First
Albuquerque (since 2003; 5 Year Plan [5YP] since 2007)	New Mexico Coalition to End Homelessness and its Steering Committee for the Albuquerque Continuum of Care	Mostly actions of individual service providers seeking resources for their clients	Local government funded the Coalition to write a 5YP, but the plan was written and is being implemented by the Coalition	One provider has funding from several mainstream agencies, but most do not; some co-location, some procedural changes	Provide the primary leadership and all the implementation	City funds Housing First, Homeless Court, centralized substance abuse intake through sobering center on its own initiative; low level of services combined with recent budget cuts are big problem

The second and third columns of Exhibit 3.1 show each community's organizing and implementing entities. In Miami, Denver, Portland, and Norfolk, these entities are the same, usually with different committees of the whole pursuing their own responsibilities within the overall plan. In Pittsburgh/Allegheny County, the county Department of Human Services is the primary implementing entity, taking ideas originating in the Allegheny County Homeless Advisory Board, of which it is a part, and some of its own ideas and giving them operational reality through its use of contracts for various homeless-related services. In Albany, the homeless coalition and mainstream agencies working together have developed some very useful mechanisms for improving access, while activities in Albuquerque are less centrally orchestrated, even though an official organizing entity exists. Much is left up to provider initiative to negotiate with mainstream agencies for their own clients.

The remaining columns of Exhibit 3.1 display the role of local elected officials, mainstream agencies, homeless service providers, and funding in promoting homeless people's access to mainstream services. It should already be clear to the reader that the communities with the strongest organizational thrust to improve mainstream access are those such as Denver and Norfolk that have the strong support of the mayor; those that have an independent flexible source of revenue (Denver and Miami); or those that are so well established in their community, with the involvement of many stakeholders, that their planning and implementation activities are widely supported (Miami, Portland, and Pittsburgh).

In terms of the scope of these communities' efforts to improve mainstream access, Norfolk focuses mostly on families while the remaining six communities encompass all homelessness within their geographic boundaries.

The Miami-Dade County, Pittsburgh/Allegheny County, and Albany organizing structures cover the whole county, which coincides with the Continuum of Care (CoC). Norfolk, Denver, and Albuquerque organizing structures cover the city only. In the case of Norfolk and Denver, the city also has county functions—that is, there is no larger county of which the city is a part. Norfolk and Albuquerque are their own CoCs. In contrast, the city and county of Denver's CoC includes six other counties and is managed by a different organizing structure, the Metropolitan Denver Homeless Initiative. Denver's Road Home works with the larger CoC community to prevent homelessness by expanding the supply of affordable housing through changes in zoning, urban design, and land use, and also expanding the supply of emergency shelter accommodations for the short term. Portland's organizing structure has evolved into a hybrid. It is mostly focused on the City of Portland, which is its own CoC, but it has recently extended its reach to collaborate with activities funded by its surrounding county that are designed to keep families facing a housing crisis in their own homes and communities rather than sending them to Portland for assistance, as was the practice in the past. Portland also participates in a regional homeless council that has planning functions for Portland, its county (Cumberland), and neighboring York County.

Snapshots of Community Organizing Structures

What follows are brief summaries of the organizing entities in the seven study communities, along with graphic depictions of how they relate to mainstream access mechanisms and the local public and nonprofit provider agencies.

- **Miami and Dade County's Homeless Trust (HT)—**HT is the hub of the county's homeless services system, as shown in Exhibit 3.2. It manages a budget of about $40 million a year, including proceeds of the county's food and beverage tax, 85 percent of which is dedicated to supporting homeless services; HUD grants through the CoC; and other public and private resources. It developed and implements the Miami-Dade County Community Homeless Plan, including periodic assessments and revisions as needed, and advises the County Board of Commissioners on matters related to homelessness. HT consists of a 27-member board that is broadly representative of stakeholders in the work of ending homelessness. HT Board members include representatives of local governments (the Miami city manager, three representatives of the county's League of Cities, one County Commissioner, the school superintendent, and the head of the district office of the state Department of Children and Families); service providers; business, civic, and religious leaders; and formerly homeless people. The Board guides the work of HT staff; many board members also take active roles in promoting homeless services, developing structures to end homelessness, and raising money and other resources. The HT routinely works to identify gaps in services or access and then takes steps to fill those gaps, using the resources at its disposal. Mechanisms are shown in the lower part of Exhibit 3.2.

- **Denver's Road Home (DRH)**—Denver's Road Home, the name Denver has given to its integrated efforts to end homelessness, has garnered national attention for its 10 Year Plan to End Homelessness for the City of Denver and its unique system of support for homeless services. Upon assuming office in 2004, Mayor Hickenlooper appointed the Denver Commission to End Homelessness, a group of 41 representatives from local government, nonprofits, philanthropic organizations, and homeless people, plus over 350 volunteers. Its seven committees contributed recommendations to the original plan and continue to meet to discuss issues and make recommendations to the Commission. Working closely with the Denver's Road Home Office, these committees address the issues and goals enumerated in Denver's 10YP, working with a highly coordinated and goals-driven approach. With local public and private support (but little state support in terms of resources), Denver provides an example of targeted resource allocation with a special emphasis on mainstream benefit receipt for homeless people through an extensive network of outreach activities. The city has taken on significant responsibilities regarding the elimination of homelessness while also bringing in more private service providers and funding from the business and philanthropic community and other private sources. Exhibit 3.3 shows Denver's Road Home at the top and the numerous mechanisms it has created and funded to increase mainstream access.

Exhibit 3.2: Miami and Dade County's Activities that Promote Homeless People's Access to Mainstream Services

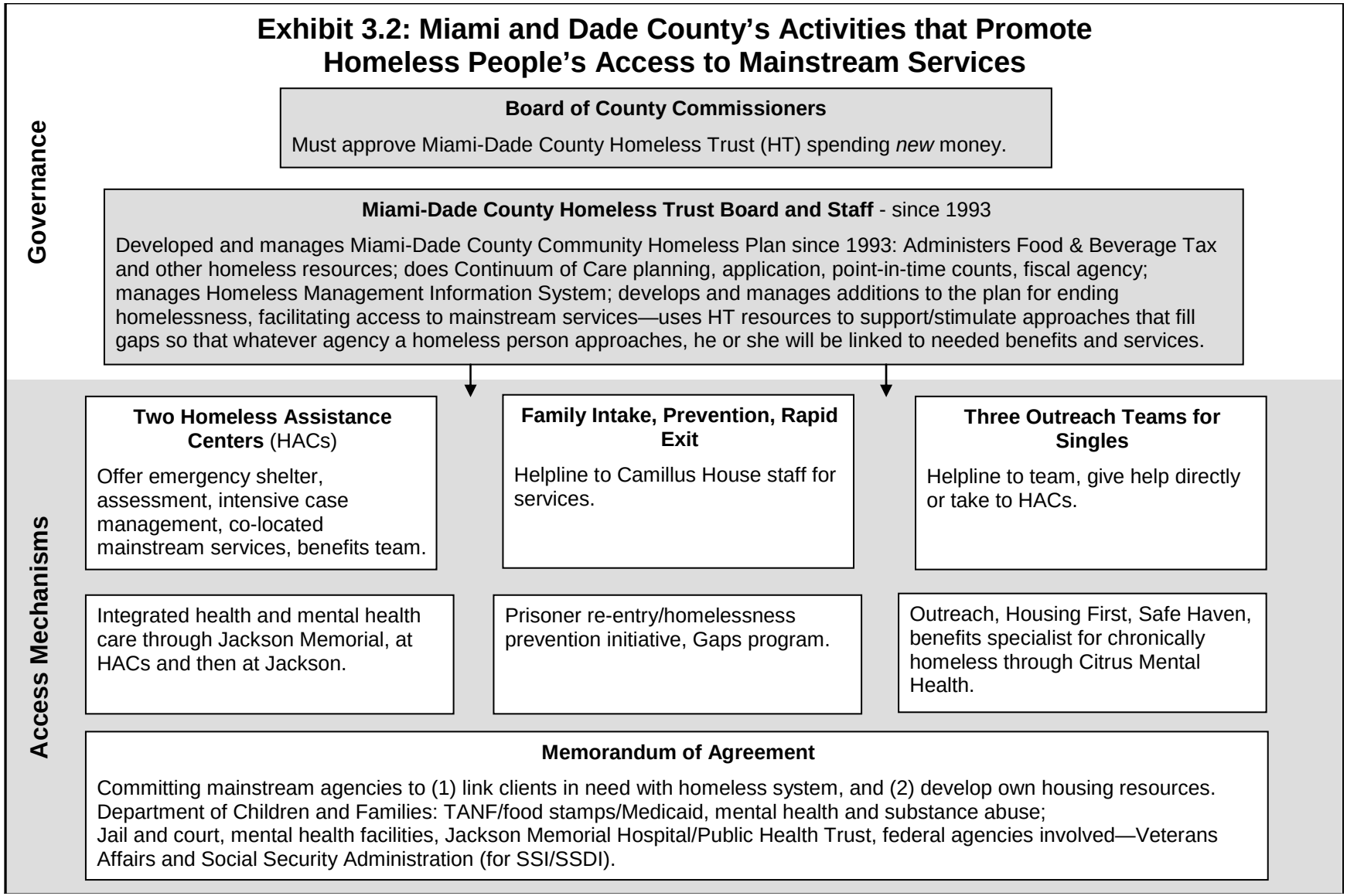


Exhibit 3.3: Denver, Colorado's Activities that Promote Homeless People's Access to Mainstream Services

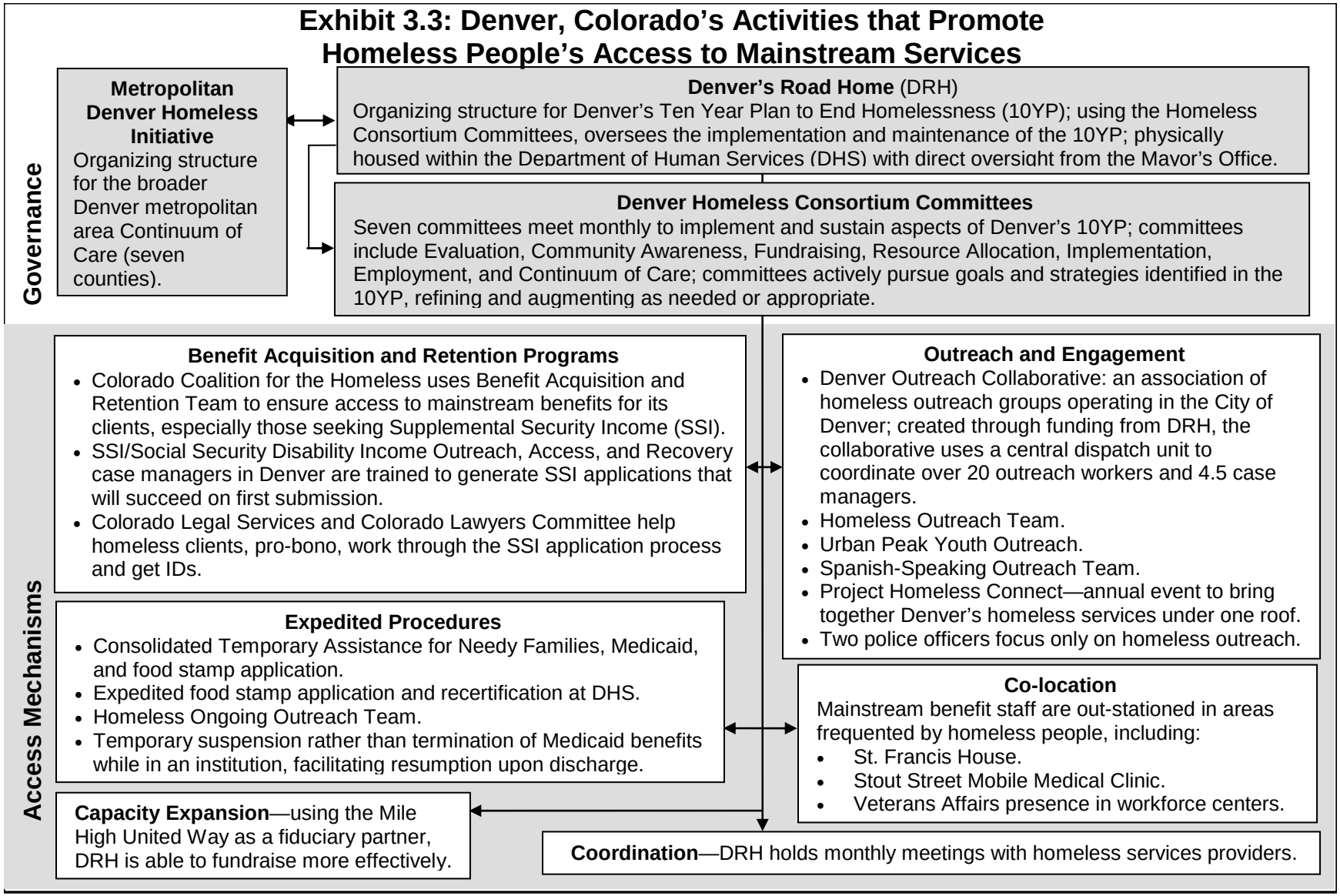
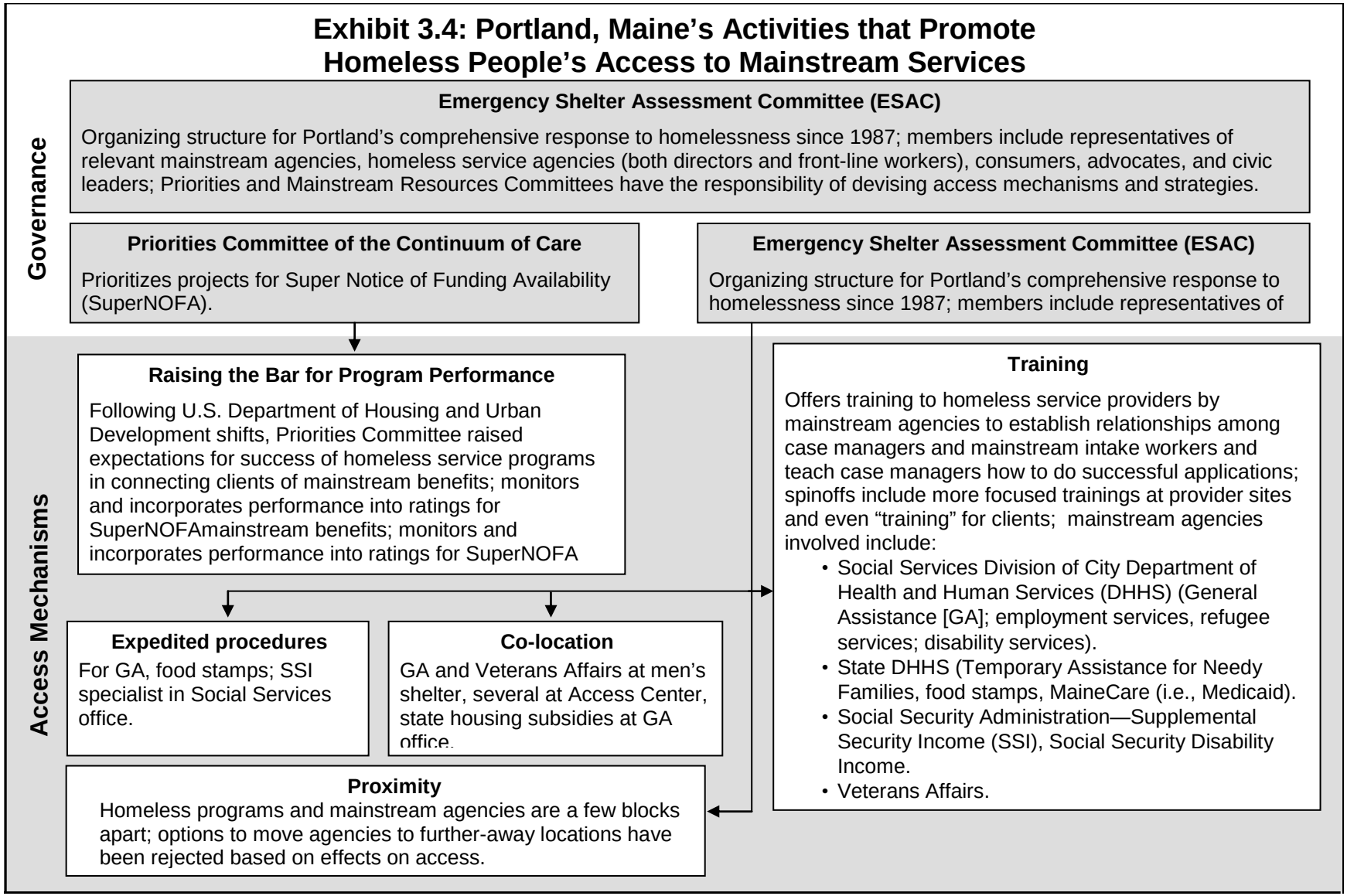


Exhibit 3.4: Portland, Maine's Activities that Promote Homeless People's Access to Mainstream Services



- **Portland, Maine's Emergency Shelter Assessment Committee (ESAC)**—Portland was the first entity in Maine to have any type of homeless plan or structure to address homelessness. ESAC, shown at the top of Exhibit 3.4, predates the McKinney Homeless Assistance Act of 1987, having been established in the mid-1980s when the City of Portland and the United Way formed a task force to examine the growing phenomenon of homeless families and develop ideas for how to address it. The initial charge of addressing family homelessness was ultimately broadened to include all homelessness. From early on, ESAC monitored who used the shelters, how long they stayed, what they needed, and similar issues. It also developed a common assessment tool for people approaching shelters for the first time and a data system for recording results and tracking shelter use and outcomes. Membership includes executive directors of homeless assistance programs, public agency directors (city and state Department of Health and Human Services divisions, Portland police, Portland Planning and Development), advocates, and case managers/line workers from across the city, providing diverse perspectives that together cover the spectrum of stakeholders. ESAC's Mainstream Resources Committee develops trainings to improve the ability of provider staff to help clients access mainstream services, while its Priorities Committee monitors providers to be sure they are doing as much as possible to link clients to these services. These mechanisms appear in the lower portion of Exhibit 3.4.

- **Pittsburgh/Allegheny County's Homeless Advisory Board**—Established in 2003, the Advisory Board is a public-private partnership responsible for overseeing the community's Continuum of Care and 10 Year Plan to end homelessness (see Exhibit 3.5). The Advisory Board's membership includes the county's Department of Human Services (DHS). DHS' Office of Community Services (OCS) has primary responsibility for homeless-related programs in the county. OCS provides staff support for the Advisory Board and serves as the CoC's fiscal agent. Other Advisory Board members include representatives of other Allegheny County government agencies; Pittsburgh, McKeesport, and Penn Hills government entities; a wide range of mainstream and homeless services provider organizations; and a highly active group of local foundations. The Advisory Board provides overall guidance and direction to the development of the homeless service system in Allegheny County. The aspects of Pittsburgh/Allegheny County's organizational structure of most interest for this chapter are: (1) the considerable integration among DHS program offices and the engagement of key players from each of these offices in developing integrated service programs and (2) the integration of foundations into the funding picture. Through the cooperative interactions within DHS, the department is able to modify service contracts, blend or shift funding, and support community providers to fill service needs identified by the Advisory Board, as shown in the lower portion of Exhibit 3.4. Many of the providers so affected serve at-risk as well as literally homeless populations such as people with psychiatric disabilities, addictions, and/or the need for child or adult protective services. Homeless and at-risk households gain access to integrated services when the same provider receives homeless, behavioral health, and possibly child welfare or aging-related funding. Foundations actively participate on the Advisory Board and work with DHS and other funders to make

resources available for services and other aspects of programs deemed important within the community but that have no immediate public source of support. The DHS structure, foundation involvement, and the highly engaged provider community are credited with the community's success in winning both HUD and behavioral health funding.

- **Norfolk's Mayor's Office to End Homelessness, Commission to End Homelessness, and the Homeless Consortium**—Norfolk's mayor established the Commission to End Homelessness in early 2004 and charged it with developing a 10 Year Plan for the city (see governance section of Exhibit 3.6). In May 2005, the 10YP was released, reflecting the input of many local stakeholders to identify gaps in the city's homeless system. Within his office the mayor also created the Office to End Homelessness (OEH) and charged it with assuring that the elements of the 10YP are implemented and are establishing and maintaining links to the various homeless initiatives in the city. Thanks to its position in the mayor's office and the mayor's strong support, OEH has been instrumental in steering public dollars (for example, Home Investment Partnership Program [HOME], Community Development Block Grant [CDBG]) into the homeless system and coordinating with the Homeless Consortium, which represents the entire homeless assistance system in Norfolk. Norfolk's mechanisms for assuring access to mainstream services, shown in the lower portion of Exhibit 3.6, focus on families, although they do reach some single adults. The Homeless Action and Response Team (HART) is a project of the Department of Human Services that began in 2003, before OEH was established. Its location in DHS gives it excellent access to TANF, food stamps, and employment and training resources, and the support it receives through OEH and the Consortium assures that it is able to connect its clients to many other resources. HART provides a single point of entry for homeless families and helps them locate housing, using emergency rental assistance for short-term coverage of rent and moving costs and working with the Housing Broker Team in DHS to mediate with family members or landlords on behalf of clients. HART also helps families access public resources and, if appropriate, gain access to transitional or permanent supportive housing programs.

- **Albany County Coalition on Homelessness (ACCH)—**ACCH has long been the organizing entity that brings providers together to focus on ways to improve homeless services in Albany County (Exhibit 3.7). The level of cooperation among providers is viewed locally as the community's greatest strength in addressing homelessness. The county departments of Social Services and Mental Health participate in ACCH and have strong administrative commitments to facilitating access to the benefits they control, including outstationing workers in homeless service agencies. Homeless people in Albany are able to take advantage of the generous benefits provided by the state of New York, although state rules for TANF impose very long wait times and onerous procedures on applicants (for example, drug and alcohol abuse screening), which hinder access to that benefit. The alliances among homeless providers and two mainstream agencies have been able to establish significantly more functional access mechanisms than are found in many of the counties surrounding Albany.

Exhibit 3.5: Pittsburgh and Allegheny County's Activities that Promote Homeless People's Access to Mainstream Services

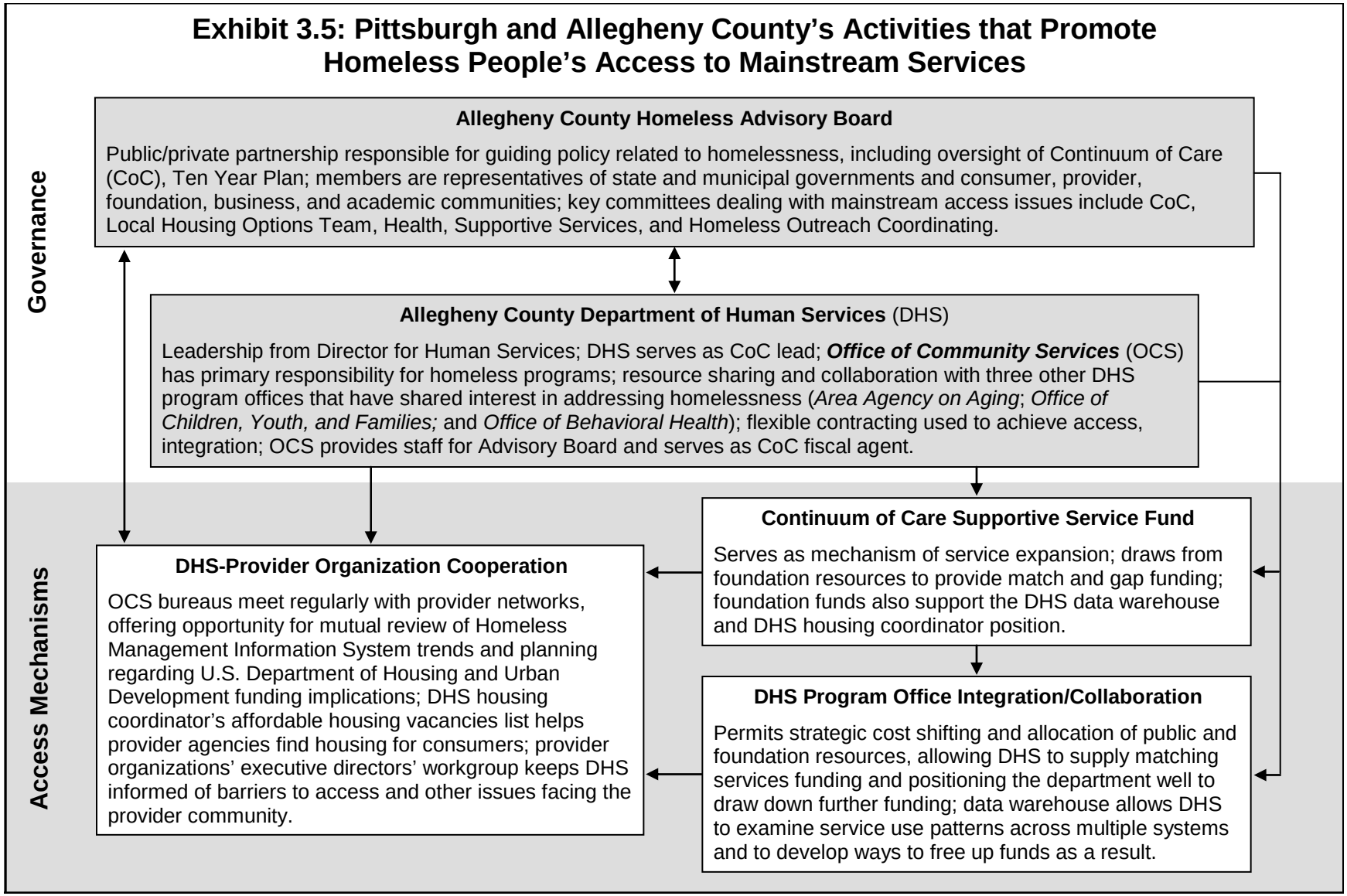


Exhibit 3.6: Norfolk, Virginia's Activities that Promote Homeless People's Access to Mainstream Services

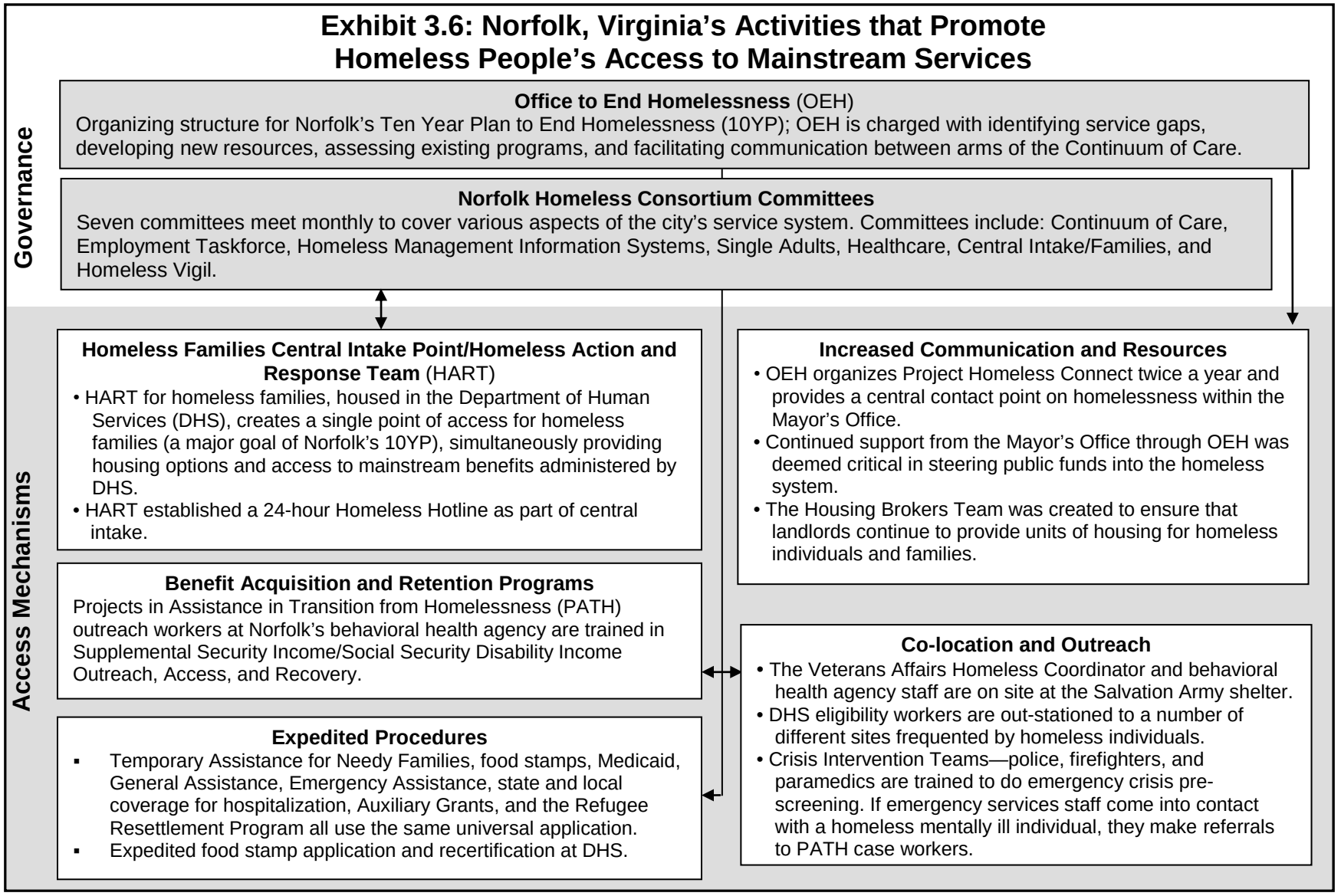
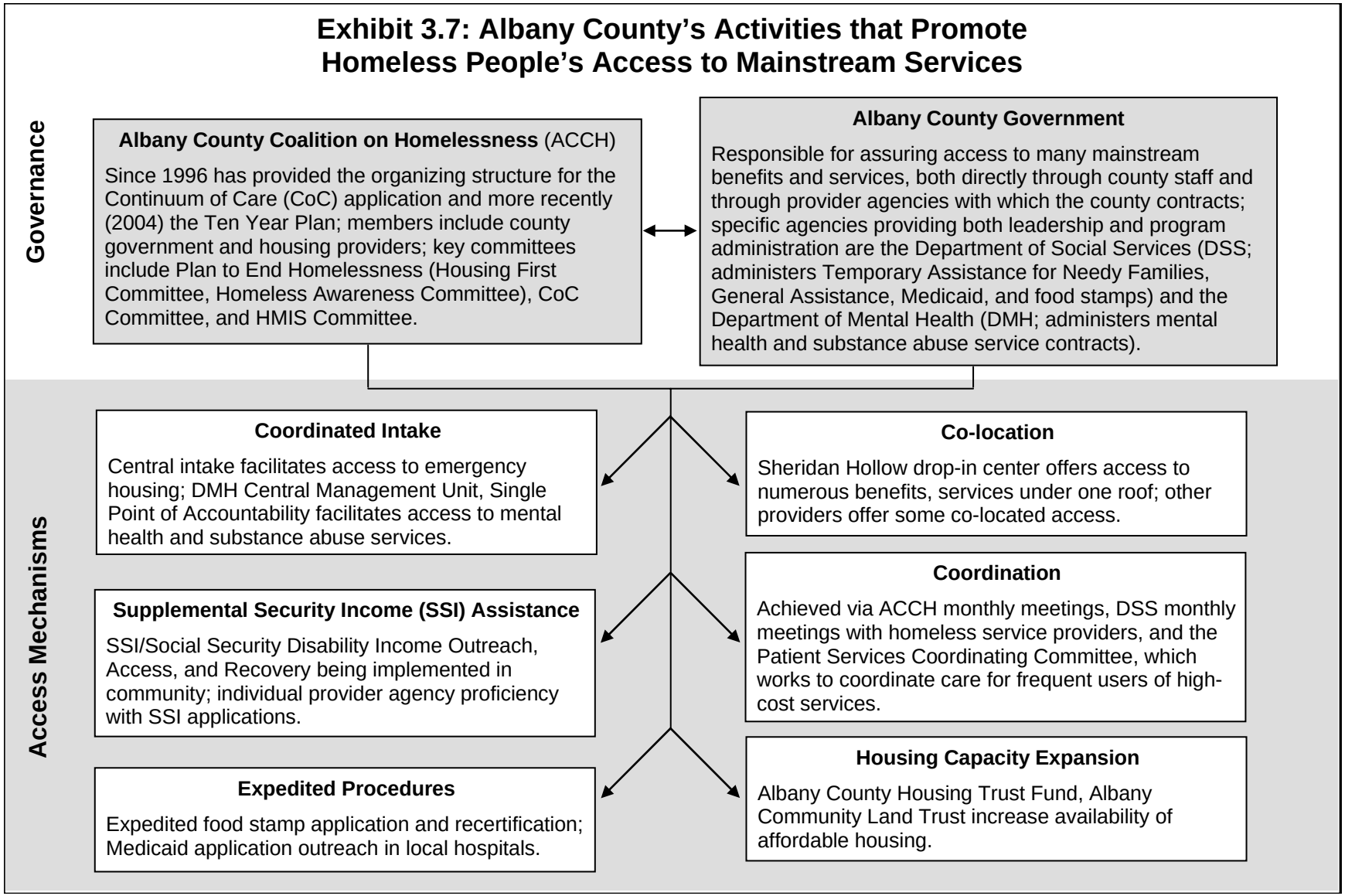
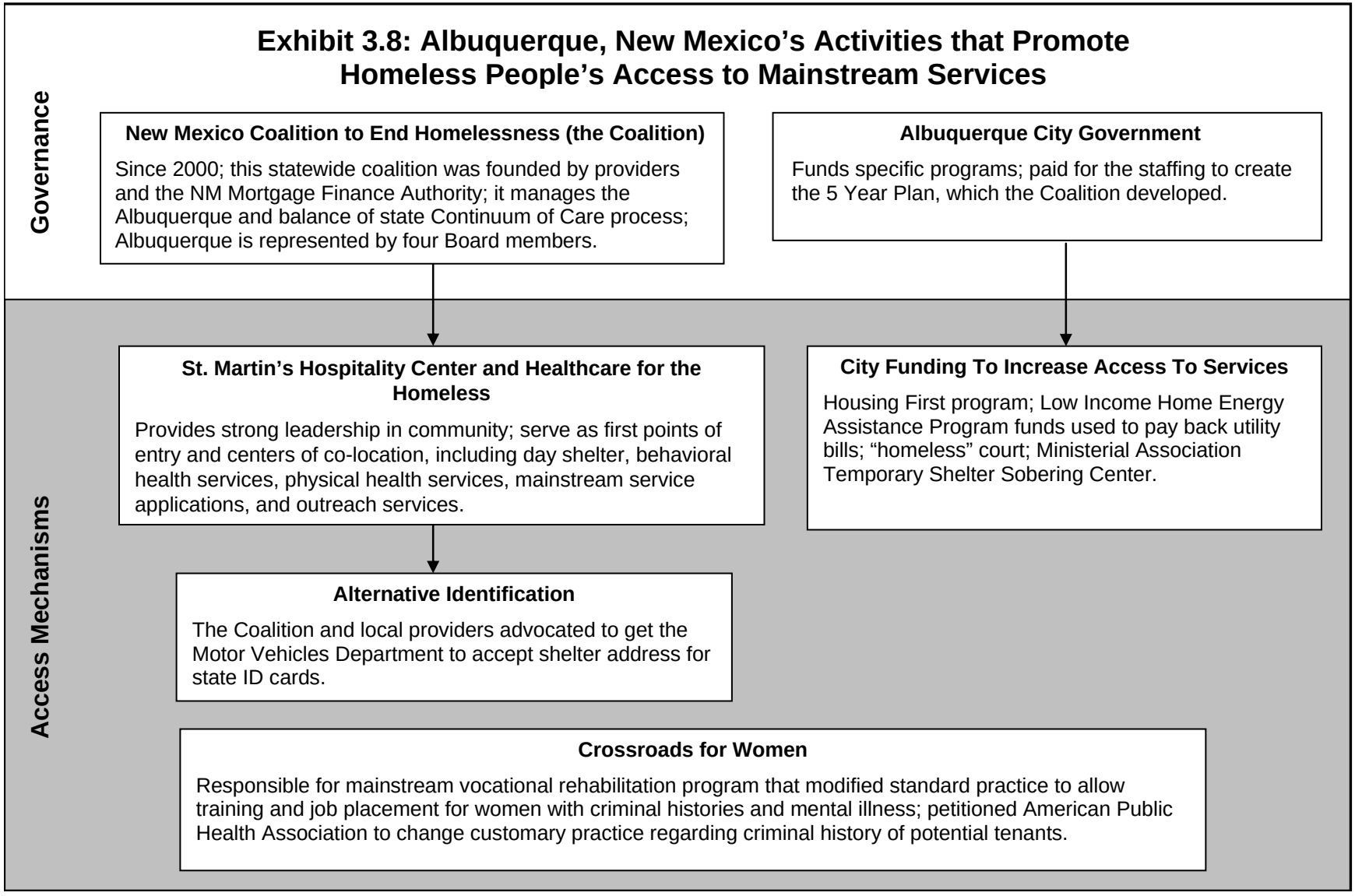


Exhibit 3.7: Albany County's Activities that Promote Homeless People's Access to Mainstream Services



- **New Mexico Coalition to End Homelessness (NMCEH)**—Albuquerque does not have an organizing entity of its own. Its CoC and the balance of state CoCs are both coordinated by the NMCEH, whose membership consists mostly of providers and one state agency, the New Mexico Housing Finance Agency, as shown in Exhibit 3.8. Leadership to improve access to mainstream benefits comes largely from three providers, St. Martin's Hospitality Center, Albuquerque Health Care for the Homeless, and Crossroads, a provider serving women ex-offenders. Given the state's minimally funded services context and budget cuts, provider efforts to establish working relationships with staff at public agencies and one-person-at-a-time case advocacy account for most of the success achieved in Albuquerque in helping homeless people get mainstream services. Crossroads has been particularly successful at getting public resources for its clients through grants and contracts.

Exhibit 3.8: Albuquerque, New Mexico's Activities that Promote Homeless People's Access to Mainstream Services



The Advantages Gained Through Strong Central Organization

Most study communities have a strong central organizational structure that has used its position to great advantage. These structures take the multi-year view. They set goals, identify gaps in existing service offerings or approaches that would get in the way of meeting goals, develop strategies to fill gaps and meet goals, and assess their progress and alter course if needed. Most have deliberately set out to increase the proportion of homeless people in their community who receive mainstream benefits, recognizing that gaining access often is not easy for homeless people and setting up mechanisms to facilitate not just access but approved applications and continued receipt. While they may not set numerical goals, their experience and sometimes formal documentation tells them that many more homeless people are probably eligible for an array of benefits than are currently receiving them, so their goal is "more." To assemble the resources to put facilitating mechanisms in place and to build community support, a number of them go to great lengths to explain their goals, strategies, and progress to their communities in the expectation that the communities will respond with both strategic and financial support.

This chapter provides some examples of what the strong central organizations in our communities have accomplished and continue to accomplish, pointing out especially the goal-setting, strategizing, monitoring, fundraising, resource allocation, and community reporting activities as they have occurred over a number of years. The most highly organized communities come first. Denver, Miami, Portland, and Pittsburgh can reasonably be considered to have created a *coordinated community response* to homelessness, and Norfolk has done so for families. Albany appears to be operating in *coordinated* and sometimes *collaborative* ways, with strong alliances at the level of public agency administrators and homeless service providers, but without the dramatic commitment of a mayor. Albuquerque, the last study community, does not have the types of organization observable in the first six communities, but it does offer an example of what providers can accomplish even when there is little strategic support for communitywide solutions from public officials. The examples that follow, many of which are quite lengthy, while others are brief, all pertain to increasing homeless people's access to mainstream benefits and services.[6]

Denver, Colorado

In Denver, the work of the Mayor's Commission's Fundraising Committee and the outreach development focus of the Resource Allocation Committee, along with implementation by the Denver's Road Home office, highlight the advantages of strategic thinking and implementation.

[6] Many of these communities have pursued other goals (for example, decreasing chronic homelessness, family homelessness prevention) with equal fervor, but this report concentrates on their approaches to increasing mainstream access.

Fundraising

As noted in Chapter 2, the Denver Commission to End Homelessness thought it would take $46.1 million to carry out its 10YP, with a good part of these resources going to create or expand mechanisms that increase access. The Commission created a foundation-funded executive director position for the DRH office to oversee fundraising and assure that the money raised was allocated to activities that would further the plan. The 13-member Committee on Fundraising within the Denver Commission to End Homelessness does the actual fundraising; the DRH Executive Director sits on that committee.

The mayor did not want the funding for the 10YP to come from places already giving, so he looked for new sources. His strategy was to get everyone to invest, allocating responsibility among three sectors as follows: $23 million from government sources, $11.5 million from foundations, and $11.5 million from private donors, including corporations. The mayor successfully lobbied for foundation support, asking for an expansion of what foundations were already giving. Foundations agreed, with the understanding that as the city implemented the initiative, the funding would shift more toward public dollars. A favorable composition of the Denver City Council aided this fundraising strategy. Foundations also made their support contingent on participation from businesses and the private sector. Fundraising is more than on target, with approximately 75 percent of the money needed having been raised by the end of the 10YP's second year (2007).

Denver has been creative in its approach to fundraising from private sources, often coupling it with community awareness campaigns to sustain community support for completing the plan. For example:

- The mayor hosts an annual "PJ Party," a fundraiser at a downtown hotel. Everyone wears pajamas to this "signature event" (the mayor and workers at about a dozen businesses wear pajamas to work a couple of days in advance to raise awareness). Hotel room revenue for those attending the party is donated to Denver's Road Home. The PJ Party raised $140,000 in 2008; Denver's Road Home was aiming to raise $250,000 in 2009. In fact, it raised $500,000, when a philanthropic couple donated a dollar-for-dollar match of all proceeds.

- Denver's Road Home has installed special "parking meters" in downtown areas most frequented by panhandlers and combined them with a "Give a Better Way" public awareness campaign. In addition to generating over $100,000 a year in donations, downtown Denver has seen a 92 percent reduction in panhandling.

- The Downtown Business Improvement District provides substantial resources for the Denver Outreach Collaborative, one of Denver's primary mechanisms for connecting street and homeless people to mainstream benefits and services.

- The Mile High United Way acts as fiscal agent for Denver's Road Home, collecting all funds raised, issuing requests for proposals for projects and services, reviewing responses, and issuing contracts. It was thought that having a nonprofit

agency serve as fiscal agent would increase the odds that individuals and businesses would contribute, rather than their giving money to a government agency. With more money, DRH has been able to support more access mechanisms.

Monitoring, evaluation, and publicizing results go hand-in-hand with fundraising. Denver's Road Home's ability to show results, both "on paper" and in terms of visible differences on the streets of downtown Denver, is the best leverage for raising the resources needed to continue the 10YP. In addition to the reductions in homelessness and panhandling achieved by the 10YP so far, DRH also tracks reductions in use of expensive crisis public services as a consequence of housing homeless people, and reinvests those cost savings in further activities to end homelessness.

Outreach Collaborative

Through the Resource Allocation Committee of the Commission to End Homelessness, DRH operates strictly from the 10YP. Its decision rule for funding projects is "How does this fit into the 10 Year Plan? How do we fill holes?" If an activity will not further the 10YP, it will not be funded, but the approach does leave room for funding new strategies that arguably will further Plan goals. United Way and DRH staff monitor grant recipients three times a year to assure they are performing up to expectations, and troubleshoot with any projects that do not appear to be meeting 10YP goals. Depending on how a program is performing, DRH will pull or increase funding—sometimes even mid-grant. As one informant said, "Sometimes we give a project more money during the year and say, 'Do more!! You are doing great, add to it.'"

The Denver Outreach Collaborative is one structure that DRH has funded in its efforts to increase access to benefits that reflects the ability of a strong central organization to fund many activities with the same goal and orchestrate their performance to cover the complex reality of homeless people's needs. All outreach within the Collaborative is geared to connecting homeless people to mainstream resources and getting them off the streets, with major results as reported below. Different components of the Outreach Collaborative target different segments of the homeless population, go to different locations, and, to some extent, have specialized access to mainstream services. Many outreach activities existed before Denver's Road Home, but DRH began to fund outreach, and especially its coordination, with the goal of improving coverage, efficiency, and follow-through. Nine programs comprise the Denver Outreach Collaborative:

- The Homeless Outreach Team (HOT) funded through DHS—goes to facilities frequented by homeless people. HOT workers establish rapport and take applications for food stamps, Medicaid, old age assistance, rental assistance, housing and motel vouchers, prescriptions, and, most recently, TANF. HOT can also provide transportation.

- The Homeless Outreach Ongoing Team (HOOT)—makes sure the applications completed by HOT get through the system; HOOT also does redeterminations.

The Team's work has significantly cut time for application approval, giving HOT leeway to take more applications.

- Colorado Coalition for the Homeless (CCH) Community Resources Outreach Team—street outreach rather than within homeless service facilities. CCH also goes out with the health outreach mobile van and does benefits connections for clients, making applications/linkages to the same array of mainstream benefits as HOT.

- CCH Community Services Team—follow-through within CCH for applications/ people engaged by CCH street outreach; the CCH Team serves the same function as HOOT for people they connect with through street outreach.

- Police Outreach—works with businesses, offers homeless people connections to other outreach teams, and does referrals.

- Urban Peak Youth Outreach—to street youth, 365 days a year. Outreach staff do some case management and connect youth to homeless services.

- Spanish-Speaking Outreach Team (SSOT)—outstationed in locations frequented by Spanish-speaking homeless people. SSOT covers the same range of activities as HOT, including homelessness prevention, helping with the first month's rent, etc.

- Family to Family Initiative Outreach Team—occasionally works with homeless families and also has a major focus on prevention.

DRH funds a total of 20 outreach workers, 18 working at various programs and 2 police officers in the Denver Police Department who work directly with persons who are homeless. In addition, DRH funds a full-time coordinator for the Collaborative, housed at CCH, plus dispatchers to take initial calls and assure a response and case managers to assure that care is coordinated. Everyone meets monthly to coordinate, in addition to having a good deal of regular communication about specific cases.

The Collaborative reaps the benefits of centralization as well as specialization. The city set up a central dispatch function to coordinate the outreach teams and send them where they need to go. At least one outreach worker is available seven days a week from 6 a.m. to 10 p.m. As one outreach worker explained, "If someone is concerned about a person he can call dispatch…The outreach worker shows up where the person is and has a whole plethora of tools—tokens, motel vouchers, transportation, resource sheet, services, and connections to networks." Dispatch can send outreach workers or it can send a taxi to take someone to a shelter where an outreach worker will meet him or her. A critical advantage of the Collaborative, as already noted in Chapter 2, is that "it can follow the person through the whole system so we don't have to drop people when they leave a shelter." Other comments about the improvements in both efficiency and effectiveness facilitated by the new Collaborative structure:

- The Collaborative has "helped our relationship with the downtown businesses. The Ritz Carlton called us instead of the cops recently! That is cool."

- The U.S. Department of Veterans Affairs (VA) has taken part in the Collaborative. According to outreach workers, the VA now has a cell phone specifically for outreach workers to call when they come upon a homeless veteran. VA staff sometimes accompany outreach workers, as well. In the words of an outreach worker, "that has been a great relationship and we had previously thrown up our hands."

Outcomes and Consequences

In the first three years of the initiative, DRH has created 60 percent of the housing stock for chronically homeless people called for in its 10YP, and expects to meet the goal of 942 units by 2010, or five years into the Plan. In its "status report" during its third year, Denver's Road Home reported the substantial impact of its efforts, putting it ahead of schedule to meet its five year goal of a 75 percent reduction in homelessness (Denver's Road Home Status Report, http://www.denversroadhome.org/state.php?id_cat=1):

> Just two years into the initiative, there was evidence that Denver's Road Home is responding with an **11 percent reduction in overall homelessness and a 36 percent decrease in chronic homelessness**. As of March 2009, in collaboration with the extraordinary leadership of the homeless providers who do the actual work of helping homeless people, DRH has accomplished the following:
>
> - 1,243 new units of housing have been developed for homeless people.
> - 3,278 homeless people have been assisted in finding work.
> - At least 2,000 individuals accessed public benefits and treatment services.
> - 957 families received eviction assistance.
> - 533 homeless persons entered housing through the Denver Street Outreach Collaboration.

In a presentation at the National Alliance to End Homelessness's Family Homelessness conference in San Diego on February 12–13, 2009, DRH's director reported findings of the Colorado Coalition for the Homeless that in Denver's permanent supportive housing units, tenants experienced a 30 percent increase in Supplemental Security Income (SSI) receipt, a 26 percent increase in Social Security Disability Income (SSDI) receipt, a 17 percent increase in receipt of food stamps, and a 32 percent increase in receipt of Medicaid. In addition, twice as many tenants had income from employment. On the savings side, use of detox services, time in jail, and other institutionalizations were reduced by about 60 percent for those enrolled in the program.

As a consequence of both DRH's actual performance and its documentation of the effects of that performance on the reduced use of crisis public services, the Denver City Council voted in August 2008 to commit up to $1.5 million a year of city funds for the next 20 years to develop more than 200 units of PSH. The new investment is based on documented annual cost savings from the reduction of chronic homelessness and the consequent reduction in use of expensive public systems. This is a rare example of a community acknowledging money saved in several systems (for example, health, mental health, and jails) and shifting it to other systems (for example, housing and supportive services) because strategists can prove that an intervention is successful (in this case, permanent supportive housing and the outreach and supports needed to move people into it from the streets).

Miami-Dade County, Florida

As one of the oldest central organizing structures in the study communities, and one of two with an independent source of flexible funds, Miami's Homeless Trust has pursued many complex and multi-faceted aspects of system development and change since it was established in 1993. Two Miami examples illustrate the advantages of having a strong central organization along with flexible resources and the continuing commitment of key stakeholders. In combination, these elements allow strategizing, planning, orchestrating implementation, monitoring and reviewing, reassessing, revising, expanding, and all the other activities that are required if long-range plans are going to be seen through to fruition. The Criminal Mental Health Project began almost a decade ago and has evolved in many directions. The recently signed Memorandum of Agreement among mainstream public agencies has potentially far-reaching consequences; it is a relatively new development that HT had been negotiating for several years.

Criminal Mental Health Project

Spearheaded by Judge Steve Leifman in 2000, Miami-Dade County's Eleventh Judicial Circuit has developed both pre- and post-booking jail diversion programs for people who experience serious mental illnesses. Most individuals served by these programs are homeless at the time of arrest or diversion, or are at risk of becoming homeless once released. The array of programs and services is referred to collectively as the Criminal Mental Health Project (CMHP). Over the years, and through many mechanisms, CMHP has significantly decreased the number of homeless individuals with serious mental illnesses who end up in jail, as well as contributing to the overall steep decline in street homelessness in Miami. It has done so through: (1) greatly increased identification of people eligible for SSI and strategies to assure rapid application and approval processes, (2) getting the resources for and developing relevant supportive housing, and (3) increasing receipt of appropriate behavioral health treatment and other services.

CMHP's first activity was to establish a pre-booking diversion program based on the Crisis Intervention Team (CIT) model developed in Memphis, Tennessee in the late 1980s. With CIT, police officers are trained in techniques to diffuse situations that have the potential to escalate into violence and to work with individuals experiencing

psychiatric crises to divert them to treatment services when appropriate, rather than making an arrest.

Judge Leifman wanted to use CIT throughout Miami-Dade County, but the county has 38 separate police agencies and entities and over 30 independent municipalities, each with its own culture, plus the county police department that covers unincorporated areas. This reality, along with initial opposition from key law enforcement leadership, presented challenges to launching the CIT approach. The City of Miami Beach was the first to agree to training, which gave the judge some real data to show other police departments what the model could do. Support for training more departments grew, following a grand jury report that was highly critical of the performance of the county police department during incidents involving people with mental illnesses, many of whom were homeless. Community outrage from a high-profile tragedy in which City of Miami police officers fatally shot a Vietnam veteran during a poorly handled crisis situation also contributed to a change among police agencies. The county mayor, who had previously been the county police chief, also became a strong supporter and asked Judge Leifman to help him train county police officers and other relevant personnel in CIT.

To support the county's diversion efforts, all arrest forms were changed. This would have been a very serious challenge, but fortunately the relevant police departments revise their arrest forms every 10 years, and the timing was right. The new form has check boxes for homeless status at time of arrest and for status as a possible mental health defendant. Individuals identified during the booking and classification process as having possible mental illnesses are seen by the jail psychiatrist within 24 hours of arrest. If the jail psychiatrist determines that the individual meets criteria for involuntary hospitalization (in Florida, as defined by the Baker Act) and the most serious charge is a misdemeanor, jail staff begin seeking treatment placement for the individual at a community-based crisis stabilization unit (CSU)—a level of mainstream mental health service that the individual would almost certainly not have received without the CMHP. If an individual meets criteria for the program he is released with an alternate bond of $9999. If the person later absconds from the crisis unit, this code is placed on the warrant and serves to notify police and correctional officers that the person is a jail diversion program participant and should be promptly evaluated by psychiatric staff at the jail and, upon court review, be returned to a crisis unit for continued treatment. The diversion process does not require that the individual be involuntarily admitted to treatment. In fact, the vast majority of CMHP participants voluntarily accept treatment; very seldom are involuntary commitment proceedings initiated.

Based on the initial success of the CMHP's diversion programs, the court, in partnership with the Florida Department of Children and Families, obtained a Substance Abuse and Mental Health Services Administration grant in 2003 to expand operations. The county has since assumed financial responsibility for continuing this expansion. The CMHP was awarded additional grant funding in 2008 from the state to expand operations to serve individuals charged with low-level felonies. Currently, the CMHP has 14 staff members, including a full-time CIT trainer, 7 case managers, 2 supervisors who provide oversight and program evaluation, and 4 part-time peer support specialists, all of whom have

experience with both the criminal justice and mental health systems. The peer support specialists are a key component, as they are integral to helping service consumers feel safer and more comfortable.

Approximately 1,800 officers from 36 of the 38 law enforcement agencies in Dade County have received CIT training. More than 900 CIT-trained police officers are currently on duty. Trainings are offered on a recurring basis, and there is special training available for law enforcement command staff, 911 personnel and law enforcement dispatchers, and for correctional officers in the jail. The CMHP cites compelling evidence of impact: before implementing CIT, an average of 13 police shootings occurred each year of people with mental illnesses, many of which resulted in fatalities. In the past four years, since a significant number of police personnel were trained, there have been only two such shootings (average of 0.5 per year). The initiative has resulted in a huge cultural change in police departments throughout the county and is enthusiastically embraced by law enforcement personnel.

Established in conjunction with the CMHP's pre-booking diversion program, the post-booking diversion program is intended to improve community response to people with mental illnesses who are arrested and booked into the jail, many of whom have homeless histories or came to the jail directly from homelessness. The program initially served only individuals charged with misdemeanor offenses, but has recently been expanded to include low-level felony cases. Under the program, people with serious mental illnesses who end up in jail and meet eligibility criteria are diverted to one of Miami-Dade County's seven CSUs, where they receive acute care services. After assessment and initial treatment in a CSU, people are connected to housing with services and treatment rather than being sent to jail, where very little treatment is available.

To help assure housing and assistance for other immediate needs for this population, the HT, along with the CMHP, secured funding from the state ($500,000) and county ($100,000) to develop a procedure for gap funding to enable immediate housing placement and to pilot the concept—another example of how the CMHP has connected people to mainstream benefits. Individuals participating in the CMHP's post-booking diversion program are screened to see who would likely qualify for Supplemental Security Income and Social Security Disability Income. For an individual who appears likely to qualify, the application process is started with the assistance of CMHP staff. While the application process is under way, the individual is placed in housing with wraparound case management and support services, which are paid for using gap funding. Upon qualifying for SSI/SSDI benefits, the person receives payment retroactively to the date of application, followed by regular monthly payments thereafter. The entire first (retroactive) SSI check goes directly to the county to reimburse a large portion of the expenses incurred by the gap funding program (it currently recovers up to 70 percent of costs). Gap funding allows the CMHP and HT to get this very fragile population out of jail and provide housing and services that stabilize them in the community. The approach definitely works and has provided access to housing for many individuals who otherwise would be homeless.

To complement gap funding and increase the odds that SSI/SSDI applications will be approved, and approved quickly, CMHP staff received training in SOAR (SSI/SSDI, Outreach, Access, and Recovery), an approach developed to expedite access to social security entitlement benefits for individuals with mental illnesses that are homeless. In addition, special arrangements were worked out with one local Social Security Administration office to prioritize these applications for processing. It took a year for the full effects of this training and the accompanying system changes to reach their full potential, but now they are working very well. Program data demonstrate that 88 percent of individuals are approved on their initial application. By contrast, nationally, on average, approval on initial application is 37 percent across all disability groups. In addition, time to approval is between 4 and 112 days with an average of 62 days. This is a remarkable achievement compared to the ordinary approval process, which typically takes between six and nine months (and which is still the reality for people who do their own applications or apply with the help of agencies that have not yet participated in the SOAR training).

Citrus Health Network, a large community provider of health and mental health services, serves people diverted from the jail who experience some of the most severe, persistent, and disabling forms of mental illness through a program called Kiva. Citrus first conducts an assessment and then arranges for the individual to be admitted to an assisted living facility (ALF).[7] Those in the program are immediately connected to case management, bypassing a process that may take up to a month for other Citrus clients. They also receive psychiatric services and help to apply for a Shelter Plus Care rent subsidy. Kiva follows a low-demand model, which is believed to be integral to its success. These services are all examples of expanding access to mental health benefits by a direct investment of resources to serve the chronically homeless, severely disabled members of the CMHP population.

In addition to the virtual elimination of shooting incidents involving police and people with mental illnesses, the diversion programs are credited with making a sizeable reduction in misdemeanor recidivism among people with mental illnesses. Prior to implementing the CMHP, recidivism among the target population is estimated to have been over 70 percent. This is consistent with national estimates of recidivism among individuals with serious mental illnesses as reported by the U.S. Department of Justice. Since implementing the CMHP, recidivism among individuals referred to the CMHP has declined dramatically. Last year (2008), recidivism was 22 percent, thanks to getting people appropriate services and housing.

The combination of pre- and post-booking diversion has also resulted in a significant reduction in the number of misdemeanor defendants housed in jail. Prior to program

[7] ALFs are the equivalent of board and care facilities in many communities. Because ALF accommodations are sometimes less than might be desired, the court established standards for cleanliness, food safety, privacy, and similar conditions, and invited ALFs to meet them. Compliance was voluntary, but the court made it clear that only ALFs that met the standards and allowed unannounced inspections would receive court referrals. Since court referrals comprised a significant proportion of ALF tenants, living conditions in many ALFs improved markedly.

implementation, an entire wing of one floor housed individuals with mental illnesses charged with misdemeanors. Today, there are just five cells used for this purpose. Additionally, the number of incidents of restraint used in the jail has decreased markedly, in large part due to changed personnel practices that put the best corrections officers on the mental health wing, with increased pay and training, rather than using it as a "punishment" assignment.

In addition to the successful programs already in place, the CMHP is working closely with Miami-Dade County and community stakeholders to develop a first of its kind mental health diversion facility, due to open for occupancy by mid-2009. This facility will expand local capacity for jail diversion and linkages to effective and efficient community-based care. It is expected to further reduce the number of county jail cells occupied by people with mental illnesses, especially those who are also homeless.

The key lessons of the CMHP are:

- Assess system gaps (in this case, between the justice and mental health systems, which had virtually no overlap before CMHP began, in how they handled homeless people with mental illnesses who were being arrested).
- Get key stakeholder commitment to work together.
- Start where you are and do *something*.
- Assess performance and use it to leverage additional resources.
- Keep working to fill gaps.
- Keep using documentation of success to build momentum and take on the next tasks.
- Build community support through publicity.
- Have someone "minding the store" who sees the whole and keeps the community moving toward ever-better approaches and outcomes.

Memorandum of Agreement

Through the Homeless Trust and the Board of County Commissioners, the community implemented a Memorandum of Agreement (MOA) in June 2008, following a year and a half of negotiations. This MOA was one element called for in Miami-Dade County's 10 Year Plan and was picked up as a priority initiative through the work of the county-appointed Community Affordable Housing Strategic Alliance. MOA partners include the Housing Trust, the Eleventh Judicial Circuit, state and local departments of corrections, the Florida Department of Children and Families (TANF/food stamps/Medicaid, child welfare, and mental health and substance abuse services), Jackson Memorial Hospital, and local foster care and mental health organizations. Local offices of federal agencies

(Social Security Administration and the Department of Veterans Affairs) also participate informally.

The MOA establishes commitments to change public agency operating procedures in two ways. First, the mainstream agencies that are party to the MOA committed themselves to developing new and/or more effective linkages to the homeless assistance system of any clients of theirs who are in a housing crisis or find themselves homeless, so their homelessness may be prevented or ended as soon as possible. This change involves developing and expanding mainstream service providers' knowledge of the full range of what the homeless assistance system offers. It also involves improving their own agency procedures to identify housing problems and issues, which previously may not have been seen as "our agency's problem." The most important locations/time points for improved linkage are when clients are about to be discharged from a public institution—from foster care, psychiatric hospitalization, substance abuse treatment, or jail—but other opportunities also exist, such as the point when people *enter* such institutions, if their stay is likely to be short. The direction of this change is *from* mainstream agencies *to* the homeless assistance system, to take advantage of its expertise in placing people in housing, with supports if necessary, and its access to the relevant resources.

The second change in operating procedures began in June 2008 and is expected to help connect homeless people to the resources of mainstream agencies and to housing, whether subsidized or not. Using the resources at its disposal, HT issued a Request for Proposal for MOA services and for an agency to offer 24-hour assistance to homeless people and those at risk of homelessness in accessing available homeless and mainstream services to prevent or end their homelessness. The City of Miami's Neighborhood Enhancement Team office won the contract (for $340,000), and now provides evening and weekend coverage of the Homeless Helpline, related outreach services countywide, well-developed connections to all MOA agencies to access their services and benefits, and three housing specialist staff. These three staff work within the city's Neighborhood Enhancement Team, the division encompassing all of the city's housing-related functions. The staff are charged with developing resources beyond those found in the homeless service system and linking people referred via the mainstream service systems to these new housing resources. For example, in the mental health service system, the housing specialists work to find housing for people being discharged from the community's Crisis Stabilization Units, and do the same for youth aging out of foster care. The City of Miami is also committed to generating additional resources from within the city's budget. At the time this study visited Miami (August 2008), the housing specialists had been functioning for a little over one month; in their first month they placed 179 people into services and housing, including 14 who were placed at least initially within the homeless system.

Staff of the Homeless Trust had the responsibility to translate the idea of an MOA from the 10YP into the reality that operates today. Because the HT had staff that could invest the time and effort required, because some members of the HT Board of Directors headed the very agencies involved in the MOA, and because the County Board of Commissioners strongly backed the concept behind the MOA, the community was able to

negotiate the needed commitments. Given the HT's long history of documenting the outcomes of its initiatives and using the information to modify and improve at the operational level, the odds are that the MOA's impact will continue to grow.

Portland, Maine

Portland's Emergency Shelter Assessment Committee has long operated as the community's central organizing structure for homeless issues. Portland does not have the independent, flexible funding[8] that allows Miami and Denver to supplement federal and block grant resources to address homelessness (nor do the other communities in this study). Everything ESAC achieves is done through careful analysis of available resources and strong collaborative arrangements among public and private stakeholders.

Following the shift in HUD policy toward prioritizing the use of its Special Needs Assistance Program (SNAP) resources for housing rather than services, ESAC took action. Portland's SNAP portfolio was quite heavily weighted toward using HUD dollars for services, because the community had been aggressive, creative, and successful in securing housing dollars (capital and rental assistance) from other sources. Portland uses its large Supportive Services Only HUD grant to provide case management and service linkages across several providers, which enables continuity of care when people move from one provider to another. ESAC members were concerned that if they did not do something significant about increasing homeless people's access to mainstream resources so they could shift dollars to housing in some of their other HUD grants, the community might lose its HUD funding.

ESAC gave the job of deciding how to bring about this increase to two of its committees—the Mainstream Resources Committee and the Priorities Committee. The Mainstream Resources Committee worked on increasing opportunities for mainstream access while the Priorities Committee worked on increasing the incentives for individual programs to help their clients get mainstream benefits.

Trainings

With the increased emphasis on helping clients access mainstream services, ESAC's Mainstream Resources Committee began organizing trainings to assure that case managers at all homeless assistance programs know what benefits and services are available, who is eligible, how they can apply, and whom to contact to facilitate application processing. Mainstream agency staff give the trainings, which are attended by service providers and case managers/line workers from every type of homeless assistance program and some mental health and substance abuse programs.

The Mainstream Resources Committee assessed the level of understanding among program staff about mainstream benefits and services, using receipt of many "inaccurate" or "inappropriate" inquiries or applications for benefits as its indicator of understanding.

[8] The food and beverage tax in Miami and the independent fundraising pursued by Denver's Road Home.

The training schedule was constructed to address the most misunderstood benefits first. Content was developed to teach program staff what each benefit or service is and what it offers, who is eligible, how to access it, what information must be provided, and whom to call if help with the application is needed. This last aspect of the trainings was quite important—the sessions brought the staff of mainstream agencies into face-to-face contact with the case workers who were trying to get their clients benefits. Having met each other at a training, subsequent interactions between case workers and mainstream agency staff went much more smoothly, according to all stakeholders, to the ultimate advantage of clients.

Trainings happen about once a quarter. The first training dealt with General Assistance (GA), which each town in Maine is legally obligated to provide to eligible households.[9] GA does not provide an individual with cash, but it can help with rent and other housing-related expenses as well as other goods and services. Following the GA training came sessions on TANF/ASPIRE (Additional Support in Retraining and Employment); two rental subsidy programs offered by the Maine State Housing Authority, one of which has attached services to promote self-sufficiency; SSI/SSDI; Low-Income Home Energy Assistance Program; veteran benefits and services; MaineCare (Medicaid, including a state-only component for people with disabilities); State Children's Health Insurance Program; and food stamps. Shalom House, which manages the state's Shelter Plus Care vouchers, also provided a training on accessing Shelter Plus Care. Training notices go out to the whole state through MaineHousing, the State Homeless Council, and the three Regional Council networks. They are also posted in shelters and distributed through ESAC membership and other mechanisms. Trainings are open to anyone who wants to attend. People come from all over the state, not just Portland; usually 60 to 80 people attend.

The people who seem to benefit the most from the trainings are staff in transitional housing, permanent supportive housing, and residential treatment programs, because emergency shelter and day center staff have long been familiar with application processes. It has also been fairly common for directors of large agencies to invite the trainers from the statewide training sessions, many of whom are based in Portland, to come to their agency and give many more members of their staff the benefit of their knowledge. One benefit of the trainings, including those that take place in individual agencies following the statewide sessions, is the opportunity they offer for case managers to develop personal relationships with mainstream service providers. Following trainings, mainstream agency staff report seeing positive results in terms of increased applications and approvals, plus a decline in inappropriate applications.

[9] The trainings have also served to teach city staff in many smaller municipalities that their communities too are obligated to provide GA, which seems not to have been widely known, or at least not widely acknowledged.

Priority Scoring Pressures

As part of the annual CoC planning and prioritizing process, which ESAC organizes every year, ESAC's Priorities Committee reviews project performance and quality and assigns priority scores to applications being proposed for the city's Super Notice of Funding Availability submission. The Priorities Committee reviews each HUD grantee to make sure it has fulfilled the terms of its existing proposal and grant before recommending ongoing funding. Any provider that is seriously out of compliance risks getting a low priority score and thus potentially not getting HUD funding for the coming year.

When HUD announced about five years ago that it would begin giving higher scores to communities that allocated more HUD resources to housing rather than services, the Priorities Committee added mainstream benefits receipt to its review criteria. The more clients that received mainstream benefits, the more those benefits could cover some of the cost of services, leaving more of each HUD grant for housing. Because Portland knows a lot about the people that use its homeless services, based on the assessment tools and database that ESAC created early in its history and that it uses regularly to assess unmet need, committee members were able to see client characteristics and make educated guesses as to probable eligibility for benefits. It could then work with providers to set reasonable expectations that still represented an increase in benefit receipt. This emphasis and review, based on program data submitted for Annual Performance Reports, has contributed to significant increases in mainstream benefits connections over the years, to the point where Portland does better than national averages at establishing such connections at every level of the system (see Chapter 2).

Norfolk, Virginia

As is true for Denver, a new mayor in Norfolk with a policy commitment to ending homelessness has made a big difference in the community's progress in organizing its resources. Recognizing that earlier shelter based policies (circa 2003) were ineffective and inefficient—"shelters and motels were filling up and people were not moving on"—the mayor launched a 10 Year Plan development process to design a new approach to ending homelessness.

The public side of Norfolk's homeless system starts in the mayor's office, where Mayor Fraim created the Office to End Homelessness to establish a clear link between his office, the city's mainstream agencies, the private providers that make up the Norfolk Homeless Consortium (an organization that oversees various aspects of the city's system), and the various homeless initiatives including those growing out of the 10YP. The director of the OEH is also an executive board member of the Homeless Consortium and works to make sure the city is on track with its 10YP. For families at least, Norfolk has created a *coordinated community response* to homelessness.

OEH's main responsibilities include:

- Ensuring the implementation and development of Norfolk's 10YP.

- Assessing 10YP programs and identifying gaps in services and performance.
- Assessing city programs that target the homeless population.
- Developing additional resources to fill service gaps for the homeless population.
- Acting as a central oversight and planning office for Norfolk's CoC.
- Bringing about collaborations and community involvement focused on ending homelessness in Norfolk.

OEH has three staff—the director, a management analyst, and a support staff person. Many stakeholders mentioned that the OEH played an integral role in steering public dollars such as HOME and CDBG funds into uses that address homelessness, and that the mayor's support has been invaluable. We might also note here that in addition to Norfolk, three other study communities have been able to convince the right authorities to commit some HOME and/or CDBG funding to homeless services, especially housing. As such uses of HOME and CDBG funds are relatively rare, according to data gathered by HUD, it is a testament to the persuasive powers of a strong organizing structure that so many study communities have been able to affect the allocation of these block grants.

Department of Human Services and Homeless Action Response Team

DHS is the primary public agency having responsibility for serving homeless individuals and families in Norfolk, and its Homeless Action Response Team is the main homelessness initiative within DHS. Predating the 10YP, HART was created in 2003, when Norfolk's resources for homeless families were consolidated into a central intake and support program. This happened in part because DHS realized the actions of its several offices were contradictory—one office was sanctioning families for failure to comply with the requirements of one benefit program; the resulting loss of income pushed the families into homelessness, whereupon DHS began subsidizing their housing. DHS leadership saw the need for a team that would identify families' issues, prioritize their seriousness, and create a plan that connected the family to all available and appropriate benefits and services while avoiding internally contradictory demands on families and inefficient and ineffective agency behavior. The consolidation and streamlining process has taken a number of years to mature, aided by the OEH once it was created.

HART serves as the central intake/single point of entry for all homeless families and some single adults, and the primary mechanism for connecting clients to needed mainstream benefits and services. As part of central intake, OEH got shelters to refer all incoming families to HART. DHS also established a 24-hour Homeless Hotline as part of central intake, during the same shift in strategies for addressing homelessness. The Hotline also refers people to HART as the first step in addressing their homelessness. Through a Memorandum of Agreement among Norfolk DHS, three local shelters, and

local providers, HART links homeless families and singles to shelters and mainstream benefits while also providing in-home services for families.

Today the HART includes child welfare workers (social workers), TANF and other benefits eligibility workers, and a SOAR worker whose charge is to get eligible families and individuals onto SSI and Medicaid. Two eligibility workers specialize in doing applications for TANF/Virginia Initiative for Employment not Welfare, General Relief, food stamps, and Medicaid. In 2007, HART served 888 families, "of whom only 18 families required a subsequent shelter placement within 12 months and 26 required a subsequent shelter placement within 17 months." HART is an excellent example of multi-agency interactions at the level of *collaboration*, involving recognition of a shared goal across agencies, modifications of agency practice toward activities that were more likely to be effective in reaching that goal, and periodic assessments of progress and mid-course corrections as needed.

HART Linkages

In addition to the mainstream cash benefits and supportive services that HART staff help with directly, HART orchestrates client access to a variety of other resources—especially those related to getting or keeping housing—that OEH and the Homeless Consortium have helped make available. A household starts at HART by completing a universal intake and assessment form—a mechanism that gathers the information needed to determine eligibility for many public programs and also assesses a household's need for various supportive services and its level of housing crisis. For those still in housing, prevention services are the first option:

- **Prevention services** for those still in housing. HART and several other providers assist the household with budgeting, verify needed information, develop a landlord agreement or agreement to pay utilities, connect the household to ongoing public mainstream benefits, and/or make payments.

If the housing situation cannot be preserved, HART staff complete a Structured Decision Making assessment with the household, do credit and criminal background checks, complete a Housing Barrier Screen, screen for child protection issues, document homelessness, and then refer for permanent housing placement or emergency shelter. After completing this assessment, HART may assist the household with one of the following:

- **Permanent housing placement** if at all possible, either through emergency rental assistance or mediating issues with family members or landlords. If the household's situation makes it eligible for permanent supportive housing, HART facilitates the placement, and does the same thing if participation in a transitional housing program seems appropriate. Placement follows various assessments, checks, and screenings.

- **Emergency shelter placement** for those who have lost housing and who cannot immediately be placed in a housing option. Once in shelter, community providers

develop a case plan, connect the household with a housing specialist, assist with accessing all mainstream benefits and services, offer employment assistance, and coordinate services as needed.

- **After care services** for those placed into transitional and permanent supportive housing. Case management and home-based services are provided for employment, individual and family counseling, education, managing one's finances, legal services, and medical care. HART generally provides after care services for 6 to 12 months.

Resources routinely available to HART and its partner service providers through the collaborative arrangements brought about under the 10YP include a Housing Brokers Team, the behavioral health services of Norfolk's Community Service Board, housing resources through CDBG and HOME, and state resources for keeping families together and preventing out-of-home placement of children through Virginia's Comprehensive Service Act.

Housing Brokers Team. The Housing Brokers Team (HBT) was created in August 2007 to help get more landlords involved with housing homeless families and single adults. It is a good example of the results of OEH and HART community assessment processes—a problem was identified, based on extensive experience with the difficulties clients face in finding housing, and a solution was developed and funded. The two-person HBT works closely with HART and other homeless service agencies to identify housing units, negotiate with landlords, and assure the quality of housing placements. HBT describes its approach as one of "landlord advocacy." The team works directly with landlords by helping with leases, providing a point of contact with DHS, negotiating late fees and evictions, and generally ensuring that landlords are happy with a housing situation. Norfolk still struggles with finding willing landlords, but many have lauded HBT for its help in bringing in new units.

Norfolk's Community Service Board (CSB) is an independent quasi-governmental agency that serves people with mental health or substance use issues, developmental disabilities, or co-occurring disorders. CSB works primarily with medically indigent people whose health care costs are covered under Medicaid or Medicare. Currently, CSB has five service locations spread across Norfolk, each of which has staff designated to help clients establish their eligibility for mainstream benefits. CSB also runs an intensive outpatient program for substance abuse and has a new crisis stabilization program where people in psychiatric crisis (many of whom are homeless) can stay for up to 15 days in lieu of hospitalization—which also helps those who have housing to keep it. CSB works with the Police Academy to provide aspects of training that teach officers appropriate ways of working with people who have behavioral health issues, teaches firefighters and paramedics to do emergency crisis pre-screening, and is available 24/7 to help public safety personnel deal with crises.

For homeless people with behavioral health issues, CSB offers a linked set of services starting with outreach and following through to permanent supportive housing. Projects for Assistance in Transition from Homelessness (PATH)-funded staff at CSB do outreach

to chronically homeless and mentally ill people to help them connect with services and ultimately with PSH. CSB receives funds through a HUD Supportive Housing Program grant to operate an Assertive Community Treatment (ACT) Team. Two PATH outreach staff working with the ACT Team are SOAR trained, and one is a certified SOAR trainer. It is particularly important in Norfolk to get people who are eligible for SSI or SSDI signed up so they can get Medicaid or Medicare, because there is hardly any other funding for behavioral health services. CSB's ACT Team currently provides support services to 22 people in Housing First units where the rent is subsidized by Shelter Plus Care vouchers; CSB has a long-term goal of serving 80 people in these arrangements.

CDBG and HOME funds have benefited homeless programs, thanks to OEH's ability to influence their allocation. HOME is one of the resources used to replace Comprehensive Services Act funds when the state restricted their use (see below). Both CDBG and HOME funds have also been used to develop "housing first" permanent supportive housing options.

Housing Resources for Family Unification or Preservation are available in Norfolk from two sources, Family Unification Vouchers from the housing authority (HUD funding) and state funding for family preservation under Virginia's Comprehensive Service Act (CSA). Norfolk had been very creative in the use of CSA funding for housing for a number of years, but in 2007 the state instituted new and far more restrictive regulations of the CSA that have cut HART's ability to use these funds by about 80 percent. Creative workarounds have been developed using grants, HOME, and other funding sources, but Norfolk stakeholders hope the state interpretation will go back to its earlier version.

Pittsburgh/Allegheny County, Pennsylvania

Pittsburgh and Allegheny County offer an interesting example of what can be done from within a key umbrella public agency when that agency's policies encourage cross-office cooperation to address a range of homeless-related issues. Responsibility for homeless services throughout the county lies with the Office of Community Services (OCS) in the Allegheny County Department of Human Services, which is also in charge of employment and training, a variety of food assistance programs other than food stamps, Head Start, and several other programs. Other offices within DHS include Children, Youth, and Families (CYF; primarily child protective services, foster care, and adoption); Behavioral Health (mental health, substance abuse, and violence/trauma and recovery); and even the Area Agency on Aging (to address the needs of homeless people aged 60 and older, including those of adults in need of protective services). All DHS agencies have responsibility for populations with high levels of vulnerability to crises, including crises that threaten their housing stability.

As the point public agency within the county for homelessness, OCS participates in the Allegheny County Homeless Advisory Board and actively pursues solutions to issues and service gaps identified by the Advisory Board and by the county's 10-Year Plan to end homelessness. Two aspects of DHS's operational style—strong cooperative relationships among DHS offices and positive working relationships among DHS offices and the

community's provider agencies—have strengthened the community's ability to *prevent* homelessness among DHS's many vulnerable populations by integrating direct services to those populations with increased awareness of the risk of housing loss and systematic approaches to counteracting that risk.

DHS uses its funding power—to issue requests for proposals and allocate resources—to stimulate agencies that are not homeless-specific to address housing crises to prevent homelessness. It can fund a mental health agency with the resources to prevent a mental health crisis from leading to homelessness, a homeless agency with the resources to address its clients' substance abuse issues, and a child welfare agency from breaking up a family when housing resources would enable it to remain intact. It also responds to ideas from provider organizations for how they could more successfully serve their clients if they had a range of resources at their disposal. Good communication and joint work on potential solutions have worked to ensure provider agency access to resources. A number of provider agency interviews identified their relationship with OCS—and OCS staff accessibility—as a major asset to providing services to homeless people in the community.

Some programs established in the last few years, in response to various aspects of the county's 10YP, illustrate this flexibility:

- Mercy Behavioral Health opened a 16-unit Diversion and Acute Stabilization Program in May 2007. This program prevents homelessness by stabilizing and housing mental health consumers in crisis and returning them to permanent housing in the community.

- Establishing an Engagement Center, as well as developing Safe Havens and a variety of permanent supportive housing options for which the service component is supported in part by the resources of DHS's several offices, created a coordinated approach to reducing chronic homelessness.

- Rental Assistance provided 940 grants for homeless prevention or permanent housing for 978 adults and 840 children in FY 06–07.

- CYF Housing Assistance provided 338 grants to 789 adults and 1,500 children.

As a result of housing multiple program offices under the same roof, DHS has been able to maintain HUD resources for the homeless service system under conditions that would otherwise have led to resource loss. For example, the Department was able to shift some Office of Children, Youth, and Families funds to OCS in the interest of addressing housing and homelessness issues. In the interest of providing both supportive services funding and match dollars for HUD programs, funding has also been shifted from the Office of Behavioral Health. Cooperation extends beyond DHS offices to other departments. Financial and provider resources, including CSBG, Medical Assistance, workforce development, and veterans' services have all provided services to homeless

people. This flexibility played a key role in the Department's ability to adapt to HUD's shift away from funding the supportive services that go with its housing resources.

Albany and Albany County, New York

Albany provides an interesting contrast to the five communities just described, because it exhibits three important strengths, despite its lack of strong commitment to reduce homelessness on the part of local elected officials. First, the directors of the county Department of Social Services and Department of Mental Health have exhibited strong leadership for creating mechanisms that increase access to the many public benefits and services offered by their agencies. Some of these mechanisms were specifically designed to aid homeless people to access benefits and some were created with the more general population of low income people in mind, but even the latter mechanisms include procedures to ensure that homeless people are a high priority for service receipt.

Second, some homeless service providers have developed very good working relationships with one or more mainstream benefit agencies. These relationships involve coordinated, and sometimes collaborative, arrangements that assure access and facilitate benefit receipt.

Third, New York is among the most generous of states in providing benefits and services with state dollars. Local government agencies within Albany County have been particularly adept at taking advantage of these funding streams. For instance, Albany County is home to the largest *per capita* concentration of residential mental health programs in the state—higher by far than New York City, which is known nationally for such programs—and homeless people with serious mental illness are a high priority for receiving this housing. Albany County also obtained state funding to support an Assertive Community Treatment team that serves many homeless people as well as formerly homeless people currently living in PSH.

The strong working relationships among homeless service providers and the two county departments have produced a significant number of mechanisms to improve homeless people's access to mainstream benefits and services, including:

- Co-location of public agency eligibility staff at Sheridan Hollow Drop-In Center.
- A central intake mechanism that facilitates emergency shelter placement for families and single adults.
- A central management unit in the Department of Mental Health that facilitates access to mental health and substance abuse programs for homeless people and others.
- The Patient Services Coordinating Committee, which works to coordinate service and benefit receipt for people identified as frequent users of expensive crisis services across different public agencies.

- Two small local housing trusts that expand available housing resources and make it more likely that homeless service providers will be able to help clients find housing.

- A 10 Year Plan to end homelessness.

Even with strong leadership from within the county social services and mental health departments, a history of collaboration among providers, and generous state-level public benefits and services, Albany does not do as well as some other study communities in some areas. For example, the Department of Social Services uses outreach workers very sparingly, and then only for Medicaid, not for TANF or food stamps as is done in other study communities. Enrolling in Medicaid may be more difficult in New York than in other states, and the local 10YP does not have the kind of political support we found in several other study communities.

Albuquerque, New Mexico

Albuquerque presents an interesting contrast to the six other study communities, in that the mechanisms we observed there are largely the work of enterprising homeless service providers pushing hard to make mainstream agencies more responsive. St. Martin's Hospitality Center and Health Care for the Homeless have evolved as locations where a homeless person may access health and behavioral health care. Case workers at these two programs have become adept at helping clients complete applications for key public benefits such as food stamps, and also take advantage of the presence of staff from the VA, food stamps, and HIV/AIDS agencies at least once a week. Crossroads for Women is another example of a program with a determined director, who has been successful at working out coordinated service arrangements with mainstream agencies. Crossroads serves women with mental illness and substance abuse disorders, most of whom are ex-offenders with felony convictions. In addition to funding from the state Department of Mental Health, which some other homeless assistance providers in Albuquerque also receive, Crossroads supports its services to clients through funding and networking arrangements with the Department of Vocational Rehabilitation, and has negotiated with the Albuquerque Housing Authority to find a way for it to accept Crossroads clients into its units or for its rental assistance programs.

Implications

The next three chapters will detail many of the specific mechanisms we observed in study communities for improving homeless people's access to mainstream services. Some of them are as simple and personal as one worker in one agency figuring out how to write successful SSI applications and doing so for the four or five clients a year from her agency that meet SSI eligibility guidelines. Many mechanisms we observed involve improved *communication* between case workers in homeless service programs and intake workers at mainstream programs. These are largely *smoothing* mechanisms that make it easier for homeless people to get *to* and *through* the door of mainstream agencies, successfully complete applications, and do what is necessary to maintain eligibility. They

operate at the street, or entry, level of mainstream agencies, and can often be set up through the efforts of people operating at the case worker/intake worker level.

To get beyond this street level and beyond simple smoothing mechanisms to more complex and coordinated mechanisms requires involvement of agency policy makers. To develop *communitywide* mechanisms that involve multiple agencies in complex interactions, survive personnel changes, and even changes in agency directors, takes a communitywide planning and implementation entity. It would be difficult to overemphasize the importance of the central organizing structures in study communities for systematically pursuing increased access to mainstream benefits and services for homeless people and creating mechanisms that reach the levels of coordination, collaboration, and coordinated community response. Several aspects of their activities deserve repeating as this chapter concludes. These are:

- The structures have a **perspective covering many years**, and organize their activities to bring about incremental improvements.

- These structures **set goals** that are broadly accepted by the larger community; improving access to mainstream benefits is one way to ensure that people have the resources to leave homelessness or avoid it in the first place. Since the overall goal of these organizing structures is to end homelessness, they all recognize the importance of helping people get the benefits they need.

- They scan the environment of their community's homeless and mainstream services to **identify needs** that are not being met and agencies that are not playing their role.

- They apply creativity and perseverance to the task of **evolving strategies** to fill gaps in existing service offerings or approaches and make sure that homeless people are able to take advantage of the new resources.

- They tend to have **strong political support**. At some time, either recently or in the past, their mission has become "front burner," that is, politically important. This support helps them assemble resources and influence stakeholders to make the system work better.

- They are highly conscious that to do the best possible job on the above activities, they need **information about what works and what does not work**, and they strive to eliminate or modify what does not work until it does what it is supposed to do. These communities gather data and analyze it to help them understand what does and does not work, and then use the evidence to develop mid-course corrections.

- Many of them pay serious attention to **building, maintaining, and expanding community support** for their efforts. They issue short, clear, easily understood reports; stage events that encourage community participation; maintain regular interactions with the press; and enlist citizens in a variety of activities that keep

them involved, help spread the word, and ensure continued support for the public outlays that are needed for the community to continue making progress toward ending homelessness.

Not every community in this study displays all of these elements of a strong central organizing structure with a homeless focus. But it is safe to say that the more these elements are present in a community's organizing structure, the more it is able to make the changes that are needed to end homelessness—the ultimate goal of the 10YPs in all of these and many more communities. Increasing homeless people's access to mainstream benefits and services, and reshaping mainstream agencies to prevent homelessness among their own clients and respond supportively to homeless people when they apply for benefits, is one key way that communities can use to reach this goal.

CHAPTER 4: STRUCTURAL BARRIERS TO HOMELESS PEOPLE'S ACCESS TO MAINSTREAM BENEFITS

Structural barriers are dealt with first both because they are the most common barrier type we found in our study communities and because they are the most relevant to discussions of "street level" access. Structural barriers come into play when benefits are available and a person is eligible for them, but various obstacles nevertheless prevent the person from successfully completing, or starting, a benefit application. The issue is one of first getting in the door and second, being able to see an application all the way to its end. Transportation, for example, is a clear example of a structural barrier. Individual characteristics such as illiteracy, paranoia, or ignorance of the benefit or one's eligibility for it present the same problems. Likewise, aspects of the benefit application process itself may lead to fewer applicants and to restrictions not deliberately prescribed by policy makers. For these structural barriers, the problem of access lies outside the program's basic eligibility rules and capacity and falls within the domain of its implementation and structure.

Unlike capacity barriers (Chapter 5) and eligibility barriers (Chapter 6), structural barriers afford perhaps the greatest opportunity for increasing access to mainstream benefits without the difficult tasks of changing eligibility criteria or increasing resources. For these reasons, they are generally more politically palatable and have the potential for informal, timely solutions. As is shown in the mechanisms below, study communities focused their efforts on addressing structural barriers to mainstream benefits more so than any other barrier type, primarily using smoothing mechanisms but occasionally expanding certain services or changing priorities and program rules.

Structural barriers, however, can also be the most pervasive, restrictive, and hidden barriers a community may face. Indeed, it is often hard to gain information on the extent of these barriers because they inherently reduce contact and communication between a program and its potential clients. In every community visited, structural barriers represented both a significant frustration for delivering benefits to homeless people and a primary target of mechanisms for increased access.

This chapter outlines the structural barriers we encountered on our site visits and the mechanisms different communities used to overcome them. Interviews revealed seven general categories of barriers:

1. **Geographic/transportation demands**—Lack of public transportation, individual transportation, and program funds for transportation, and the burden of travel time make it more difficult for people to access services.

2. **The sometimes negative atmosphere of the application office, stigma, and other environmental matters**—The general comfort of homeless people in provider offices and the level of stigma attached to benefits and homelessness may serve as deterrents to pursuing services.

3. **The complexity (cognitive demands) and length of benefit applications**—Access may be limited by the difficulty and timeliness of the application process.

4. **ID/documentation requirements**—Homeless people may not be able to supply required documentation, given the difficulty of obtaining and keeping photo identification and related documentation**.**

5. **The complexity of maintaining enrollment**—Recertification requirements, change requirements, and benefit-specific rules for maintaining receipt make it difficult for homeless people to sustain access to needed benefits and services.

6. **Staff knowledge of systems and processes, or lack of it**—Access may be limited by the lack of knowledge of provider staff and homeless people on what benefits are available, how to apply for them, and who is eligible.

7. **System interaction problems**—Lack of formal and informal links among programs creates another set of barriers to accessing benefits and services**.**

Geographic/Transportation Demands

Transportation to a benefit office or to the service itself stands out as a common problem in all seven study communities, although some find it significantly more troublesome than others. Staff noted that they do not have enough travel funds to get homeless people to medical appointments, job interviews, emergency shelters, or the multiple visits required by benefit offices. Others explained that a lack of public transportation posed the main transportation barrier, not just a lack of resources for travel fares. For some, public transportation systems do not exist and even transportation to and from schools and shelters—a federal mandate under the McKinney-Vento Act—is not available.

At the time of our site visits, increases in gas prices had raised public transport costs, taxing the already minimal transportation budgets of homeless service providers. Moreover, interviewees noted that the increases in ridership of public transportation in middle income neighborhoods, caused by the hikes in gas prices, shifted routes and resources out of the low-income areas where providers offer services and shelter.

Still more interviewees said simply that their public transportation system did not span a large enough area or run enough routes, leaving the homeless offices and services well out of the range of the city's transportation services. Staff in some communities reported that indirect bus routes, sometimes with multiple transfers, could make trips to providers take over two hours for some homeless clients. Even programs with vans designated for transporting homeless people reported that various services are too far away to make a trip worthwhile in the eyes of both the case manager and the client. In the words of one provider, "[our agency] is still in the mode that we have office hours so come in and see us. These are not the people that are going to come in…transportation is an issue."

Mainstream Benefit(s) Affected

Transportation and geographic barriers varied by community, but affected all mainstream benefits in at least one instance across the study communities. Those benefits that require frequent or multiple interviews and appointments are particularly cumbersome for homeless people. These requirements included benefit maintenance (recertifications, Continuing Disability Reviews, etc.) and multiple initial interviews for Temporary Assistance for Needy Families (TANF) or General Assistance (GA), food stamps, Medicare/Medicaid, housing, and Supplemental Security Income/Social Security Disability Income (SSI/SSDI).

Mechanisms to Reduce Transportation Barriers

Smoothing mechanisms

Transportation issues are handled primarily through smoothing mechanisms, although some communities and benefits make specific efforts to expand the amount of transportation for homeless people through alternative, private funding sources, and by changing program rules to complete benefit applications off site.

Provide Program Transportation

Many homeless services providers simply use program funds to provide transportation, often in the form of an agency van, or in tokens for taxis or public transportation. Program transportation in Norfolk, Virginia, for example, includes the following:

- Norfolk's Health Care for the Homeless Program set up a van to pick up people staying at shelters and drop them off at a local indigent care clinic, Park Place. Agencies have the option of calling Park Place 24 hours in advance of an appointment or of walk-in hours to request a ride.

- Similarly, Norfolk's Salvation Army provides regular transportation to and from the Department of Human Services (DHS) and various other agencies specifically for mainstream benefit application.

- The U.S. Department of Veterans Affairs (VA) office in Norfolk is also currently setting up a bussing system to the Veterans Hospital in nearby Hampton.

- Virginia's Employment Center's remote employment service facilities now provide transportation to the employment One-Stop for those that need intensive employment services.

That is just one community. Similar programs exist in all seven study communities, although many mentioned that low program funding makes expansion and continued use of both vans and travel vouchers problematic.

Site Offices Conveniently

Others went a step further and located their agencies and programs to alleviate problems of transportation, setting up in close proximity to benefit offices. The shelters in Portland, Maine, for instance, are reportedly exceptional at referring homeless people to the Maine Department of Health and Human Services (DHHS) office in part because they are located so close to one another. Shelter staff can walk out the door and point to the DHHS building or, if necessary, they can walk people there directly. This is seen as a key factor in accessing benefits (homeless people often need someone to walk them through the entire benefit application process). As described in Chapter 3, the DHHS office had at one point been able to prevent a planned a move to the outskirts of town based in large part on the importance of the office's proximity to the shelters.

Similarly, Department of Children and Families (DCF) benefits in Miami, Florida, are delivered through the Automated Community Connection to Economic Self-Sufficiency (ACCESS) system. The system is designed to facilitate access to food stamps, TANF, and Medicaid. There are nine ACCESS service centers in Dade County, each complete with various updated technology to facilitate smooth application processes. Because of its proximity to downtown Miami, the Central office serves the most homeless people.

Take the Office to the Clients (Outstation Workers)

Many mainstream agencies in study communities outstation workers—that is, workers from a program or agency go to homeless assistance programs during regularly scheduled times to do intakes and deliver services. In addition to alleviating issues of program knowledge and system interaction (see below), workers from various agencies and programs go to service sites such as shelters, emergency rooms, and day centers to bring benefit applications and information to homeless clients. In many instances, applications may be completed and processed entirely away from the main benefits office, eliminating the need for transportation to and from benefit offices. Interviewees found using outstationed workers to be extremely helpful and effective, noting that locations were chosen strategically, generally using ones that homeless people frequent most often.

Specific incidences of outstationed workers are evident in almost all of our communities:

- The Health Care for Homeless Veterans program (HCHV) sponsors a number of outstationed workers at homeless shelters, indigent care clinics, and treatment facilities. In Norfolk, the VA Homeless Coordinator is on site at the Salvation Army. In Miami, HCHV staff go to Housing Assistance Centers (HACs), several substance abuse treatment facilities, and an emergency shelter. Interviewees reported that for Miami, these visits generally involve a significant amount of coordination ahead of time to ensure that the facility has room for the HCHV staff to meet with clients, and that there are veterans who are interested in hearing about HCHV services. Whenever possible, the host agencies are asked to provide key client information (Social Security number, military service information, etc.) prior to the visit, so that HCHV staff can better prepare for the meeting.

- The VA in Albany sends a worker to the Rescue Mission three times per week. Additionally, the VA will send veterans' medications to the Mission via courier and, when requested one day in advance, transport veterans to medical appointments.

- Norfolk Department of Human Services eligibility workers are outstationed to a number of different sites, including health care providers and the Community Service Board (Norfolk's mental health service provider) offices.

- Staff from the Community Service Board and the Virginia Employment Commission come regularly to the Norfolk, Virginia, Salvation Army to meet with clients about available benefits.

- Department of Children and Families staff in Miami are stationed at provider organizations in the community, including the Citrus Primary Health Care Center adjacent to Citrus' mental health care offices. Previously, ACCESS staff were also located at an HAC, but funding for the position ran out. Plans are currently underway at the DCF to bring ACCESS staff to 10 area hospitals.

- In Albany, both the Department of Labor and New York State Office of Vocational and Educational Services for Individuals with Disabilities provide regular staff coverage to Saint Peter's Addiction Recovery Center. Albany's Public Assistance Comprehensive Employment program has representatives on site at the homeless drop-in center one day per week, and provides job listings plus job assessment and assistance with transportation to interviews. Additionally, Educational Opportunity staff come to the Albany homeless drop-in center monthly to recruit for GED preparatory classes and job training programs.

- Denver has five workforce centers operated by the county that provide space to a VA representative.

- HealthConnect, a community health initiative serving children in Miami, is co-located with Citrus Primary Health Care Center, a clinic that serves the homeless population.

Eliminate Need for an Office Entirely (Outreach Workers)

Outreach workers also provide some measure of transportation assistance by either bringing applications for people to fill out without their having to come into the office, or by arranging transportation services once they make the initial contact, as is the case with Denver Outreach Collaborative (see below). Outreach workers differ from outstationed workers in that they are not tied to a particular location and often spend much of their time on the streets.

More often than not, outreach mechanisms reduce barriers due to lack of knowledge about benefits and failures of different systems to interact; these will be described in more detail later in this chapter. In some communities, however, outreach workers

eliminate the need for transportation, just as outstationed workers do, by conducting the entire benefit application process outside of the office. For instance, in Denver, Homeless Outreach Collaborative members carry applications for a variety of benefits and services, help clients complete them, and then bring the completed forms back to the office for processing. Health providers in Denver bring their office to the clients using mobile clinics to visit shelters and outside locations frequented by homeless people. Mobile clinics provide a full range of services and some that belong to Denver's Homeless Outreach Collaborative bring benefit workers along. Unlike outstationed workers, the mobile clinics do not always link up with another program or site, but often park by bridges or in parks and are free to contact people completely unconnected with Continuum of Care (CoC) programs. For instance, the Colorado Coalition for the Homeless, through the Stout Street Clinic, operates an outreach van that goes to 13 areas in the city, including shelters and outdoor areas, five days and two evenings a week.

Establish Multi-Service Centers

Multi-service centers, at which users may access multiple services and benefits, are an effective tool for minimizing travel expenses as well as integrating services, as discussed below. Almost all of the study communities had at least one multi-service center, often located in programs serving homeless people. Examples from study communities include the following.

- Albany's Sheridan Hollow Drop-In Center serves as a base of operations for Albany's homeless population, and a mechanism for smoothing access to multiple benefits and services. Specific functions include co-location/onsite hours for personnel from providers of public benefits and services; case management and other staff support; day shelter; meals; mailboxes/mailing addresses; and access to computers, showers, and laundry facilities.

- St. Martin's Hospitality Center in Albuquerque offers a day shelter with the usual services of showers, meals, and mail and message receipt. It is also a behavioral health services provider under contract with public agencies to serve homeless people. Connections to standard mainstream benefits such as TANF and food stamps are done through St. Martin's case managers, without co-location. But St. Martin's offers something fairly rare in multi-service centers for homeless people—direct access to behavioral health services. When people with behavioral health problems (mental illnesses and addictions) use St. Martin's day facilities, staff are able to connect 65 to 70 percent of them to mental health programs.

- St. Francis House in Denver provides a day shelter with mail and storage, a health clinic, phone services, employment services, a clothing room (donated clothing), and shower services. It is open during the day when most of the shelters are closed and provides space for outreach workers from Denver's DHS, VA, Denver Health, the Benefit Acquisition and Retention Team from Colorado's Coalition for the Homeless (see below), mental health workers, and a mobile unit from a local indigent care clinic – Stout Street Clinic.

- Miami's Homeless Assistance Centers (see Chapters 3 and 5) are a prime example of multi-service centers, linking clients to a wide variety of services and benefits.

- In addition, Exhibit 4.1 provides a comprehensive example of co-location in Houston, Texas.

Exhibit 4.1: A Drop-In/Access Center for All Homeless People, with Extensive Co-Location

Drop-in centers offer the lowest-barrier type of program within a community's homeless assistance system. The availability of showers, mail and message service, and breakfast and lunch draw people in, making these centers excellent places in which homeless people can connect with representatives of mainstream agencies and begin the process of applying for benefits.

The city of Houston is especially rich in Drop-In/Access Centers, and provides this example. Three Houston agencies operate access centers—Service of the Emergency Aid Resource Center for the Homeless has its Resource Center, the AIDS Foundation of Houston has its Benefits and Resource Counseling Center, and veterans are served through the U.S. Vets Initiative Service Center. The SEARCH Resource Center is open to all homeless people and serves about 8,000 unduplicated persons a year. The other two centers serve only specialized clientele. The U.S. Vets Initiative Service Center serves only homeless veterans. It is located next door and coordinates intensively with a Department of Veterans Affairs health clinic, and both are on the first floor of a building offering permanent supportive housing to disabled homeless veterans. The U.S. Vets center experiences about 2,000 visits a year, made by about 700 different people. BARC serves only people with HIV/AIDS, who may or may not be homeless.

All three access centers offer basic onsite services, initial and ongoing needs assessments, easy access to specialized services co-located at the access center for certain days and hours each week, and referrals. Each also offers a certain amount of case management for clients who want to take steps to leave homelessness. For instance, about 20 percent of SEARCH's guests receive case management services each year to help them get into transitional or permanent supportive housing, detoxification or substance abuse treatment, and to link to other needed services. Access centers serve as a primary referral source to the extensive array of housing and other services offered by the sponsoring agencies. Most referrals to the transitional and permanent supportive housing offered by SEARCH and AIDS Foundation of Houston come through their respective access centers. Access centers also help connect their users to other agencies and resources, through co-location and direct agency-consumer contact and through case management offered at the centers.

Using SEARCH's Resource Center as an example, one can see the array of mainstream services it makes available to its consumers on site. The Resource Center is located in the same building as a major Health Care for the Homeless Clinic, and regularly links consumers to these health care resources. Staff of the county's Mental Health and Mental Retardation Agency are co-located at the center and are able to see clients, make assessments, and initiate applications to become a client. Employment services are offered through the regular presence of Worksource staff from a Houston One-Stop. Connections to addictions recovery services are offered onsite by Counseling and Recovery Resources, Inc. Center users may connect with these co-located resource staff on their own during the hours they are present at the Center, or may take advantage of the center's case management resources to help them put together a package of services and service connections.

For more information, see Houston, Texas Case Study in Spellman et al., 2009.

Changing mechanisms

In a number of study communities, state public assistance offices are undertaking efforts to modernize their programs, including food stamps and TANF, that change the program structure and application process. Under Food and Nutrition Services guidelines, the requirement for face-to-face interviews for food stamp recertification may be waived if a face-to-face interview causes the applicant "hardship." States are also conducting face-to-face interviews outside of the office or are conducting interviews by telephone. Some states reportedly received waivers to eliminate face-to-face interviews for food stamp recertification altogether, even without documenting hardship. Florida, for example, has a statewide waiver for the mandatory face-to-face recertification interview every 12 months, as do Pennsylvania, New Mexico, and New York. Other states are using call centers for certifications, as well as recertification procedures and online application submission processes. Information regarding state policies is available at the Food and Nutrition Service, U.S. Department of Agriculture (USDA).

Expanding Mechanisms

Portland, among others, used private connections with philanthropic or charitable organizations to expand the city's available transportation for homeless people. Local churches and nonprofit agencies are reportedly helpful in providing rides to benefit offices.

Atmosphere of Application Office and Stigma

The reputation of an agency's staff, waiting time, or even physical layout proves to be a barrier for some homeless people, as is also true for those with housing. Indeed, interviewees from the majority of study communities mentioned fear, indignation, embarrassment, and indifference as reasons for lower rates of benefit receipt in the homeless population. In these circumstances, homeless people make a *choice* not to seek out mainstream benefits or to complete a benefit application, even though a different choice might appear on the surface to be more to their advantage. In the words of one benefit provider, "the distrust level is so high you can't get them in once, let alone twice."

Office Environment

Providers on a number of occasions expressed concerns about the office environment of mainstream benefit providers. Staff demeanor, waiting lines and times, and even the proximity to government reportedly discourage homeless people from going to application centers. For some, the thought of waiting in line for two hours only to be treated rudely overshadows the benefit itself. For others, deep-seated fears of authority—whether based on experience or associated with mental illness—keeps them from coming in. Fear of Immigration and Naturalization Service workers, in one instance, caused a mother not to seek benefits for her child.[10] In another instance, a homeless person with

[10] Fear of deportation and misunderstandings about application procedures reportedly cause some eligible legal immigrants to refrain from seeking benefits.

schizophrenia simply refused to go into a crowded building. Case managers told us about a "waiting list" for those clients seeking limited services, and an informal "wish list" for homeless people whom case managers could not persuade to come in off the streets. General staff reductions at mainstream agencies may aggravate these circumstances in at least one of the study communities—interviewees told us that because of 20 to 30 percent fewer staff at benefits offices, staff are not able to form the same, more personal, relationship with clients that they had in the past, and that clients could not always expect to see the same case worker with whom they had grown comfortable.

Other interviewees claimed that unwelcoming office environments are intentional, or meant to weed out less attractive clients. In employment programs in two of the study communities, for instance, funding depends on high placement rates, creating an incentive to discourage less "work-ready" people from applying. The homeless population struggles in this regard, at times lacking proper clothes, interview skills, dental care, and other factors deemed important for getting and maintaining a job. Program staff complained that if they took on some of these more vulnerable clients, they would never be able to maintain funding.

Exhibit 4.2: Shelter-based Employment Portals in the City of Los Angeles

The Community Development Department (CDD) of the City of Los Angeles runs the city's Workforce Investment Act programs, including its One-Stops. For close to a decade, CDD has focused on making its One-Stops more accessible, supportive, and friendly to people with disabilities, through extensive required training (called Legacy) and special staff called "Disability Coordinators." Through these efforts CDD One-Stops have a higher-than-national-average placement rate for people with disabilities. CDD first focused on homeless people as a specific population in need of employment services in 2003, when it received a grant under the federal Chronic Homeless Initiative to offer housing and employment to extremely hard-to-serve homeless people through a program called LA's Homeless Opportunity Providing Employment (HOPE). As part of LA's HOPE, CDD opened an employment portal at the New Image Shelter, the largest overnight shelter in the County of Los Angeles. The portal, which is a self-directed resource room, provides computers with direct links to CDD's job listings, job assistance materials (for example, classes on resume writing), and one-on-one computer instruction. The New Image EmployABILITY employment portal is open five hours a night, five nights a week and receives 600 visits a month with approximately 40 new visitors a month.

CDD opened another portal in April 2007. Known as the Living Independently Through Employment (LITE) Program, this portal receives funding from Community Development Block Grant resources through the mayor's office, City of Los Angeles, is operated by the Skid Row Development Corporation, and is located at the Volunteers of America Drop-In Center in the heart of Skid Row. The LITE Program offers necessary community support services, case management, and coordination with One-Stops, which are available to people using both portals. In the LITE Program's first couple of months in operation, it was able to place close to 70 people in employment and had almost as many participating in and completing short-term training courses that prepared them for specific jobs. Hundreds of people use the portal monthly to access job leads. Registration and placement numbers for LITE and New Image have been maintained jointly since the portals operate collaboratively. From December 2007 through December 2008, 2,522 clients had used center resources at least once and case managers opened files for more than 1,400 users. Of the people with open case files, case managers assisted 239 people to find full-time permanent positions, another 202 to find part-time or short-term employment, and 125 people to enroll in or complete training opportunities. For those working, the average hourly starting wage was $10.58 an hour.

So-called *intentional* barriers require, to some extent, a change in a program's policy in order to remove incentive structures that negatively affect homeless clients. As an example, Exhibit 4.2 describes an initiative in LA where employment one-stops have

made conscious efforts to open up employment services to even those that are hardest to serve.

Environmental barriers are most common in government employment centers and benefits and human services offices, although similar complaints were sometimes noted about hospitals and veterans' service centers.

Stigma

Stigma attached to a benefit reportedly dissuades some eligible homeless people from applying for it. Stigma means that a person would not want to be known to be receiving a benefit, and would somehow feel diminished if the fact came out. The existence and operation of stigma associated with public assistance receipt is well known in the benefits literature. It should be noted, however, that homeless people may experience additional hardship in making the decision to apply for benefits because they feel that homelessness itself is stigmatizing and they may have to admit their homeless status during the application process and be unable to give an address. The possibility of admitting to having a mental illness almost certainly adds a third dimension of stigma.

Getting Too Little for Too Much

Homeless and housed people alike often weigh the environmental barriers to applying against the value of the benefit itself, causing some potential clients to conclude that applying is not worth the trouble. One community has a GA program with benefits so low that most providers we interviewed did not know they existed; of those that did, few were willing to refer clients—the benefits, they felt, were not worth the hassle of applying and maintaining eligibility.

Others saw program requirements such as TANF employment requirements or time restrictions for a number of benefits as too burdensome and antagonistic, or unrealistic. Interviewees in two communities commented on a general "punitive feel" of benefits such as TANF, and the application process was described as lacking flexibility and requiring applicants to jump through nonsensical hoops (for example, employment orientation for people who already have a job). A proportion of homeless clients, we were told, assess the costs and benefits of application and decide that the costs are too high.

Mainstream Benefit(s) Affected

For at least one study community, environmental barriers were evident for all mainstream benefits. A few barriers, however, were mentioned more often than others across communities. Benefits offices were reportedly "unfriendly" to homeless people across many communities. Interviewees often singled out TANF as overly punitive in its work requirements and GA as insufficient and thus not worth the trouble. Providers and case managers reported poor office treatment and long waiting times for offices distributing TANF, GA, food stamps, Medicaid/Medicare, and SSI/SSDI. Employment and training programs, as mentioned, also received criticisms for being less than welcoming to homeless people who are not "work ready."

Mechanisms to Reduce Environmental Barriers

Smoothing Mechanisms

This section deals with mechanisms that address the office and benefit culture—that is, efforts specifically designed to increase an individual's confidence that the experience of applying for a benefit will not be insulting or upsetting. This may be a difficult task considering how intangible the problem can be, and the challenge of making an office or benefit more inviting. It can be as simple as increasing an office's light and air flow or having a friendly greeter at the front door. Interviewees mentioned a variety of mechanisms for speeding up in-house processes and for creating a generally more accepting environment.

Community Education

In numerous communities interviewees told us that educating clients, staff, and the community about what it means to be homeless, as well as what it is like to apply for a particular benefit, is the surest means of helping homeless people overcome negative perceptions of an application process and for staff to provide more hospitable services. Programs like Project Homeless Connect, an annual get together of homeless people and providers occurring in most of our study communities (see below), work to educate staff, community members, and other homeless people on just who is actually "homeless." In Denver, outreach workers on the Homeless Outreach Team (HOT) provide regular education sessions to both providers and clients on the availability of benefits and services. Moreover, Denver created a permanent committee as part of its Homeless Consortium that deals primarily with "Community Awareness," or disseminating information pertaining to the Denver CoC. As one interviewee explained, with education came acceptance and better working relationships.

Outreach and Outstationed Workers

Outreach and outstationed workers circumvent the issue of poor or intimidating office environments by taking the application process into the community where the homeless population is more comfortable. Denver's Homeless Outreach Team, specifically, visits facilities and outdoor locations where homeless people are known to gather, such as the Samaritan House shelter, the Volunteers of America shelter, or even underneath bridges, and works to make a connection before trying to get them to come in. As one HOT member told us, it can be difficult to create an environment where a homeless person feels comfortable to follow through on benefits applications: "Just building the relationship is huge. It can take a long time for people to trust you." The Team tries to connect homeless individuals and families with housing and benefit programs, working mainly with food stamps, Old Age, rental assistance, SSI/SSDI, housing vouchers, prescriptions, motel vouchers, and, recently, TANF. Through training and experience, the HOT staff is well educated about homelessness and attributes some of its success to making an effort to understand clients' situation.

Moreover, Denver's Department of Human Services pays for an employee at the Workforce Center specifically to deal with homeless clients. The DHS Workforce Center employee travels to shelters to sign homeless clients up for employment services.

In Office Changes

For office congestion and waiting lines, multiple communities created alternative office procedures. For instance, in Denver, HOT locates some of its staff in the lobbies of benefit offices, where they identify homeless people and provide them with a more personal and speedy application experience. Portland's Department of Health and Human Services office sets aside a corner for onsite triage, where people with short questions, screening issues, or quick claims can go to skip the line. In Miami, some simple tasks such as changes of address can be completed by phone, and DCF offices provide phones in their lobbies so that homeless people or others without access to phones can call the office call center and complete tasks like certification and recertification of food stamps, without waiting to see a worker. Moreover, the Miami DCF offices and Maine's DHHS offer computers to facilitate the application process for people who lack Internet access; the DCF's Miami Central office, for example, has 30 computers available for applicant use, with DCF staff members available to help with the online application process. Florida also established a document imaging system for case files, reportedly cutting down the length of time for file access, file updating, and, thus, client waiting periods.

Complexity (Cognitive Demands) and Length of Application

Once a homeless person makes it to the point of applying for a benefit, a number of barriers may arise beyond mere eligibility. Levels of cognitive ability and available time vary widely in the homeless population. For some, the length and complexity of the application itself is a significant hurdle. Issues of documentation and maintaining contact will be dealt with below; here we look at the burden of completing the application itself. Respondents in all study communities mentioned cognitive and educational deficits that limited a homeless person's ability to fill out a benefit application. Illiteracy is a major problem for homeless individuals and families accessing benefits. One interviewee estimated the average reading level was 6th grade for her clients; some could not read at all. On another level**,** computer illiteracy has become a problem as states and county benefit offices modernize their application process using kiosks and online tools. A VA homeless coordinator distilled the problem for us, "a lot of the vets don't know what a computer is!"

Still more clients find specific applications to be too difficult and overly time-consuming. Aside from documentation requirements, descriptions of what is needed and how to write it down are often not straightforward, especially for benefits like SSI. Case managers themselves reported problems, struggling with issues such as proving a client has schizophrenia rather than drug induced psychosis, or simply highlighting the relevant aspects of a disability. In particular, the length of applications and reliance on multiple, spread out appointments for various benefits like SSI posed significant problems for homeless people.

For a variety of benefits, interviewees mentioned that some homeless people would be sent out for more information and would not return. In a similar vein, homeless people had trouble keeping required appointments and would reportedly get frustrated to the point of leaving if the process took too long. As one case manager put it, "they don't show up, we can't find them, they fail to cooperate…There is a tremendous amount of wheel spinning." When the process for applying for basic benefits can take close to two hours, some homeless, as well as housed, people get frustrated and leave.

Too often, persistence and extensive help are necessary components for successfully getting past the bureaucratic structure of mainstream benefits. A shortage of case managers—most notably at the emergency shelters—exaggerates the effect of this barrier.

Mainstream Benefit(s) Affected

In general, interviewees found food stamps to be the least complicated and most timely benefit for homeless people to access, although some programs do require a face-to-face interview, generally requiring clients to wait in line or return for an appointment. Homeless clients at all study communities can apply and begin receiving benefits on the same day or in up to seven days through expedited food stamps (also described in Chapter 8). TANF, Medicare/Medicaid, and SSI/SSDI benefits, on the other hand, can take anywhere from 30 to well over 90 days, according to some interviewees.[11] The wait for a housing subsidy or public housing unit could be as long as five years. In addition, TANF requires more than one meeting before one can start receiving benefits and, according to one respondent, a significant portion of homeless clients do not make the second meeting.

SSI/SSDI is far and away the most cumbersome application process, both in terms of the time needed to complete an application and have it accepted, and the complexity of the application itself. One interviewee explained, "it is hard for folks that don't have case management trying to navigate SSI. For homeless people who try it on their own, about 80 to 90 percent are denied due to not making it through the entire process." At any rate, clients generally need significant help from specifically trained case workers to navigate the application process successfully.

Mechanisms to Reduce the Length and Complexity of the Application Process

Smoothing Mechanisms

Smoothing mechanisms to address problems of benefit complexity and length of application range from special teams to assist people to special applications to minimize the amount of paperwork a client needs to fill out. In addition, communities make heavy

[11] Interviewees at Norfolk's Department of Human Services told us that pregnant women were eligible for expedited TANF benefits that must be received within 12 days.

use of legal aid from nonprofit agencies and local firms interested in pro bono work. In all study communities, however, local providers recognize the unique difficulties the homeless population has in applying for mainstream benefits. Some mainstream agencies go so far as to flag applications from homeless clients for completely separate processing procedures.

SSI/SSDI Specific Mechanisms/Benefits Teams

Several study communities use specialized teams of workers that have training in one or more specific mainstream benefit and, often, experience with the community's homeless population. Frequently, benefit teams spring up around the most difficult benefit applications (SSI/SSDI) and use SSI/SSDI Outreach, Access, and Recovery (SOAR) training and similar mechanisms to improve the application process. SOAR teaches case, eligibility, and social workers exactly what the Social Security Administration (SSA) is looking for in SSI/SSDI applications—specifically, how to engage a disabled client, how to establish a medical record, and how to submit a complete SSI application. Multiple interviewees attested to the success of the training; some complained that trainings were not offered often enough. In response to the demand, a SOAR outreach worker in Virginia was sent to California to learn how to train others. SOAR workers we interviewed told us that their clients' SSI applications are accepted at significantly higher rates and in as short a time as two to four weeks; it can take up to six to nine months otherwise. In Miami, roughly half of the city's criminal justice service providers have been trained in SOAR.

In some communities, programs such as Denver's Benefit Acquisition and Retention Team (BART) use methods similar to SOAR but have not participated in the formal SOAR training. In these cases, broad knowledge of the application process and established relationships with a benefit office are used to get an application processed quickly. Over a four-year period, the Denver team worked out a relationship with the SSA office where BART provides accurate and complete applications and makes sure an applicant is at all the required interviews. In turn, the SSA office expedites those claims. Interviewees noted that BART significantly reduced the amount of time it took to get applications completed and reviewed and that they reduced the denial rate, boasting a 70 percent success rate for initial applications, rising to 90 percent when counting appeals.[12] Similarly, Portland, Maine's County Social Services office uses a single highly trained and experienced staff member, whose 15-year relationship with the local SSA office greatly facilitates approval of SSI/SSDI applications.

[12] If there is an initial denial, BART reportedly looks to see if it can get a decision early in the appeals process. If a client is denied because of an incomplete or inadequate substantive medical record and is later able to assemble more documentation, the client can submit that evidence to the reviewing office at any point in the process. Reportedly, if the client also provides a cover note asking the reviewing office to review for a potential decision on the record, it will likely oblige. According to interviewees, the claim will then be brought directly to a judge, who will look at the record. Many times, interviewees noted, the BART team will get a reversal without going to a hearing. Because of this, the BART team is a great help to those who cannot or will not pursue the lengthy appeals process.

Still other communities use similar teams for a broader set of benefits. Shelters, indigent care clinics, mental health facilities, and detoxification centers maintain full-time staff to deal specifically with benefits for homeless clients, allowing workers to become more efficient and to establish relationships with benefit offices. Many programs view these positions as an investment that will return cost savings because the programs would otherwise have to provide the respective services or benefits with their own resources. Denver Colorado's HOT Team, run out of the DHS, tried to cut down on both the complexity and length of the application process by training staff to make sure applications are complete and to take only the number of applications they can process in one day. This, according to interviewees, ensured that homeless people would not get frustrated with the waiting period. In the words of one interviewee, "don't let them wait around for you to process them!" To expand the number of applications the HOT Team can handle, Denver's Department of Human Services set up the Homeless Ongoing Outreach Team (HOOT) to file applications and deal with redeterminations coming through the HOT Team. Reportedly the HOOT significantly cuts down the backlog of HOT applications, allowing for shorter application and recertification periods. With the combined efforts of HOT and HOOT, interviewees reported that over 100 applications for homeless people can be filed every day (see *Mechanisms to Increase System/Process Knowledge*, below, for additional outreach initiatives).

Outstationed workers

Similarly, outstationed workers address problems of application length and complexity, as well as those of transportation and office atmosphere. Not only does a staff member from a particular benefit agency provide constant reminders that the benefits exist, but co-location also makes it easier to work through any confusion or mistakes. Indeed, rather than having an incomplete application sent back to a client or case manager, outstationed workers are available to troubleshoot and take care of small problems that ordinarily would produce unacceptable waits. In the words of one case manager, "we had a domestic violence case, and she couldn't get into the [city shelter] because her Medicaid hadn't switched on. [Name of outstationed worker] was able to call the right people and she got in the next day…that process could have taken a whole month." Having someone onsite eliminates the time-intensive process of communicating across agencies and provides a knowledgeable resource for case managers connecting their clients to benefits.

Disability Advocacy Programs/Legal Aid

Many homeless services providers take advantage of legal aid firms or pro bono work offered by private firms when dealing with the benefit application process for the homeless population. Some use firms for individual cases while others approach the problem more systematically, bringing together lawyers to lobby for changes in application procedures or to review what areas of a program could legally be changed (see ID and Documentation Requirements below). Examples include:

- Pittsburgh's Disability Advocacy Program employs staff to help with both the application process and filing appeals for disability benefits. The program maintains a list of lawyers who are available for pro bono work.

- Albany's Legal Aid Society for the Homeless provides outreach and legal assistance to homeless people having difficulty accessing welfare benefits, food stamps, Medicaid, and unemployment; it also assists with matters related to child support (both securing support and relieving arrears).

- Camillus House, a Miami shelter, facilitates access to SSI/SSDI and other benefits by collaborating with Legal Aid in two ways. First, consumers having difficulty obtaining benefits can be referred to Legal Aid; if referred, they will be called within 24 hours and offered a 15-minute phone consultation. Second, the organizations have been holding monthly workshops on benefit access. These workshops are led by a Legal Aid lawyer and held at the shelter; attendance is encouraged through offering refreshments and gift cards.

- The Mental Health Center of Denver (MHCD) brought in Social Security lawyers for the SSI/SSDI appeals process, noting that, although most people are still denied on their first attempt, the acceptance rate at appeal was nearly 100 percent after MHCD started asking lawyers for help.

Flagging and Expediting Applications

As mentioned above, in Denver, SSI benefits teams and state Office of Disability Adjudication and Review offices reached an agreement on processing certain applications first. Interviewees in all study communities reported similar relationships with other mainstream benefit programs, where applications from homeless people are flagged and expedited.[13] Examples include:

- Veterans Affairs interviewees in Pittsburgh and Norfolk mentioned that veterans benefit workers try to expedite claims that are flagged as coming from a homeless veteran.

- The Colorado SSA Office of Disability Adjudication and Review established a relationship with the Colorado Department of Human Services wherein homeless applicants are flagged and put on top of the review pile.

- One local SSA office in Miami has become the point office for SSI applications for homeless people. Two days per month, this SSA office closes to the general public and focuses exclusively on clearing applications from people who are

[13] It must be noted that a large part of the success that some case workers have in assisting homeless people to apply for benefits relies on personal relationships they formed over their years as case workers. This issue is dealt with below, in the *System/Process Knowledge* section.

homeless. Applications are then "red flagged" at the Disability Determination Office.[14]

- Unlike many housing authorities, in the majority of the study communities local housing authorities give preference to the homeless population during the Section 8 Housing lottery, putting homeless clients on top of the waiting list. Some communities give out a certain amount of "preference cards" to homeless people. A case manager explained, "We ended up having 10 people get Section 8 Housing out of the 10 people we submitted–it took three to four months rather than five years."

Universal Applications

In Miami, Norfolk, Pittsburgh, and Portland, benefit programs use a universal application so that people don't have to apply multiple times for multiple benefits. In Norfolk, the tool asks for information on individuals' homeless status, as well as all mainstream benefits they receive. It also includes questions to determine what other benefits a household/individual is eligible for. As mentioned earlier, TANF, food stamps, Medicaid, GA, Emergency Assistance, state and local coverage for hospitalization, Auxiliary Grants, and the Refugee Resettlement Program all use the same universal application. Case managers and eligibility workers noted that having one application cut down on the burden of gathering documentation and the overall application process and automatically enrolled homeless clients in a variety of benefits they otherwise might not have applied for. Similarly, Miami's DCF uses a single unified application for all DCF programs, gathering information and entering it into a software program that uses the data to calculate the array of benefits and services for which a given household is eligible.

Expedited Food Stamps

As mentioned, homeless people can get food stamps on an expedited basis. Applicants providing proof of homelessness ("proof" varies by state) can receive food stamps in 7 days or less, far faster than the normal 30-day process. In Miami, applicants are asked to indicate whether they are homeless at the time of application, and to give their total income and resources, which trigger categorization as an expedited applicant. Expedited applicants are interviewed the day of their application. For expedited applicants who have previously received food stamps and have retained their Electronic Benefit Transfer (EBT) card, the required identification card for food stamp recipients, the new food stamp funds will be available the next day. For those without an EBT card, a new card will arrive by mail within a week at most, more typically within four days. While the technology supporting expedited status has been in place since 1990, the system is reportedly working better at the time of this report than it did previously.

[14] Applicants with Homeland Security or immigration issues cannot be processed through the SOAR-facilitated system.

Automatic Enrollment

Some communities are developing programs that automatically enroll clients in a benefit program if they are denied, or waiting for, another benefit. In Pittsburgh, for example, the Department of Public Welfare is currently working to launch a program called Healthcare Handshake, whereby children in families deemed not eligible for Medical Assistance will automatically be enrolled in the Children's Health Insurance Program.

Categorical Eligibility

Some states have used categorical eligibility in their administration of food stamps. They automatically assume eligibility if a household or individual receives TANF, GA, or SSI benefits, skipping the need for verifying certain eligibility criteria. Reportedly this automated process eliminated requirements for duplicate resource and document verification (see below), thus cutting down on administrative work for staff and documentation requirements for clients.

Combined Application Program

Of the study communities, Florida, Pennsylvania, Virginia, and New York run a Combined Application Program (CAP) for single adults on SSI who want food stamps. CAP programs flag single SSI recipients and give them shortened applications for food stamps without requiring a face-to-face interview. Information on the individual is shared between the food stamp office and the SSA.

> "Recently a woman in her 50s came to the Social Work office at St. Francis Center. She was gaunt and in a wheelchair, and had not had an ID for a couple of years. She lived mostly with friends or on the street. She needed her birth certificate to obtain an ID, but without an ID it can be very difficult to obtain a birth certificate. Through conversations with the client the social worker was able to determine that she had a brother living in a mountain town, but the client had no recollection of his phone number. Directory services yielded no listed phone numbers for his name. However she knew he worked for a car dealership. A few phone calls later, the brother was located at work. He spoke with his sister and was able to order his sister's birth certificate, which he then sent to his sister at St. Francis. The client was able to obtain her ID, which allowed her to apply for state and federal benefits such as food stamps and SSDI."
>
> *- Carla Slatt-Burns, Shelter Case Worker,*

Language Lines

Colorado, Maine, and Miami mentioned using translation services when clients do not speak English or another common language well enough to complete applications. Applicants to human services departments have access to dual headsets that can translate numerous languages, or to translators. In Portland, DHHS reported it can handle up to 29 different languages in addition to Spanish, Somali, and Sudanese, which they have in house. Miami uses a phone-in interpreter service that staff can use when working with an applicant who does not speak one of its three standard languages—English, Spanish, and Creole. Denver also provides translators and fields a Spanish Speaking Outreach Team for mainstream benefits and services.

Intensive Case Management

Intensive case management stands as the most prevalent means of getting homeless applicants through any or all mainstream benefits application processes. "Hand holding" throughout the entire process is deemed necessary for a substantial part of the homeless population. One interviewee put it clearly, "With the VA benefits, I will actually physically bring people to the claims rep. You can tell them about it, but they don't have the wherewithal to get it done."

Case managers, shelter staff, and mental health providers all shared instances of going to a benefit office and waiting in line with their client. Otherwise, they told us, the client would not make it through. In these circumstances, staff time and case worker loads can become burdensome. To alleviate this, outstationed and outreach workers are particularly helpful for both clients and providers. One case manager lauded the DHS in Denver for its outreach efforts, noting that the outreach workers come regularly to his office and are "very helpful, especially when we don't have time to take them [clients] over."

ID/Documentation Requirements (for example, Proving Residency)

A lack of an official, government issued identification card and various application documents stands as perhaps the most acute and pervasive problem in the study communities. In almost every interview we conducted, the issue of IDs featured prominently. Brought on in most cases by city residency requirements or by fears of identity theft and illegal immigration, a large portion of homeless services and benefit applications require a state issued ID, proof of residency, and proof of citizenship.[15] These requirements proved to be difficult for many homeless people to meet. In the words of one interviewee, "getting an ID is one of the most ridiculous things on the planet at this point, and they need them."

The majority of complaints focused on the process of getting IDs and birth certificates once you had lost your originals—a common occurrence. Many gave us the phrase "you need an ID to get an ID!" And it was true; only a few organizations can get state issued identification without first having an individual's birth certificate. Even with a second form of ID, the process is still reportedly difficult. To get a Social Security card in Virginia, for example, one either has to go out to the Social Security office (which is "far," according to the provider staff in Norfolk) or send in one's original ID and thus lose one's ability to get into emergency shelter and to apply for other benefits. In all, interviewees mentioned that the process for getting an ID ranges from weeks to months, often requiring travel to different agencies or even to different states. Moreover, the fee to

[15] Exceptions existed in some of our communities where various identification bills exempted certain populations from providing state issued identification. Examples from Colorado House Bills 063-1023/07-1314 include exemptions for those under 18; those applying for food stamps only; those applying for Medicaid only; those in adult protection; and those applying for Community Services Block Grant, Emergency Shelter Grants, and Shelter Plus Care, among others.

get a birth certificate is considered prohibitive. The overall process varies according to the strictness of the ID laws in the state issuing the documents.

For those born out of the state or country, the process for getting a new ID issued is exponentially harder and more expensive, compounded by transportation barriers and sheer costs. Clients are required to retrieve documents from another state, then file for new identification, and then apply for benefits. As is obvious, for the homeless population these steps stand as particularly significant problems. Homelessness is marked by transience, often across state lines; once a person or family moves, many find it difficult to establish residency in a state where they do not have an address. One case manager noted, "I have told people they have to go back to the state they came from to get an ID...There is a better chance that the state you came from will issue you an ID." Some states set extremely strict laws. In 2006, for instance, Colorado passed HB1023 aimed at undocumented people in the state, and added stringent requirements to prove lawful presence. Only a few specific forms of ID are valid.[16] In all states, a number of factors make it more difficult to obtain ID documents, including name changes or small mistakes on existing identification.[17]

Providers mentioned that IDs posed a problem even for homeless people coming out of public institutions such as jails and prisons. A provider who works with ex-offenders expressed her frustration, noting, "ID is the worst!...I cannot tell you what a pain in the neck that is. I understand why it is difficult. But why for incarcerated people! We know them! Why can't we get them an ID?

Indeed, we found that some of the corrections systems in the study communities will not provide an ID upon reentry into the community.

Lack of documentation other than IDs also proves to be barrier. Homeless individuals and families reportedly have a hard time establishing proof of residency, medical histories, or even basic income information that they need for means tested benefit applications. Youth, in particular, struggle to produce documentation of all kinds, often lacking both the ability to order documents online without credit cards and even the documented history (in particular, a medical history and a history of residence) needed to establish eligibility for some benefits, like SSDI.

[16] The City of Denver reportedly tried to pass legislation to expand acceptable documents. The bill passed both houses of the state legislature but was ultimately vetoed by the governor. Reportedly, TANF, food stamps, and Low Income Energy Assistance Program have more flexibility in the types of documents accepted. For Aid to the Needy and Disabled and other Colorado state benefits, acceptable documentation remains very restricted.

[17] One social worker noted the case of a woman who had adopted a different spelling of her name when she was a child; she could not get an ID.

Mainstream Benefit(s) Affected

In general, IDs and documentation problems affected all mainstream benefits, aside from indigent care clinics that took clients coming off the street with no requirements. Food stamps and Medicare/Medicaid, with straightforward income requirements, reportedly ask for the least amount of documentation. They do not mandate that clients produce proof of residency (only citizenship) and they do not require *specific* identification forms, such as a birth certificate. For food stamps, as an example, a library card could work, and if a case worker vouches for an individual's identity, no documentation is needed. Veterans' services, too, are lauded for needing only a specific VA document (a DD214) for most benefits.

However, as stated above, SSI and SSDI prove to be difficult because of the extensive documentation needed to confirm a disability and establish a history of care. Welfare/TANF, too, demands much in terms of identification, proof of residency, Child Support Enforcement Unit (CSEU) documentation, income, and employment.

Mechanisms to Reduce Identification and Documentation Barriers

Smoothing Mechanisms

Interviewees gave numerous examples of mechanisms designed specifically to help people obtain the necessary documents and identification for benefit receipt. Initiatives range from comprehensive programs where clients are walked through the entire process of getting an ID or document, to safekeeping measures where clients may use program file cabinets or safes to lock up and store their identification material.

Comprehensive ID Initiatives

In Miami, Homeless Opportunity Providing Employment (HOPE), a provider of homeless services, operates the Identification Project dedicated to obtaining identification documents for people who are homeless. In recent years, because providers frequently raised the issue of proper identification when discussing barriers, the Homeless Trust decided to determine the extent of the problem by including a question on a yearly point-in-time survey, asking whether respondents had had trouble related to lack of identification. The results indicated identification needs were a widespread problem.

In response, the Homeless Trust allocated food and beverage tax funds under its control to support a project to help with identity documents. In 2008, the Trust sufficiently funded HOPE, as part of Miami Beach's Identification Project, to support a new, part-time (.75 FTE) staff person plus the costs of document retrieval for homeless people throughout the county (not just from Miami Beach, which was the target of the original activity). Activity increased from processing 200 requests a year to processing 200 requests a month. People generally are referred to the program by other provider agencies. Most requests are filled through Vital Check, a commercial service that obtains government records nationwide. This service is reportedly quick for in-state documents

but lags for out-of-state requests (although not as much as if one tried to get the documents oneself). The project also helps people get state-issued identification cards by coordinating transportation from the program to the city offices that issue the cards. Additionally, the program works to obtain residence cards for people in the process of immigrating to the United States. The demand for program services, however, far exceeds staffing resources.

A similar comprehensive program is run out of Norfolk, Virginia's Project Homeless Connect (see below). Using the food stamp eligibility database from DHS and corrections records, the ID Innovation project is able to produce a qualified identification record for most of the clients coming through Project Homeless Connect. With their qualifying record, program staff are then able to connect clients with a city-sponsored ID that they can use to obtain primary ID from the Department of Motor Vehicles, and to get into employment programs, city shelters, and other homeless services. Interviewees in Denver also reported ID booths at its Project Homeless Connect, where numerous agents from law firms, providers, and city government come together to facilitate the process of getting a form of identification.

Legal Aid

Denver, among other communities, makes use of legal firms specifically to help people retrieve identification documents. As an example, the Colorado Lawyers Committee takes on pro bono work that addresses systemic issues like identification, as well as mental health and incarceration issues. As part of its work, at the time of this report the committee was creating 30 "ID Swat Teams" among associates in large firms. These teams will take on cases having to do with identification requirements, looking to expand definitions of acceptable documents and expediting the process for claims. Interviewees noted that there are a total of 120 attorneys working on the Swat Teams, focusing on homeless clients specifically. In addition, the Colorado ID Collaborative, an organization made up of representatives from DHS, Colorado Legal Services, Colorado Coalition for the Homeless, MetroCareRing (an emergency services provider), and the Colorado Lawyers Committee, takes on specific cases having to do with obtaining identification, including coordinating help for people having significant difficulties. Interviewees noted that within the past two years, the collaborative reduced the number of documents needed for benefits and helped the state determine a more rapid way of getting IDs. The group also maintains a fund for providers and people that need help with document fees. Denver's Road Home, in addition, contracts with Colorado Legal Services for case-by-case help in getting birth certificates, dossiers, and licenses.

Exhibit 4.3: Increasing the Odds of Successful-the-First-Time Supplemental Security Income (SSI) Applications through Improved Access to Better Health Care Data

Electronic data retrieval and improved medical documentation speed the way to successful SSI applications.

Every effort to house homeless people with multiple disabilities and provide them with adequate supportive services encounters the issue of how to pay for those services. If they are SSI beneficiaries and receive the related Medicaid coverage, tenants themselves are potential sources of cash income and medical insurance coverage, which can help pay for supportive services. Most long-term homeless people with disabilities are not receiving SSI, however, and therefore are not covered by Medicaid.

A major stumbling block for SSI applications for homeless people is the difficulty in documenting the nature, duration, and extent of disabling conditions. Homeless people usually seek medical care at the facility most convenient to them when they need care, so their records may be scattered in many facilities. Rarely has the medical professional being asked to fill out SSI/Social Security Disability Income (SSDI) documentation known the person long enough to be able to report that a condition has existed for a long time at a high level of disability. Another stumbling block is that the information contained in the medical record itself, once a case worker has obtained it, often is not sufficient to satisfy the application requirements.

In Los Angeles, the county Department of Health Services (DHS) has been working in a number of ways to improve the quality and success of SSI applications for chronically homeless people, and thus increase both their income and their access to health care through Medicaid. In addition to SSI/SSDI Outreach, Access, and Recovery (SOAR) training for case workers, which a number of study communities do and which is described above, DHS has focused on improving access to vital health care information that is required for SSI applications, dramatically shortening the time it takes to get the information, and improving the information itself.

- Improving access to medical documentation. To overcome the barrier of poor access, DHS assigned two highly experienced registered nurses to retrieve the needed documentation from the many public health care facilities under DHS management or contract. All seven DHS hospitals use the same data system, but it is not linked across hospitals and each hospital has its own way of assigning patient numbers. The DHS nurses were given access to all of these systems, but initially and for several years they had to go to each hospital to search for its patient records. In June 2008, DHS succeeded in centralizing electronic access to all of the hospital data systems in one place, greatly facilitating the nurses' job of verifying when and where people got care, and for what. The new structure of data access makes it a lot easier for the nurses to get the data for the case managers, thus speeding up the process of completing SSI/SSDI applications *and* providing the exact information to document the nature of disabling conditions and how long they have existed.

- Improving the medical documentation itself. DHS has found that SOAR training, with its concentration on case workers, does help its intended audience improve its ability to prepare successful applications, but is limited in that it reaches only a few of the people who need it. In addition, even if case workers were able to access the documentation, the documentation available in hospital records often does not itself provide the specific information the Social Security Administration needs before it can approve an application for SSI.

  DHS is developing a project that will train health care professionals in proper documentation while simultaneously expanding the role of the two registered nurses mentioned above to improve existing documentation, initiate pertinent documentation when it is missing, recommend applicable diagnostic tests, coordinate with community-based providers to document outpatient services, and act as liaisons with the Social Security Administration and its Disability Determination Services to assure that everything possible has been done to submit complete and successful applications.

  The DHS-funded team will include a case management component to ensure that all steps of the SSI application process are completed, documentation is complete, historical medical and psychiatric records have been identified and acquired, and similar activities. In addition, DHS, the county Department of Mental Health, and the Sheriff's Department will each provide a single point of contact person who will facilitate access to health and other records to assure strong documentation.

For more information, see Chapter 3 in Burt, M.R., 2009.

Access to Larger Data Sets

As noted above, homeless service providers in Norfolk are able to make use of large data sets to produce a qualifying identification record. In Miami, DCF workers have access to the Homeland Security, SSA, and state office databases, facilitating information transfer and in some cases reducing the document burden for benefit applicants. Through their access to the Florida Vital Statistics database, DCF workers may produce information to establish applicants' citizenship status. Additionally, workers are able to use SSI/SSDI benefit databases and program documentation as proof of citizenship, for those applicants already receiving SSI/SSDI.

In addition, Exhibit 4.3 provides an example from LA where health records were made more accessible to case managers filling out SSI/SSDI forms. Clearly, the example suggests that information sharing is a great boon to the SSI/SDI application process, even with other access mechanisms like SOAR-trained case managers.

Document Imaging

In Florida, as part of the ACCESS system, all client documentation is stored electronically, including permanent records such as birth certificates and identification cards. The document imaging process can reduce processing times for office eligibility workers, and thus shorten waiting periods, and can alleviate the burden of losing identification and documentation. Client information can also be accessed statewide, thus avoiding transportation barriers for a highly transient homeless population.

Certificate Payments

Numerous interviewees reported that their program or office pays for the costs of obtaining birth certificates or immigration status certificates to help clients receive a state-issued ID from the Department of Motor Vehicles. As an example, the HACs in Miami will cover the $380 fee required to reapply for documented immigrant status after it has expired.[18] Others worked out deals for homeless people. In Albany County, for example, birth certificates can be obtained free of charge for homeless clients with a supporting letter from the Homeless and Travelers Aid Society (HATAS), a service program for homeless people.

Safe Keeping

Recognizing the difficulty some homeless people have with keeping their identification documents safe and organized, providers in almost all of the study communities offer document storage in locked file cabinets and safes in the office. Often an agency holds original documents, providing photocopies to the client upon request. In one community, a provider agency arranged an agreement with benefits offices such that photocopied identification material could be signed by the provider agency as proof of its authenticity.

[18] Programs noted, however, that providing such services were a significant drain on program resources, unless a deal was brokered for homeless individuals.

Changing Mechanisms

In addition to, and often because of, the smoothing mechanisms, changes have been made to a number of programs to allow for broader ranges of acceptable documentation and identification. Some changes are effected through litigation; others made use of flexibility afforded to program offices by state administrators.

In a number of interviews, respondents mentioned that local Department of Motor Vehicle (DMV) offices relax identification requirements for receiving a state issued license. In one case, the DMV accepts DD214s (discharge papers from the military) as identification of veterans, while in other communities DMV staff take sufficient medical records. Still others have worked out an agreement where temporary IDs created at shelters, local ministries, clinics, and jails are accepted as sufficient documentation of identity—or in place of a birth certificate—to receive an official form of identification.

Partnerships, too, have developed around the issue of IDs. Interviewees at Norfolk's employment One-Stop mentioned working with the parole system as part of a new program in which parolees are now given a "signed and sealed" 3 x 5 card containing a photograph and the information that they need to obtain primary identification. Shelter staff in Miami (Citrus and Camillus House), moreover, create photo IDs for homeless people, while working with DCF to ensure that the IDs will meet the state's requirements.

Complexity of Maintaining Enrollment

Some homeless people have trouble maintaining benefits once they've been deemed eligible and start receiving them. A lack of address or other contact information poses a particular problem for case managers trying to follow up with a client about the ongoing requirements of keeping a benefit, and it also makes it hard for clients to receive the benefit. As one staff member from a benefit office put it, "We lose a lot of people—they disappear."

Others struggle with keeping benefits while entering and exiting medical and criminal justice institutions. Many study communities work under state laws that terminate, rather than suspend, benefits when in jail, prison, or health institutions, requiring a client to reapply upon release.

Mainstream Benefit(s) Affected

TANF, food stamps, and Medicaid/Medicare all require recertification every one to three years. SSI/SSDI requires Continuing Disability Reviews. All, therefore, demand continued contact between case workers and clients. Interviewees noted that homeless beneficiaries lose their benefits when the addresses they give prove unreliable, or they do not receive important communication regarding welfare requirements. This is reported to be particularly common at recertification intervals for food stamps and in relation to TANF workforce requirements.

Mechanisms to Keep Homeless People from Losing Benefits

Smoothing Mechanisms

Smoothing mechanisms for maintaining benefits involve facilitating client contact with case managers and benefit offices and staying updated with the status of clients' benefits.

Program/Shelter Address and Voicemail Usage

Across the study communities, both public and private homeless programs allow clients to list the program address as a personal address, accepting mail on a client's behalf and storing it until called for. This in turn allows clients to receive benefits and to stay connected with case workers or benefit workers for changes in their eligibility status or recertification needs. Several communities also have community-based or shelter-based voicemail accounts where clients can receive audio messages. Often, these accounts are donated by a private communications firm or are purchased at a discount by a local homeless services provider or city agency.

Reinstating Benefits

A number of communities deal directly with institutionalization and benefit terminations. Case maintenance officers in Miami's DCF receive alerts about changes in their clients' criminal justice status that can trigger activation of appropriate benefits. In Colorado, Medicaid waivers are used for people on SSI and Medicaid; Medicaid benefits are simply switched off (suspended) when people enter an institution and reinstated when they leave, rather than being terminated. In other communities, this practice of benefit suspension is used for more than just Medicaid benefits.

Similarly, in Miami, as a result of a new Florida policy, former SSI recipients who have been incarcerated for a year or more are now eligible to receive Medicaid and food stamps immediately upon their release, while they are still waiting for their SSI to resume.

Additionally, Miami HACs can facilitate applications for pending food stamp benefits, so that residents can access food stamps immediately upon leaving shelter. After HAC residents complete an application for food stamps and receive approval, they are placed in "pending" status because the HAC provides all meals, making any HAC resident ineligible for food stamps while still at the HAC. When the resident's date of exit from the HAC is known, ACCESS, Miami's benefits system, changes the person's status from "pending" to "active" and releases the appropriate amount of funds (that is, food stamp credits) into the person's EBT account. Once the person leaves the HAC, he or she can use the EBT card to purchase food.

Other programs hire staff specifically to target people coming out of institutions without benefits. The Community Services Board in Norfolk, Virginia, for example, has hospital liaison staff who work closely with hospitals and discharged patients to get clients back on benefits that were terminated upon hospital admission.

In Pittsburgh, Healthcare for the Homeless assists with prerelease applications for welfare office benefits, as well as community-based mental health services and medication, for people scheduled to be released from the county jail. This program was so successful that Pennsylvania was interested in replicating it in other counties, although at the time of our site visit it was on hold as a result of union concerns.

Change Mechanisms

As mentioned, some states received a waiver from the USDA to conduct recertification interviews for food stamps via telephone. This, in combination with telephone availability at shelters, enables homeless people to readily maintain their food stamp eligibility.

System/Process Knowledge

System and process knowledge stands as a barrier to homeless people on two fronts. First, homeless people often do not understand the full extent of the benefits for which they are eligible. Second, staff of homeless programs and public agencies alike have a limited understanding of the benefit system in its entirety, at times unwittingly giving out false referrals, incorrectly discouraging homeless clients' applications for alternative benefits, or failing to inform people of additional benefits for which they are eligible, especially based on homeless status. While unavoidable for large service systems and complicated eligibility criteria, these factors pose significant barriers to benefit receipt.

System/process knowledge barriers differ from system interaction barriers (described below) in that they deal specifically with the lack of knowledge about the benefits system as a whole and how to maneuver through its many levels of bureaucracy rather than the lack of formal connections between service programs. Interviewees in many study communities expressed frustration with case managers who incorrectly tell homeless people they are ineligible for a benefit or who do not understand the fastest and most efficient means of referring a client, or with benefit providers who erroneously turn people away. In one instance, interviewees reportedly found that some welfare case workers incorrectly assume shelters have feeding arrangements and refuse client applications to food stamps on the grounds that they are already being fed. Learning the full extent of available mainstream benefits and forming the relationships to smooth the process can be a lengthy process; with high staff turnover and large complex systems, this reportedly poses a significant problem in many communities.

Mainstream Benefit(s) Affected

Clearly, system/process knowledge affects all mainstream benefits. VA, SSI, mental health/substance abuse, employment, and certain health care benefits, however, are less known in some of the study communities and reportedly more often overlooked by both clients and referral sources.

Veterans, in particular, reportedly do not pursue benefits, especially for highly stigmatized disorders like mental health (post-traumatic stress disorder, in particular) or substance abuse.

Mainstream benefits programs administered by the state and local human services offices, generally TANF, GA, food stamps, and Medicaid, are more known and had established, extensive referral networks.

Mechanisms to Increase System/Process Knowledge

Smoothing Mechanisms

System/process knowledge is addressed by mechanisms that: 1) confront client needs through outstationed workers and outreach programs and 2) increase staff knowledge through educational initiatives and a greater focus on bringing program staff together. Formal system interaction barriers and mechanisms will be dealt with below; here we look more closely at mechanisms specifically designed to increase staff and client ability to find and successfully complete benefit applications.

Outstationed Workers and Benefit Staff

Out stationed workers provide increased awareness for both staff and clients, acting as a constant reminder that a benefit remains available and as a resource for eligibility questions. Taking the idea of an outstationed worker one step further, some agencies hire staff people to become experts on the broader benefits system and to connect project clients with mainstream benefits. In a sense, these programs are trying to replicate and make permanent the relationships and expertise outstationed workers provide. As an example, Denver Hospital fields a team of benefit workers devoted to getting patients onto the Medicare and Medicaid rolls by creating links to DHS and by becoming experts in the application process. More examples of both outstationed workers and benefit staff have been described above.

Outreach Workers

Outreach workers, by going to areas where homeless people congregate but do not have ready access to benefits systems, are perhaps the most effective mechanism for finding clients who would otherwise not apply for a mainstream benefit. Outreach teams, like the Benefits Acquisition and Retention Team in Denver, also make presentations, describing services and benefits at schools, hospitals, and other places that would have a referral base.

Denver's broader outreach effort stands out in its attempt to enroll the Denver homeless population in the full spectrum of benefits. The Denver Outreach Collaborative is a conglomerate of all city homeless outreach groups. In an attempt to provide more coverage and less overlap in both case management and outreach, Denver's Road Home put out a Request for Proposal to bring together and coordinate the groups. Each agency that is part of the collaborative has its specialty, focusing on a specific population of

homeless people or on an area of the city. Interviewees at the collaborative explained that the program has "helped our relationship with the downtown businesses," and educated both the general public and the homeless population on what services and benefits are available to homeless people. In addition, the VA actively works with the collaborative. The VA now has a cell phone specifically for outreach workers to call when they come upon a homeless veteran, and VA staff sometimes accompany outreach workers, creating a close network between the two agencies.

According to interviewees, the Denver outreach collaborative focuses on finding people, building relationships, and case management. "If Jamie is sleeping under the bridge, I will try and get Jamie to come and fill out some applications. If he doesn't want to go, we have to work with him." In addition, the city set up a central dispatch to coordinate and disperse the teams, available 7 days a week, 6 a.m. to 10 p.m. Interviewees lauded the collaboration, with one noting, "our Denver Street outreach collaborative can…follow the person for the whole system so they don't have to drop people when they leave a shelter. That is key." Interviewees noted that if anyone sees a person on the street, dispatch can be called and a HOT team member will arrive with a "plethora of tools," including transportation tokens, motel vouchers, resource sheets, and connections/applications to benefit and service networks.

Denver's HOT program noted that to alert homeless people in an area to their presence, they use fliers that direct people to a certain location. The team works specifically with food stamps, Old Age benefits, rental assistance, interim benefits for SSI/SSDI applicants, SSI/SSDI, Housing Vouchers, prescriptions, motel vouchers, and, more recently, TANF. They also, as mentioned above, put on education sessions for staff members in provider agencies and for homeless people.

Camillus House, a large multi-faceted homeless service agency in Miami, also coordinates efforts with outreach teams through its Homeless Helpline. The agency works closely with the City of Miami and Miami Beach teams, and also, although less so, with the Dade County team. The Camillus homeless prevention program frequently receives calls from people who are already homeless. Camillus staff contacts the appropriate outreach team, and follows up later to ensure that the caller received services. During working hours, the referral goes to the team in the caller's geographic area; if the call comes in after hours, it goes to the City of Miami team, which is on duty 24 hours a day to serve the entire county.

While Denver and Miami have more extensive outreach networks, all study communities used outreach teams to reach the hardest to serve populations. A few models stood out.

- *PATH:* Study communities used the Substance Abuse and Mental Health Services Administration's Projects for Assistance in Transition from Homelessness (PATH) grants to form teams of case workers focused on stabilizing homeless people with serious mental illnesses (SMI) or co-occurring substance abuse disorders. PATH teams refer heavily to mainstream service agencies (often

accompanying their client to the office) in some of the study communities, and some used SOAR training for their case workers.

- *ACT*: Assertive Community Treatment (ACT) Teams work to serve people with serious mental illness, sometimes in tandem with PATH workers, using a combination of outreach and case management. Although ACT is an evidence-based practice commonly used with housed people with serious mental illness, ACT Teams in a number of our communities focused on homeless people, connecting those with serious mental illness to permanent housing situations and mainstream benefits. Denver, for instance, fields three ACT Teams through homeless and mental health services providers, each combining outreach with permanent supportive housing. The one at the Mental Health Center of Denver uses different levels of case management depending on the needs of the individual, ranging from case manager to client ratios of 10 to 1 (High Intensity Team) to 40 to1 (Community Outreach Team). In addition, the Community Service Board in Norfolk, Virginia runs an ACT Team and a PATH Team with a shared goal: working toward housing the hardest to serve, chronically homeless people and then surrounding them with supportive services, the strategy known as Housing First. Using PATH, Community Development Block Grant, and city funds, the PATH Team acted as the outreach arm, providing links to mainstream benefits, while the ACT Team set up services and housing.

- *Health Care for Homeless Veterans:* As mentioned above, over a number of study communities, HCHV provides a great deal of outreach and outstationed workers pursuing the goal of introducing both potential clients and other providers to their services.

Training

Interviewees from a number of our communities noted the importance of training staff on how to access mainstream benefits. The Mainstream Resources Committee of Portland's Emergency Shelter Assessment Committee, for example, organizes quarterly trainings, given by mainstream service providers, for shelter directors and case managers, with the specific goal of teaching staff people how to access mainstream services (for more information see Chapter 5).

Similarly, mainstream agencies in a number of the communities give informational talks to local homeless services providers. In Pittsburgh, for example, both the Commonwealth of Pennsylvania Access to Social Services system's Community Partners program and the Department of Public Welfare regularly hold informational talks at provider agencies in order to smooth the application process and teach providers how to navigate the benefit system.

Intervention Teams

Miami, Denver, and Norfolk use variations of Crisis Intervention Teams (CITs), whereby members of a city's public health and safety units are trained to deal with homeless

people, often making links to various service and benefit systems. Norfolk's Community Service Board (CSB), a quasi-governmental agency for mental health services, does a mental health component in Police Academy training and also works with firefighters and paramedics to do emergency crisis pre-screening. CSB staffs its office 24 hours a day, 7 days a week in order to respond to emergency situations, sending either a "pre-screener" or a PATH worker when fire and emergency services or the police call in a mental health situation. If they are homeless, clients are referred to services through the agency's PATH Team. Another example, described at length in Chapter 5, is the use of CIT-training as part of Miami's Criminal Mental Health Project.

System Interaction Problems

Homelessness is a condition that transcends any one government agency or provider, and often requires the full range of public benefits. It may be as much an issue of employment, physical disability, mental health, substance abuse, or domestic violence as it is an issue of housing. It therefore requires significant interaction between different systems. Jails, for example, need to interact with shelters and service agencies; hospitals need contact with government benefit providers, indigent care clinics, and shelters, to ensure that those leaving institutions without a home will be able to get back on their feet.

Unfortunately, provider "silos" are a common problem in communities across the country. In a number of the study communities, even those with exemplary systems by most accounts, interviewees mentioned that a lack of interaction among service providers, both public and private, continues to pose a real problem for access to mainstream benefits. Too often, discharge planning does not include arranging for benefits; benefits with compatible eligibility criteria do not automatically cross-refer clients, and referrals are too often not made. For some homeless people, interaction with one section of the mainstream benefits and homeless services system does not mean access to any other part of the service system. Instead, providers focus on one benefit or only a small group of benefits.

Mainstream Benefit(s) Affected

Benefits normally housed in a Department of Human Services or Social Services—GA, TANF, food stamps, Medicaid, child care—interfaced successfully in most communities. Bridging over to housing, disability insurance, employment, mental health, and other benefits, however, proved difficult. Each is generally run by a different agency and often located in separate offices**.**

Mechanisms for Increasing System Interaction

Smoothing Mechanisms

Fortunately, study communities have taken a number of steps to break down silo walls and link up service systems. The majority of smoothing mechanisms designed to overcome structural barriers use formal and informal connections among service systems. Some are systemwide, such as the initiatives described in Chapter 5. Whether through

Memorandums of Agreement or friendly conversations, systems need to establish connections among services to address the interlocking needs of homeless people in a timely and comprehensive way.

Informal Connections

Facilitating personal cross-agency connections is integral to an agency's ability to provide homeless clients with access to mainstream benefits. Some communities, like Denver, have structured their system around creating these relationships by holding systemwide meetings and creating cross-agency committees (see Chapter 5). Others have fostered personal connections through targeted initiatives and events. Indeed, interviewees in many of our communities noted that "informal collaboration has improved in recent years," in part due to participation in the types of initiatives mentioned here.

Cross-system trainings are used in all study communities to forge personal relationships among various staff as well as to educate system actors about available benefits.

For the majority of our study communities, Project Homeless Connect (PHC) serves as an important initiative to establish cross-agency relationships and smooth access to a large number of benefits and services. While there is some community variation on the success of PHC and how it is run, a PHC event is essentially an annual or semi-annual forum for displaying a city's homeless services and other services that might benefit homeless people, such as employment, and for establishing connections among providers and clients. The event is generally put on by the organizing body of the city's CoC, with help from other various community partners and government agencies. Interviewees noted that they rely on the event to put faces to names and create the relationships needed to make referrals. PHCs are held in a large facility divided into different service areas. In most communities, each homeless client attending is paired with a volunteer trained to take a homeless individual around to the various service/benefit sections. In Denver, services included housing, employment, medical care, VA, SSA, Resume Labs, lunch, hairdressers, massage therapists, child care, hygiene kits, ID help, and much more. Communities generally hold PHCs once or twice a year and invite providers under the condition that they will provide services on the spot, so that homeless clients will walk out having received something more than just information.

A similar initiative, called Project Stand Down, targets veteran's services. The primary focus of the event is on the immediate provision of needed services. However, the event is also used as an opportunity to assist veterans in applying for VA and other mainstream benefits.

Additional examples of relationship facilitation in the study communities include:

- Staff at numerous mainstream benefit agencies include many people who previously worked as homeless services providers or at other mainstream benefit agencies in the community and who maintain relationships with previous

coworkers and knowledge of agency protocols. Conversely, homeless providers also look to hire staff with experience in mainstream benefit offices.

- A monthly Providers' Forum in Miami offers providers an opportunity to update one another about their programs and about developments that have occurred since their last meeting.

- Norfolk holds monthly Healthcare for the Homeless (HCFH) meetings where numerous informal relationships and initiatives have begun and been nurtured. As an example, Park Place Clinic has worked out a clear referral process with the Norfolk Hospital Emergency Room, sending homeless clients to the clinic when they do not need emergency care. This relationship began through conversations at the monthly HCFH meetings.

- Citrus Primary Health Care Center staff in Miami meet monthly with representatives of the Homeless Trust and other outreach teams and prevention staff to discuss the situations of people who are known from Homeless Management Information Systems data to have been homeless for over 90 days, which at the time of our site visit included 250 to 300 names. Monthly meetings serve to improve outreach efforts and facilitate service provision for people on agency caseloads.

- In Pittsburgh, a number of homeless service organizations' executive directors have formed a workgroup, using foundation funding. This group works to help keep DHS informed of the issues facing the community's provider agencies.

- The Albany County Coalition on Homelessness has monthly meetings to spur provider coordination. The membership mix (both executive directors and line staff) was noted as helpful.

- Albany's Department of Social Services (DSS) meets monthly with shelter providers and other community partners to facilitate resource sharing and problem solving.

- DSS workers in Albany tour shelters as part of the city's Homeless Awareness month, meeting shelter staff and learning about homelessness.

- The Legal Aid Society of Northeastern New York works to build and maintain collaborative relationships with provider organizations. These relationships are an important factor in the organization's success in providing legal assistance to homeless people; the provider organizations are responsible for appropriately screening and referring people to Legal Aid, as well as facilitating transportation to and from appointments.

Formal System Connections

In addition to the large scale initiatives mentioned in Chapter 5 and the examples of formal outstationed and outreach agreements, many study communities have introduced more specific initiatives that formally link service systems that handle mainstream benefits with homeless people. Unlike the informal relationships mentioned above, these connections are made concrete through formal agreements, ensuring greater longevity and stability in the face of staff turnover. Examples include:

- The Denver Outreach Collaborative, described in detail in Chapters 3 and 5.

- Health Care for the Homeless Grants in Norfolk set up referral slots at the Park Place indigent care clinic specifically for homeless people staying at the Salvation Army.

- ACCESS Housing (a permanent supporting housing [PSH] program for people with HIV/AIDS in Norfolk) uses Ryan White funds to support services at Norfolk's Community Service Board for mental health services. This funding stream enables immediate admittance for ACCESS clients, circumventing the waiting list.

- Harbor House in Norfolk, a rehabilitation program for homeless ex-offenders, has a memorandum of understanding (MOU) with the Norfolk Rehabilitation Housing Authority (NRHA) whereby NRHA considers ex-offenders coming out of the program as sufficiently rehabilitated and eligible to receive public housing units.

- Catholic Charities, Denver Rescue Mission, Colorado Coalition for the Homeless, the Denver Street Outreach Collaborative, DHS, and other homeless providers all set up a formal referral process to the VA for homeless veterans.

- Urban Peak, a youth provider in Denver, has a formal collaboration with the I Street indigent care clinic, the Stout Street Clinic, and MHCD to get medical services and Med-9 forms, the form needed for SSI applications in Colorado.

- The Workforce Center in Denver has an MOU with the Vocation Rehabilitation Center to provide services for those who are homeless.

- The Albany DSS Adult Protective Services unit has established a discharge protocol for homeless adults leaving medical hospital units. Hospitals coordinate discharge with both the client and the Adult Protective Services unit.

- Miami's extensive jail diversion programs, where both the pre- and post-booking programs create a new route of entry to the mental health and substance abuse service system, ensure that homeless people with serious mental illness who would otherwise have either been arrested or remain incarcerated are instead connected with the service system and provided with a way to avoid or leave jail, enter housing, and get services.

- Miami's Homeless Trust worked with mainstream service agencies for over a year to develop a memorandum of agreement (MOA) that obligates the agencies to work with the homeless system to address housing crises of agency clients rather than having them fall through the cracks into homelessness. Public agency parties to the MOA also agree to identify resources of their own that can be used to stabilize people experiencing housing crises and prevent homelessness.

- Camillus Health Concern, a Miami-based health care program for the homeless, is a formal partner with Dade County's public health care delivery system, Jackson Health System. As a result, Health Concern patients are eligible for Jackson prescription cards, which enable them to obtain medication without a fee.

Other communities have taken on system interaction more directly, still. Exhibit 4.4, below, describes the comprehensive approach to homeless services taken by the Norwich Community Care Team (CCT) in New England. By setting up formalized relationships over multiple agencies and programs under the umbrella of one team, CCT exemplifies a coordinated community response to structural barriers, especially those concerning system interaction.

Exhibit 4.4: Assuring Access to Care Through a Multi-Agency Team

A coordinated community response is the highest level of community organization and system change described in Chapter 5. This example of a multi-agency team provides everything for single homeless adults from prevention through housing placement and follow through to assure no return to homelessness.

The Norwich Community Care Team (CCT) is recognized throughout New England as a model for wraparound services that seek to prevent homelessness if possible, end it as quickly as possible, and assure that people, once back in housing, do not lose it again and return to homelessness. It focuses on single homeless adults, especially those with disabilities, who are chronically homeless. What began in 1989 as a coordinated effort of a few agencies now involves 18 agencies and counting. The CCT's theme is, "we need everyone; we won't succeed if we think 'we-they.'" In addition to homeless service providers, state agencies (adult probation), regional agencies (Southeast Council on Alcohol and Drug Dependence, Eastern Region Mental Health Board, Eastern Region Service Center, Southeast Mental Health Authority), city agencies (Norwich Human Services and Police departments), health agencies (Williams Backus Hospital, American Ambulance, and Generations Health Clinic), and the Clergy Association participate.

A core element of the CCT is the Hospitality Center, offering daytime respite, mobile outreach, primary health care (supplied by Generations Health Center, a federally qualified health center), evening meals (supplied by church groups), case management, rent and security deposits for those moving into housing who need them, focus groups, and individual counseling. City Council action provided Community Development Block Grant funding that has enabled the Norwich CCT to hire a manager and other staff for the Hospitality Center, and also supports the local share of Medicaid and state health insurance billing for medical services, so activities through CCT performed by nurses, certified nurse assistants, and other medical personnel for Medicaid beneficiaries receive significant financial support from federal and state coffers to supplement local dollars.

A mobile van from the Hospitality Center, staffed by Generations Health Clinic, offers diagnostic and treatment services, provides medications, and facilitates applications for Supplemental Security Income (SSI) for people at other locations. SSI/Social Security Disability Income (SSDI) Outreach, Access, and Recovery (SOAR) training has made the application process easier and considerably more successful, and the local Social Security office is supportive of the Norwich CCT. Because help for physical health problems is relatively easy for people to accept, giving primary care has become a way to establish a relationship with a CCT member and provide a gateway for

further involvement and assistance with other issues.

Monthly meetings of all Norwich CCT members review activities, policies, and current caseload needs, and develop approaches to overcome any barriers to service delivery that service staff encounter with any regularity. They also serve as case conference/team meetings to review specific cases and take any actions needed to assure that clients get what they need. CCT case workers help people get state General Assistance cash and medical benefits (known as State-Administered General Assistance in Connecticut); get food stamps; apply for SSI, SSDI, Medicaid, or Medicare as appropriate; find and move into housing; get medical, substance abuse, and mental health treatment as needed; reconnect with family if appropriate; connect to jobs; and offer other services as needed. In the winter months, direct care workers hold weekly meetings to address the needs of people sleeping outside.

The CCT's key to success has been merging case-level action with policy changes. It is essential that both case managers and agency directors attend the CCT monthly meetings. Barriers to service receipt that case managers encounter can be resolved by agency directors (policy changes can be made if needed, more training or shifts in staffing can be authorized, and so on). Agency directors can work with each other to develop approaches that are appropriate for both agencies and facilitate client access and service receipt. Agency directors can convey to case workers changes they are considering and get feedback as to their feasibility, potential usefulness, and modifications that will achieve the goal in the least disruptive way. Gaps in services can be discussed in the presence of everyone who knows anything about the issue, and solutions proposed and examined jointly before any action is taken that might ultimately have to be withdrawn.

Over the last few years 40 to 50 percent of CCT clients moved to permanent housing, where most continue to receive supportive services. Shelter use is down, and relatively few people who received CCT assistance to move into housing came back into shelter within the next year.

For more information, see Chapter 3 in Burt, M.R., 2008.

Conclusion

Structural barriers have an acute effect on the homeless population, especially those with physical and mental disabilities or educational deficits. Often, homelessness exacerbates the existing structural barriers, making the process of applying for and maintaining benefits more difficult. Across the study communities, similar barriers exist within the homeless population. The extent of the barriers, however, depends on the structure of each community's service systems and the existence of specific initiatives to improve access.

Fortunately, through the mechanisms described above, the study communities we visited are able to address some of the structural barriers effectively. Interviewees noted the success of an array of mechanisms, from targeted initiatives like SOAR to systemwide events like Project Homeless Connect, in opening up community resources for even their hardest to serve clients. Indeed, for many program and agency staff, these mechanisms are a necessity in linking homeless individuals and families to mainstream benefits—without them, they note, the population would go unhelped by mainstream benefit agencies.

Many of the above mechanisms, however, are service and staff intensive, and the shift in the U.S. Department of Housing and Urban Development's (HUD) focus away from services has reduced some homeless service agencies' ability to extend staff for special initiatives. Others, however, are able to draw on new sources for funding or they continue to use HUD resources for services, either taking a lower score in the Super Notice of

Funding Availability process or, as some noted, blurring the lines between what is considered "operations" and what is considered "services." Still more agencies are dipping into reserves to maintain these programs, deeming access to mainstream benefits a necessity for their homeless clients and ultimately a cost-saving measure for their organizations. For the latter, interviewees were unsure at the time of this study how long they could maintain current levels of spending.

CHAPTER 5: CAPACITY BARRIERS TO HOMELESS PEOPLE'S ACCESS TO MAINSTREAM BENEFITS

While many barriers relate to eligibility or structural issues that reduce eligible people's access to mainstream benefits, some relate to a fundamental problem with benefit or service availability. These *capacity barriers* may stem from complete absence or insufficient supply of a benefit or service, insufficient value of the benefit or service when it is available, extended application or approval processes limiting the immediate availability of benefits, or any combination of these problems. For example, General Assistance (GA) cash benefits are completely absent in many communities; where GA is available, it is not sufficient to purchase the basic shelter, food, and other goods that recipients need. Food stamp benefits are available everywhere, but there is generally a gap between the value of the benefit received and the price of the food needed to fully meet recipients' needs. Supplemental Security Income (SSI) also does not meet all of recipients' income needs, providing as it does an income level of about 75 percent of poverty, and its approval process considerably delays its availability for people who actually are eligible.

Mechanisms to address capacity barriers often involve increasing resources. For this reason, they typically require more planning and consensus building than mechanisms to address structural barriers, and are less likely to be implemented quickly and almost never on an informal basis. At the same time, addressing capacity barriers is usually associated with comparatively significant payoff, in terms of the number of recipients impacted, the magnitude of the impact for each recipient, or both.

In this chapter, we review the capacity barriers our study communities reported and the mechanisms they use to address these barriers. The capacity barriers communities reported tended to fall into two general categories:

1. **Delayed availability**—Access may be delayed by waiting lists for benefits and services that are in short supply.

2. **Lack of availability**—Access may be prevented, or its impact reduced, by absence of needed benefits and services, insufficient supply, and insufficient value of benefits and services.

Most study communities reported some mechanisms that address capacity barriers related to individual benefits or services. Additionally, three study communities—Denver, Miami, and Pittsburgh—have developed strategies to significantly increase the availability of funding. These mechanisms address capacity barriers across systems, facilitating expansion of and access to multiple benefits and services.

Some of the mechanisms identified in this chapter are also described in Chapter 4 or 6. Mechanisms may address more than one type of barrier, and it is important that readers reviewing the capacity barrier mechanisms in this chapter learn about all the relevant

mechanisms we encountered, even if in some cases they are also cited in other chapters. These cases are noted in the text, and the reader is directed to the chapter containing the more detailed description of the mechanism in question. In addition to the mechanisms observed in the study communities, exhibits throughout this chapter offer details on exemplary capacity-related mechanisms in communities included in other studies sponsored by the U.S. Department of Housing and Urban Development (HUD) and by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Delayed Availability

The communities we visited reported multiple barriers related to delayed availability of benefits and services. Waiting lists are a common approach to managing insufficient capacity. Some communities go even farther, in the face of limited capacity, closing waiting lists and creating lotteries to determine who will get the next available benefits. These approaches reflect an even greater imbalance between benefit need and supply, and are accompanied by more pronounced delays in benefit receipt for those with high lottery numbers.

Mainstream Benefit(s) Affected

Delayed availability is a potential concern with most mainstream benefits and services, but is encountered most often with benefits and services such as mental health and substance abuse care, low/no-cost medical care, and subsidized housing. The application and determination process for these resources may be relatively quick, but approved recipients may then be required to wait until the benefit or service becomes available. Ultimately, delays of any length constitute a barrier, as applicants' needs for benefits and services are often immediate.

Mechanisms to Address Delayed Availability

Changing Mechanisms

Study communities offer many examples of changing mechanisms to address delayed access. These mechanisms reduce or eliminate delays in access by making changes in service and benefit eligibility or to the eligibility determination process. A number of communities used mechanisms that prioritize homeless people's access or offer presumptive eligibility or expedited application processing; additionally, one provider reduced delays in housing access by becoming certified as a housing inspector.

Priority Access for Homeless People

In instances of delayed access involving waitlists or similar barriers, communities can reduce or eliminate the delay by prioritizing homeless people's access to the benefit or services. As evidenced by the following examples, this type of mechanism can be applied to a range of benefits and services.

- As described in Chapter 4, Ryan White funding offers a mechanism whereby consumers in the Norfolk AIDS Care Center for Education and Support Services Permanent Supportive Housing (PSH) program can bypass the waiting list for mental health services provided by Norfolk's Community Service Board.

- Chapter 4 also discusses the use of lottery systems to prioritize homeless applicants' access to Section 8 housing. Denver's Road Home (DRH) uses such a system, and interviewees reported high rates of access and greatly reduced wait times as a result of this program.

Norfolk's Family Unification Vouchers (FUVs) are set aside for homeless providers, allowing some homeless families to skip the community's five or more year waiting list for Section 8. Families hoping to receive FUVs must be accepted by both the (private) landlord and the Norfolk Redevelopment Housing Authority, and these requirements often pose barriers themselves, in that many families do not meet eligibility standards for Section 8, and those that do may face discrimination from landlords.

Presumptive Eligibility and Expedited Processing for Homeless Applicants

In some situations, mainstream benefit and service providers use presumptive eligibility as a mechanism to address delayed availability. Similarly, some communities offer expedited application processing to homeless people seeking benefits and services. This most often occurs with welfare office benefits, particularly food stamps, but in two study communities this approach facilitates timely access to U.S. Department of Veterans Affairs (VA) benefits.

- As identified in Chapter 4, Pittsburgh's Veterans' Leadership Program has an agreement with the VA whereby homeless veterans' benefit applications are expedited. The Norfolk VA has a similar policy, although it has had less impact recently because returning Iraq and Afghanistan veterans have been given higher priority than homeless veterans.

- Also described in more detail in Chapter 4, homeless food stamp applicants in Miami are presumed to qualify on the basis of income; this reduces the application burden, potentially shortening the application process. Denver, Norfolk, and Portland also offer expedited status to homeless food stamp applicants.

- As described in more detail in the *Mechanisms to Address Delayed Availability* section below, in Norfolk, presumptive eligibility for SSI is available to homeless people whose applications are submitted by a SSI/Social Security Disability Income (SSDI) Outreach, Access, and Retention-trained worker.

The above examples of presumptive eligibility apply to benefits. Timely access to mainstream services is also critical, and in some cases just as difficult to achieve. Exhibit 5.1 offers an example of the approach one state uses to reduce homeless applicants' waiting time for mental health and substance abuse services.

Exhibit 5.1: Presumptive Eligibility for Mainstream Behavioral Health Services

Presumptive Eligibility—the idea that outreach workers can identify and pre-approve people for mainstream behavioral health services—is an important tool for the Hawaii Continuum of Care system.

People with mental illness or co-occurring disorders represent a significant portion of persons who are chronically homeless. Research tells us that many of these individuals have been in contact with mainstream mental health or substance abuse services, but by the time people are homeless and begin to use Continuum of Care services, that connection has been lost. Public mental health systems have eligibility criteria, usually including the diagnosis of a major mental illness and loss of functional skills. Most systems require a process of certifying eligibility before an individual can receive services. In the Hawaii system, as in others, the typical path for system entry includes an assessment, a diagnostic interview with a psychiatrist, and a referral for ongoing services. The entire process requires several appointments and the wait for case management is typically 60 days.

The Hawaii Department of Health, Adult Mental Health Service Division (AMHD), administers the Substance Abuse and Mental Health Services Administration's Projects for Assistance in Transition from Homelessness program. Program administrators realized that any delay in establishing eligibility for mental health services constitutes a significant barrier for people who are homeless. Especially for people who are chronically homeless, the process of waiting for appointments, enduring multiple assessments, and waiting for assignment to a case manager often means that people drop out and never receive the services they need.

In May 2005, AMHD issued a policy describing a presumptive eligibility process for persons who are homeless (AMHD: Eligibility P&P #60.601). The policy clarifies that individuals who have a substantially increased risk of homelessness or arrest are eligible to participate in the presumptive eligibility program. The presumptive eligibility procedure short-cuts the eligibility process and allows immediate access to mental health case management, housing, the Community Resource Fund (a fund set up to provide resources, including start-up housing resources such as deposits), and community mental health center services, including medications.

For more information, see Homelessness Resource Exchange (www.hudhre.info/mainstream).

Prerelease Applications and Temporary Suspension

Many mainstream benefits are not available to otherwise eligible people who are incarcerated or hospitalized. As a result, benefits must be established or reinstated following periods of incarceration or hospitalization. The mechanisms described in the Chapter 4 section entitled *Reinstating Benefits* address structural barriers, but are also applicable to the capacity-related barrier of delayed availability. For people returning to the community from psychiatric institutions or jails and prisons who are very likely to be homeless at release, pre-release applications assist with the timely receipt of a variety of benefits. Temporary suspension of benefits also reduces access delays for multiple benefits for those who are institutionalized or, in the case of some benefits, for those who live in shelters. Mechanisms described in Chapter 4 and applicable here include "pending" food stamp approval status for residents of the Miami Homeless Assistance Centers (HACs) and eligibility-upon-release for Medicaid and food stamps for former Florida SSI recipients who have been incarcerated for a year or more.

Provider Housing Inspection Certification

Once a public housing authority issues a housing voucher and the recipient locates an appropriate housing unit, delays are often encountered while waiting for a housing authority representative to inspect and approve the unit. In addition to delaying access to housing, the wait for inspections may also deter otherwise cooperative landlords from accepting tenants with vouchers because no rent is coming in during the interim. Miami's Citrus Health Network, a primary and mental health care provider that operates both Shelter Plus Care and Housing First residential programs, has circumvented the housing authority's five to six week inspection time by becoming certified to perform housing inspections.

Expanding Mechanisms

While most mechanisms used to address delayed access can be categorized as changing mechanisms, the addition of interim coverage for people with pending applications constitutes an expanding mechanism. Two of the communities we visited have developed unique approaches to providing interim coverage of medical costs to Medicaid applicants, and one offers housing and services to people with pending SSI applications.

- In Albany, people with complete Medicaid applications may request temporary benefit cards to cover immediate health care costs. While our interviewees noted that this process is not without its own barriers, it does offer quicker access to critical health care coverage than would otherwise be available. Additionally, New York's Office of Mental Health provides Albany County's Department of Mental Health with a small amount of money that can be used to cover the costs of psychiatric medications and treatment for Medicaid applicants who have not yet been approved.

- Denver's Department of Human Services (DHS) uses General Assistance funds to provide prescription vouchers to homeless people whose Medicaid applications are pending, or who require Medicaid redetermination. There is no wait time for the vouchers and eligibility criteria are minimal.

- Aid to the Needy and Disabled is a program in Denver that provides bridge money, paid by the state, until SSI benefits are available. Recipients must have a completed SSI application under consideration, and also must not currently be receiving Medicaid.

- Miami's gap funding, described in Chapter 3, offers an important mechanism to address the long period between submission and approval of SSI applications. In this case, program funding is used to pay for housing and services while consumers await determination of eligibility, and retroactive SSI benefits are later used to reimburse the program for a significant portion of the expenses incurred during the determination period.

- As described in Chapter 4, in Norfolk a Health Care for the Homeless grant allows the Park Place Clinic, a federally qualified health center (FQHC), to provide additional appointment slots for homeless people needing urgent access to primary care.

Lack of Availability

Study communities grapple with a wide range of barriers related to lack of availability. In some cases, such a barrier results from the complete absence of a benefit or service that homeless people need. However, insufficient supply of these benefits or services can also cause significant barriers, delaying access for some applicants (see previous section), and preventing it for others. Even when services and benefits are available in sufficient supply, they may not be of sufficient value. In such cases, those who do apply receive a benefit or service that does not fully meet their needs. Others may choose not to apply at all, based on word-of-mouth or other knowledge about the utility of the service or benefit**.**

Mainstream Benefit(s) Affected

As with delayed availability, lack of availability is often a barrier to access to most mainstream benefits and services. Subsidized housing and reduced cost medical and dental care are rarely available in the quantity required, given that low-income people cannot pay market costs for these necessities. In some cases, the issue is insufficient benefits, rather than complete lack of availability. Food stamps and Temporary Assistance for Needy Families (TANF) fall into this category; they may be widely available, but fall short of meeting recipients' needs for food subsidy and income. General Assistance is completely unavailable in many communities, and insufficient in those communities that do offer it. Mental health and substance abuse services are rarely available in sufficient quantities; additionally, the services that are available may not meet consumers' needs.

Mechanisms to Address Lack of Availability

As might be expected, many of the mechanisms that address lack of benefit or service availability are typically expanding mechanisms, in that they add resources to increase the availability of benefits and services. These mechanisms include increased funding to support the expansion of a variety of services—short-term employment to provide homeless people with an opportunity to supplement insufficient GA, TANF, or SSI incomes; Medicaid program expansion; mental health and substance abuse service expansion or development; development of new housing; employment training for people leaving prison; and shelter-based daycare and educational resources for children.

Increased Funding

Many of the communities we visited were successful in obtaining funding from nonfederal sources, including state government, local government, private foundations, and general agency fundraising. In many cases, this funding is a generic expanding mechanism, in that it can be used to expand the supply of any mainstream benefit or

service. In other cases, communities secured new funding for a particular benefit or service. We also found examples of outside funding being used to expand services at the organizational, rather than the community, level. Exhibit 5.2 describes a successful funding expansion mechanism in Massachusetts that the state Department of Mental Health has had at its disposal for two decades; examples from study communities follow.

Exhibit 5.2: Massachusetts Department of Mental Health's Use of Special State Funding to Stimulate Extensive Development of Permanent Supportive Housing

Having state funding for mental health services for homeless people and a clear multi-year purpose and strategy to end their homelessness can transform the community-based housing stock for people with serious mental illness.

Preventing homelessness or ending it quickly for Massachusetts residents with serious mental illness has been a strong element of the state Department of Mental Health's (DMH) agenda for more than two decades. To this end, DMH has invested heavily, both directly and indirectly, in addressing homelessness among persons with serious mental illness. A key element in the DMH strategy has been the Special Homeless Initiative—state funding that began in 1992 with a $1 million start-up appropriation, grew to about $19 million by 1999, and reached about $25 million for 2008.

DMH housing coordinators work with DMH providers and state and local housing agencies to promote housing supply efforts; increase housing subsidies to DMH clients; and assist case managers, discharge planners, and other DMH and provider staff to help DMH clients obtain housing or housing subsidies. The department identifies available housing resources and assists relevant agencies and providers to apply for all federal and state homeless and non-homeless housing opportunities. Policies and protocols emphasize the importance of housing for people with serious mental illness, adding assistance to find and keep housing as part of the services considered essential. Training for department and contract staff stresses the importance of housing, and that treatment cannot work if people lack stable housing.

Of Massachusetts's 21 Continuums of Care, all but 6 have currently operating housing projects for which the Special Homeless Initiative provides funding for supportive services. DMH has focused Initiative resources on establishing a comprehensive DMH service capacity dedicated to this population, and using the service funds to leverage and access transitional housing and affordable permanent housing with services, as described below. Linkages and alliances with other departments and providers, statewide and regionally, have been essential in developing the current level of housing. Statewide examples include: 1) an agreement with MassHousing, the state housing finance agency, to ensures that 3 percent of all units developed with MassHousing financing are directed to DMH and the Department of Mental Retardation to house people with serious mental illness or mental retardation, 2) an agreement with Massachusetts Department of Housing and Community Development to operate two rental assistance programs and one housing development program that together house more than 1,200 DMH clients, and 3) working with 101 of the 254 public housing authorities in the state to provide housing.

DMH's access to substantial resources through the Homeless Initiative and other community services initiatives has allowed it to provide services funding for many housing units to match the housing component most commonly supplied by federal resources (primarily the U.S. Department of Housing and Urban Development's Support Housing Program and Section 811 programs). With the help of Homeless Initiative funds, among others, DMH increased statewide community residential capacity from 2,746 in 1991 to 7,897 in 2006. In Metro Boston, capacity increased from 470 to 2,345 people. DMH also significantly shifted the types of housing it offered over the same time period, changing its system from one primarily dependent on group homes to one with mostly independent and service-supported apartment residences.

For more information, see Burt, M. R., 2007.

- As indicated in Chapter 3, Miami has clearly been very successful in gaining resources to fund services for homeless people, including the food and beverage tax (FBT) and state funding obtained through ongoing lobbying efforts in the state legislature. The former provides nearly one third of the Homeless Trust's budget, and the latter has yielded start-up or ongoing funding for a range of programs including the community's pre-arrest diversion programs, the gaps program for SSI applicants leaving the county jail, a forensic diversion unit, a high-quality daycare program at one of the HACs, crisis stabilization beds and other supports for people with psychiatric disabilities, and new permanent supportive housing. Miami is also better able to draw down HUD funding as a result of the FBT; the community receives roughly 40 percent of Florida's HUD funds.

- Dade County's Office of Community and Economic Development provides homeless project set-asides using Housing Opportunities Made Equal funds and revenues from a Dade County surtax on real estate transactions. This arrangement has been in place since 1995, and has contributed to the production of nearly 2,500 permanent support housing units since that time.

- Also in Miami, the Homeless Trust works with the Community Redevelopment Authority to direct redevelopment tax revenues (tax increment financing) to housing for homeless people. These revenues are expected to contribute to 200 new housing units per year.

- Denver offers another example of a community that has met with great success in securing new funding. As described in Chapter 3, Denver's 10 Year Plan (10YP) is being implemented via a combination of government, private donor, and foundation support. Foundations were already providing some support to the city's efforts to address homelessness, but agreed to increase these resources significantly in response to the mayor's requests for support to launch the 10YP initiative. Denver's Road Home allocates these funds through a competitive process facilitated by its Resource Allocation Committee.

- Pittsburgh has been able to draw extensive support from foundations to facilitate expansion of services. These resources primarily come from local foundations, a number of which work closely with Allegheny County's Department of Human Services. DHS has a goal of developing a central repository for foundation funds. In the meantime, such funding supports the community's Continuum of Care Supportive Service Fund, which DHS has been using to provide match and "gap" funds since 2006.

- Organizations in Albany have successfully applied for New York Homeless Housing and Assistance Program support, which provides capital funds for emergency, transitional, and permanent supported housing. This is a competitive funding source administered by the state Office of Temporary and Disability Assistance. These grant applications are generally structured to fund a portion of a project, and are initiated by the program applying for them rather than the community as a whole.

- The Albany County Housing Trust Fund is a 10YP initiative driven in part by the County Executive, who recognized that lack of affordable housing is a root cause of homelessness in the community. The Fund is a co-controlled funding program for affordable housing, which draws on money diverted from the sale of foreclosed properties. The presence of a local housing trust fund positions the community to leverage funding from the state and national housing trust funds.

- Administered by United Tenants (a tenants' rights organization) and supported by state and local funding as well as voluntary community contributions, the Albany Community Land Trust is working to retain 20 to 25 houses and 25 rental apartments. Marillac, one of the community's homeless services providers, is working with the Land Trust about the possibility of collaborating on a program to facilitate Marillac families' tenancy in Land Trust properties.

- In Norfolk, grant funding supports the St. Columba Medication Assistance Program. These funds are used to pay for medication for Park Place and Salvation Army clients, as well as transportation to and from the pharmacy for Park Place clients. The program is heavily used—to the point that it was at risk of exhausting its funding at the time of our site visit—and is considered an important asset to the community's system serving homeless people.

Medicaid Coverage Expansion

As mentioned in Chapter 3, Maine has extended its Medicaid coverage (MaineCare) to people who do not fall into the two federally required categorical eligibility groups (TANF and SSI recipients). People receiving MaineCare through this mechanism are referred to as "non-cats" and do not receive the full range of services afforded to categorically eligible people. Nevertheless, not only does non-categorical coverage expand the availability of Medicaid for Maine residents, it also serves as a mechanism to facilitate access to SSI and to categorical Medicaid coverage. Providers are able to use records of services provided via non-categorical coverage to document recipients' disabilities, thus assisting them in qualifying for SSI.

Maine's approach offers an example of Medicaid coverage expansion through state policy change. Such coverage expansion can also be achieved by organizational change at the local service level. Exhibit 5.3 describes the use of federally qualified health centers to support the expanded availability of primary care, mental health and substance abuse care, dental services, pharmacy care, and case management for formerly homeless people living in permanent supportive housing. FQHCs are a key component in services for homeless people in several study communities, including Denver and Norfolk, but not specifically as providers of supportive services for PSH tenants.

Exhibit 5.3: The Role of Federally Qualified Health Centers (FQHCs) as a Source of Supportive Services for Permanent Supportive Housing (PSH) Tenants

Federally qualified health centers offer an important approach to funding supportive services for PSH tenants.

Homeless people with major disabilities have high needs for health care and related services, but providers in many communities have found that supportive services are the hardest aspect of their activities to fund. State and local public agency resources are usually inadequate, already committed elsewhere, and subject to reduction or cancellation from year to year due to budgetary fluctuations. Helping PSH tenants gain Medicaid eligibility (usually as a consequence of a successful application for Supplemental Security Income) is one way to access service resources that attach to the tenant, rather than to the program, and that will continue as long as the tenant remains an SSI beneficiary. Often, however, PSH tenants need more intensive services over a longer period of time than "regular" Medicaid will pay for.

A federally qualified health center is a type of clinic funded through the Bureau of Primary Health Care in the U.S. Department of Health and Human Service's Health Resources and Services Administration. It must be located in a "medically underserved area" or serve a "medically underserved population." Funding for new FQHCs is highly competitive, but it is possible to bring nonprofit or public clinics into the FQHC orbit as expansions of existing FQHCs. FQHCs must serve people of all ages, have a sliding fee scale to accommodate people's ability to pay, and offer a specified array of services including many that are important to homeless people—primary and preventive care, mental health and substance abuse treatment, dental care, case management, and pharmacy services (using drug pricing discounts available to the Public Health Service). There is a priority on supporting FQHCs that serve chronically homeless people.

FQHCs are set up to bill Medicaid, and may establish rates that reflect the true level of care needed by the people they serve. FQHC rates for a given service are usually considerably higher than standard Medicaid rates (for example, if it takes an hour a visit to work with a formerly homeless person with severe psychiatric impairment, an FQHC can use an hour and get paid for it, compared to a "regular" Medicaid rate for a psychiatric visit that might cover only 5 or 10 minutes to renew a prescription).

The JWCH Institute in the Skid Row area of downtown Los Angeles succeeded in becoming an FQHC on its second application, and is now a partner with a number of other health care providers in a multi-service center serving Skid Row called the Leavey Center. It offers something that we might call the *FQHC-services-to-tenants-in-PSH model,* which has the capability of becoming an important new direction in the difficult task of finding adequate sustainable resources for the supportive services component of PSH.

By assembling many types of care under an FQHC umbrella as the Leavey Center does, it is possible to pay for primary health, mental health, substance abuse, dental, pharmacy, and other types of care through Medicaid. Of course, patients must be Medicaid beneficiaries for this billing to be possible, so it is very important that procedures for submitting and approving SSI applications be as efficient and effective as possible (see Error! Reference source not found.). FQHCs are ideally suited to provide the documentation and case work needed for successful SSI applications, which in turn make recipients eligible for Medicaid.

Work is under way in two other parts of Los Angeles County to build health care networks for homeless people centered on existing FQHCs. It takes time to become an FQHC, and more time to develop the connections to PSH tenants. But in the end, the continuing funding that results is likely to be more secure than expecting local public agencies to come through with initial contracts and annual renewals for case management, mental health and addictions treatment, and other aspects of support for PSH tenants.

For more information, see Chapter 3 in Burt, M.R. 2009.

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congregations to mentor and fund long-term housing solutions for homeless families. Two Rescue Mission case managers staff the program, focusing much of their effort on taking crisis line calls and screening callers to determine program eligibility. The program was initiated by the mayor's office—Mayor Hickenlooper holds an annual luncheon to encourage local churches to get involved in the program and cover participants' deposits and first month rents; he also has a clergy council that oversees the program.

- As described in footnote 7 in Chapter 3, Miami's jail diversion program has been able to expand the availability of adequate assisted living facility (ALF) housing by developing a set of standards for housing service and quality, and requiring that ALFs agree to unannounced visits as a condition of remaining on the list of facilities that will receive court referrals.

Re-entry Job Training

Two communities have responded to the insufficient availability of job training, particularly for people who have been incarcerated, by launching unique employment supports tailored to the needs of ex-offenders.

- Albuquerque's Crossroads for Women spearheaded an initiative to improve job skills and employment rates among homeless women with psychiatric disabilities who have criminal records. While the program does not restrict its services to homeless people, the women who access the program tend to be homeless. This initiative involves partnerships with the state Department of Health and Office of Vocational Rehabilitation and is now backed by a state-level memorandum of understanding addressing the vocational rehabilitation needs of homeless ex-offenders with psychiatric disabilities.

- In Norfolk, the Virginia Employment Commission One-Stop has partnered with the Department of Rehabilitative Services, Norfolk Redevelopment Housing Authority, Goodwill Industries, and two local organizations, Second Chances and Skill Training Employment Placement Upward Progress, to provide comprehensive reentry services to ex-offenders. While the program does not exclusively serve homeless ex-offenders, it takes a holistic approach to the problems ex-offenders face and addresses homelessness as one barrier to employment. Second Chances also operates a social business enterprise called Klean Slate that provides transitional and on the job training for program participants.

Shelter-based Child Care and Educational Resources

Shelters and other homeless service providers in several study communities offer child care and/or educational resources for children. In at least one case, these services remain available to former residents who have found housing.

- The Homeless Children's Education Fund, a Pittsburgh nonprofit, addresses the lack of out-of-school educational resources for homeless children. The Fund was founded and is directed by the former director of the local school intermediate unit (a regional administrative agency for education programs). Among the Fund's accomplishments is creating learning centers in local homeless shelters. In each case, the shelter provides the space and security for the program, and agrees to take over the cost of Internet connection after the first year. All other costs are covered by the Fund, and the resulting center is considered the property of the shelter. The Fund has operated for nine years; it began with money from the intermediate unit, which was donated in lieu of a retirement gift for the Fund's director. DHS assisted the development of the Fund by donating in-kind services, and the director was able to generate much of the Fund's financial resources through his extensive community connections.

- Miami's HACs provide daycare and after school programs for residents; these services are also made available to people who have moved out of the facilities.

Provision of Medical and Dental Care

Several of the communities we visited have developed mechanisms to expand the availability of medical and dental care. This involves funding care at low or no cost to recipients, offering new care at more accessible times and locations, and developing care that addresses gaps in existing services.

- In Miami, the Homeless Trust purchases both health care and dental services for uninsured homeless people. Services are provided at the HACs, which offer ambulatory care clinics staffed by Jackson Health System employees. The HACs also provide a high volume of dental care—over 24,000 dental procedures have been performed since 2005. Former HAC clients are linked to regular health care through the Jackson Memorial system once they leave the HAC.

- Homeless people seeking shelter or services through the Albany Rescue Mission have access to the facility's regular, free health clinic, while those using Denver's Rescue Mission can access free medical and dental care as a result of that organization's partnership with two nearby providers, St. Francis and Intercity Health Center. The service is only for those who are uninsured, and is available on Saturdays only.

- In Denver, the Stout Street Clinic provides primary, dental, and eye care, and full pharmacy services; these are supported by a variety of sources including the Susan G. Komen Foundation (breast cancer screening and services), Public Health Services Act Title X (family planning services), and tobacco tax funds.

- The Denver's Road Home respite program is intended for persons who are homeless, have been hospitalized, and are discharged from a hospital after recovering from a medical illness, but are not well enough to be discharged to a shelter or the streets. The goal of respite is to move them into permanent housing,

which is accomplished with case management assistance where needed. Program partners are Denver Health and the Stout Street Clinic. There are 45 beds at three different locations funded directly by DRH, not by federal, state, or city revenues. There are no restrictions on eligibility, except that clients must be homeless and medically needy. People stay two weeks to six months, avoiding lengthy hospital stays or inappropriate discharge to a shelter.

Many communities have recognized that seriously ill homeless people need such respite care programs, and HUD funding has been used to support a number of them. Denver's is one of the few whose funding comes from local resources. Portland, Oregon's Recuperation Care Program, the focus of Exhibit 5.4, differs from most respite programs in a number of ways. First, it is funded directly by the hospitals that refer clients to it, rather than by any type of public money, whether federal, state, or local. Second, the agency offering it also runs housing, health, employment, addictions recovery, and other programs. The recuperative care program is structured, through connections to all agency components, to assure that clients have access to a wide range of services and supports that they will need on an ongoing basis once they no longer require recuperation care. It thus presents a very rich, as well as effective, model for communities to follow.

Exhibit 5.4: Respite Care for Seriously Ill Homeless People, With Subsequent Links to Services and Housing

Respite care can relieve hospitals of unnecessary expense and facilitate access of very sick homeless people to housing and ongoing supportive services.

The Recuperation Care Program (RCP) in Portland, Oregon, is a collaboration among Central City Concern (CCC), Portland's largest provider of supportive housing; the area's five hospitals; and CareOregon, the largest Medicaid managed care organization in the state. Participating hospitals, which cover most of the program's costs through contracts with CCC, refer homeless patients to the RCP—technically, the criterion for referral is that the patient "lacks medically stable housing at discharge." These are hospitalized patients who have been treated and do not need to be in a hospital any more, but who are still too sick to be on their own and have no home where they can be cared for until they recover. They need stable housing and continuing medical care if they are to recuperate fully; being homeless would seriously jeopardize their recovery, and possibly their life.

Central City Concern houses RCP clients temporarily (up to 90 days) in rooms especially equipped for recuperative care in one of its single room occupancy buildings. Necessary health care is provided through RCP staff and the Old Town Clinic, a federally qualified health center that CCC also runs. When RCP clients are ready, the RCP housing coordinator helps them find housing in the community, either in CCC buildings or with private landlords, seven of whom have agreed to work with RCP clients despite their less-than-desirable profile as tenants. Ongoing health, mental health, and addictions services continue to be available to former RCP participants through the Old Town Clinic. Participants are also taught how to identify their day-to-day needs and where in the community they can turn to get those needs met.

Impact. From the hospitals' point of view, the RCP relieves them of having to provide very expensive, yet uncompensated, care to homeless people whose conditions no longer justify hospitalization as medically necessary, but whom they cannot in conscience release knowing that they will return to the streets. It is well worth their while to pay CCC to provide recuperative care. Two hospitals extended their contracts during the RCP's first year of operation, having used up most of their 12-month contracted capacity within the first three to six months. For instance, the second contract with one hospital was for $300,000, up considerably from the initial $100,000. RCP client numbers have increased from 45 in the first

year to 164 in the most recent year.

From the point of view of the RCP, as a route for homeless people with obvious health care needs to move toward housing, the program also appears to be a success. In the first half of 2007, for instance, the RCP served 47 individuals. As of fall 2007, RCP had resolved the health care issues of 79 percent, with some still receiving care. Its staff had helped 13 individuals move to permanent housing, and tracks housing retention. Others may have moved to other programs within the homeless assistance system, or to other treatment or residential options. From July 2005 through May 2007, at discharge, 19 percent of participants went to PSH; 23 percent went to transitional housing programs; 20 percent went to stable housing placements with significant others, family, and friends; 18 percent went to other venues including hospital readmissions, incarceration, and being lost to follow-up; and 20 percent returned to the streets. The RCP was able to help at least 62 percent of the people it served to leave homelessness.

For more information, see Chapter 5 in Burt, M.R. 2008.

Conclusion

The availability of resources—whether a result of state, local, or other sources' generosity—has a major impact on communities' ability to circumvent capacity barriers. Miami is an excellent example—the community has clearly cultivated and now benefits from Florida's responsiveness to issues related to homelessness and willingness to allocate funding to homeless initiatives, as well as from its own willingness to tax itself to provide relevant funding. Pittsburgh benefits from a large and engaged local foundation network. Albany's homeless residents benefit from New York's unusual generosity in terms of Medicaid, GA, and state housing program funding. Denver, while not located in a notably generous state, has been able to develop considerable resources by developing a 10YP and drawing on a diverse base of local sources to implement it.

Denver, Miami, and Pittsburgh demonstrate the kind of far-reaching results that can be realized when organizing entities succeed in developing new resources and applying them strategically. Generally speaking, there is nothing new about identifying the need for expansion of resources to address unmet needs or undertaking private fundraising efforts and lobbying local, state, and federal governments for resources. In these communities, however, such activities have the backing of high-ranking officials, and are supported by unusually advanced organizational structures. These characteristics set the communities' initiatives apart, and suggest a path that other communities may wish to pursue.

In addition to organizing structure, the experiences of study communities overall point to the importance of both local context (state generosity, foundation resources) and skill (advocacy, resourcefulness). Ideally, both are present, but in reality communities may have little control over local factors.

In thinking about access and how a community's service capacity affects it, it is useful to understand the difference between access and generosity. Reducing delays in getting benefits represents an improvement in access. Figuring out how to supply more actual resources or raise the benefit level relates to capacity and generosity, which might or might not ripple through to access. If a community increases the value of a particular benefit for those who get it, without making it possible for more people to get it, the

change reflects generosity but not increased access. If additional resources are used to see that more people get the benefit, such as by enacting a local rent subsidy program or expanding resources for mental health care that provide rent subsidies or mental health care to twice as many people, then the community's generosity has produced an access-expanding mechanism, whether the new subsidies or mental health care provide a benefit at a similar, higher, or lower level than the old ones do.

Of the three categories of barriers we have discussed, capacity barriers are most pertinent to community responses to HUD's shift of its resources toward housing rather than service costs. This shift has had the potential to directly impact capacity of most benefits and services used by homeless people. It follows that a community's ability to mobilize additional resources to support services in transitional and permanent supportive housing relates to the degree to which the community has successfully adapted to the policy change. For example, while Pittsburgh was certainly affected by the shift, the availability of foundation resources was one critical factor in the community's ability to continue to meet the needs of its homeless residents. The Allegheny County Department of Human Services' structure and funding flexibility was another critical factor. Ultimately, each of the study communities has initiated a variety of successful mechanisms to address capacity barriers. These mechanisms range considerably in scope, and also vary according to state and local factors. They offer a useful selection of possible approaches for other communities interested in improving their response to capacity barriers and, by extension, to the HUD policy shift.

CHAPTER 6: ELIGIBILITY BARRIERS TO HOMELESS PEOPLE'S ACCESS TO MAINSTREAM BENEFITS

Eligibility barriers are restrictions excluding some homeless people from qualifying for the mainstream benefits and services they need. Most eligibility restrictions for the major benefits are embedded in federal policy. Such barriers are not easily influenced at the local level, as evidenced by the limited number of relevant mechanisms observed in the study communities. Eligibility barriers should be distinguished from both structural barriers, which relate to problems that eligible people have accessing otherwise available services, and capacity barriers, which relate to lack of or limited availability of services, as well as delays in access among eligible applicants. Although the eligibility barriers discussed below are not new to this study, the few mechanisms the study communities have developed to address them are.

There are some areas of overlap between eligibility barriers and the remaining two barrier categories. Eligibility expansions may also be capacity expansions (for example, funding for gaps between existing programs or health care for people without insurance). This approach is more feasible for local decisionmakers to implement, and we did learn of many such mechanisms. They are discussed in Chapter 5, among other mechanisms that improve system capacity. Additionally, we consider mechanisms that help people prove their eligibility to be related to structural barriers, in that they do not alter or expand eligibility policy. Study communities offered many mechanisms to facilitate proof of eligibility, and these are discussed in Chapter 4. The focus of this chapter is exclusively on mechanisms that alter or expand eligibility criteria, making benefits and services available to homeless people who otherwise would have been considered ineligible. Eligibility criteria affect the full range of mainstream benefits and services. Interviews revealed six subcategories of eligibility barriers:

1. **Criminal History**—Criminal and legal problems, including previous incarcerations and felony and misdemeanor charges, leave people ineligible for a wide range of mainstream services.

2. **Categorical Requirements**—All mainstream benefits and services have categorical requirements, such as age, disability status, and residency, that limit the eligibility of homeless people.

3. **Homelessness**— A primary challenge for homeless people wanting to use homeless-specific resources is documenting and verifying length of homelessness to satisfy the U.S. Department of Housing and Urban Development's (HUD) definition of chronic homelessness.

4. **Family Size/Composition**—The amount and type of benefits for which people are eligible depends on family size and composition; many benefits are not available to single adults.

5. **Mental Health and Substance Abuse**—Access to mental health and substance abuse services may be prioritized according to diagnostic criteria.

6. **Health Insurance—**Access to health insurance is often necessary to be eligible for medical, mental health, and substance abuse services.

Despite the volume and variety of eligibility barriers encountered, communities reported few mechanisms altering or expanding eligibility. As discussed above, this is likely a result of the limited means that local decisions makers have to address federal policy. The exception to this rule comes with eligibility barriers related to criminal history; a number of communities described mechanisms developed in response to these barriers.

Because of the general lack and uneven distribution of mechanisms related to eligibility barriers, the format of this chapter differs from that of the structural and capacity barriers chapters (Chapters 4 and 5, respectively). In this chapter, we first discuss criminal history barriers, the mainstream benefits they affect, and the mechanisms communities use to address them. In Chapters 4 and 5 each subcategory of barriers and mechanisms is discussed in this format. However, because of the lack of mechanisms to address the remaining sub-categories of eligibility barriers, we will use the rest of this chapter to simply describe the remaining eligibility barriers—and the benefits they affect—in more detail.

Criminal History

As an eligibility barrier, criminal history encompasses all criminal and legal problems, including both felony and misdemeanor charges, as well as previous incarcerations. Both federal and local policies include criminal history as an exclusion criterion for some mainstream services and benefits.

Mainstream Benefit(s) Affected

Criminal history occasionally proves to be a barrier to eligibility for a number of benefits and services, but is most frequently a barrier to housing access. HUD regulations preclude HUD-funded housing availability for people with felony drug offenses. Similar or more onerous restrictions may be placed by locally sponsored housing authorities (HAs) or other programs, and by individual landlords. In these cases, eligibility for housing can be denied depending upon the category of offenses. In many of the study communities, it is nearly impossible to find housing for people with arson arrests or sex offense histories. Due to Dade County sex offender ordinances, for example, none of the area's assisted living facilities will accept sex offenders. Boarding homes are the only option for people with such a history in this community. As the more stringent restrictions originate with local HAs or other local sources, they can also be changed locally.

Mechanisms to Address Criminal History

Study communities reported a number of mechanisms to address criminal justice-related eligibility barriers. These fell into three categories: changes in eligibility restrictions, homeless courts and related programs, and liaisons working between landlords and tenants. While homeless courts help people avoid criminal charges and convictions, study communities also employ a number of mechanisms to establish or protect eligibility among people who already have criminal histories. As might be expected, these mechanisms relate mostly to housing. For the most part, mechanisms that address eligibility barriers are by definition changing mechanisms, in that they work to modify existing policy. This is most clearly the case with the first group of mechanisms in this section, but can also be applied to the remaining mechanisms. Housing liaisons do in fact expand eligibility, albeit in a less formal sense, and homeless courts theoretically expand eligibility by helping to prevent some homeless people from establishing a criminal record.

Changes in Eligibility Restrictions

Organizations in Albuquerque and Pittsburgh have developed mechanisms to expand eligibility for HUD-funded housing. While the Albuquerque approach was developed in response to the local HA's establishing more restrictive criteria, the Pittsburgh mechanism has the capacity to expand federal eligibility criteria.

- Crossroads for Women is a provider agency within the Albuquerque Continuum of Care system that provides housing, mental health, case management, life skills education, and vocational assistance to women who are homeless and suffering from mental illness and substance abuse disorders. In 2005, the Public Housing Authority (PHA) issued new rules that prohibited housing for anyone with a felony conviction, and eliminated exceptions based on substance abuse histories and substance abuse recovery. This ruling affected many of the women served by Crossroads. Therefore, Crossroads called a meeting with the PHA and was told that the only chance for the women it served to secure housing was to file what the HA refers to as a *hopeless appeal*. Crossroads now completes an appeals packet, describing the Crossroads program; about 90 percent of the appeals are successful—women are deemed eligible for housing assistance. To facilitate the success of this "work around," Crossroads simultaneously submitted a set of legal documents that examined the new rules, and made the case that a complete and permanent ban from public housing assistance is inconsistent with federal laws.

- In Pittsburgh, the city housing authority has been granted Moving to Work (MTW) status. MTW is a HUD demonstration program that grants housing authorities greater flexibility in the interest of promoting resident self-sufficiency, improving program efficiency, or increasing housing choice (HUD, n.d.). The Pittsburgh HA has used its MTW status to adopt a rehabilitation clause allowing some applicants with felonies to be eligible for housing if they can demonstrate that rehabilitation has taken place since they committed the felony.

Homeless Court

Special courts for people who are homeless may reduce barriers related to criminal justice. For the purposes of addressing eligibility barriers related to criminal history, such programs serve a preventative function in that they help recipients avoid convictions. Mental health courts, substance abuse courts, and other mental health or substance abuse jail diversion programs can serve a similar function and, while not designed specifically to address homeless issues, may serve many homeless people. Chapters 7 and 8 include more detailed discussion of Miami's mental health jail diversion programs.

The homeless court in Denver is essentially a docket in the city and county of Denver for people experiencing homelessness. Once a month providers in the community can call Denver's Road Home office (DRH) with clients who are homeless and have an outstanding warrant, meaning there are one or more offenses on record against them that have not been settled by paid fines or completed jail time or community service. DRH staff verify with the courts that the person qualifies for homeless court. If eligibility is verified, the person's case is entered on the docket; outstanding warrants are generally vacated and fines are reduced or eliminated.

Liaisons between Landlords and Tenants

Norfolk's Housing Broker (HB) Team, first mentioned in Chapter 5, works to expand the number of landlords willing to house homeless clients. By providing housing expertise and a point of contact for the landlords, the HB Team has been able to negotiate to eliminate late fees and increase the availability of housing units. The Team has been able to assist clients with criminal histories. Team members note, "Having a third party helps with criminals. We call landlords, and tell them, 'we've met that person.' I've placed at least three people that had felonies and had been turned down by landlords." The HB Team was created in response to a paucity of landlords willing to house homeless people in an increasingly competitive private housing market.

Other Eligibility Barriers

As described earlier, the remainder of the chapter offers descriptions of the five remaining categories of eligibility barriers, as well as the benefits and services they affect. Study communities provided few, if any, mechanisms to address these sub-categories of barriers, although in some cases relevant mechanisms in Chapters 7 or 8 are referenced.

Categorical Requirements

Most, if not all, mainstream benefits have categorical requirements that limit the eligibility of homeless people. For example, eligibility for most mainstream benefits and services is limited to legal adults and emancipated minors. Homeless youth, therefore, may have difficulty accessing necessary services. Categorical requirements vary across

benefits and services. Below, we describe the requirements associated with six of the benefits and services commonly needed by homeless people.

1. **Temporary Aid to Needy Families (TANF):** To participate in TANF, applicants must seek work or participate in work-readiness activities, unless they meet state criteria for exemption from these activities. Additionally, applicants may be required to prove that their children are attending school, that they are complying with child support enforcement, that their children's immunizations are current, and they have complied with other health screening requirements (Rowe, Murphy, and Kaminski, 2008).

2. **General Assistance (GA):** General Assistance programs, where available, provide financial benefits for indigent people. These benefits provide limited financial resources for those who are not eligible for TANF. The amount of assistance available and the means of disbursement are determined by individual states. Often, as in Maine, GA will pay for things like rent or utilities, sending the money directly to the landlord or utility company, but will not give cash payments to recipients. Some states limit GA to families, but others offer it to both families and single adults.

3. **Food stamps:** To be eligible for food stamps, people must have limited income and assets, including vehicles. Households receiving food stamps are expected to spend about 30 percent of their income on food. For this reason, the household's net monthly income is multiplied by .3, and this amount is subtracted from the maximum available benefit, which is determined by the size of the household. With some exceptions, able bodied adults between 16 and 60 who receive food stamps for more than three months must register for work, accept suitable employment, and take part in an employment and training program to which they are referred by the local office. Legal immigrants are entitled to food stamps if they have lived in the country for five years, are receiving Supplemental Security Income/Social Security Disability Income (SSI/SSDI), or are minors.

4. **Veterans' benefits:** The U.S. Department of Veterans Affairs (VA) offers a wide range of benefits and services including disability and pension benefits, as well as primary care, mental health care, and substance abuse services. These benefits and services are available to veterans and their families who meet the discharge requirements. Most VA benefit requirements relate directly to active duty service. For instance, having spent six months of military service for military reserve training purposes does not count towards active duty service. However, veterans may qualify for benefits if they were called up to active duty while serving in the National Guard or the military reserves, completed the term for which they were called, and were granted a discharge other than dishonorable. Veterans discharged early for a service-connected disability are also exempt from active duty requirements.

5. **SSI/SSDI:** Eligibility criteria for SSI and/or SSDI are diagnosis, duration, and disability. All applicants must have a disability that prevents them from being

able to work. People applying on the basis of psychiatric disability must have a qualifying DSM diagnosis. Applications must provide evidence that the diagnosis and disability have been present for at least one year. Young adults living on their own, people recently discharged from jail, and those without an established history with a single provider often find it difficult to meet the diagnostic criteria.

6. **Medicaid:** Federal regulations governing Medicaid stipulate that eligibility is based on receipt of TANF or SSI. Such recipients are categorically eligible—that is, they belong to a category that makes them eligible. Many states supplement the health coverage of other indigent people who have major disabilities or health care needs. However, this health care coverage tends to be more restrictive than that available to categorically eligible people.

There are few expanding mechanisms in place to address categorical requirements for mainstream benefits and services. These include both expanding the range of people who are eligible to receive various benefits and providing interim or alternative benefits for those whose applications are rejected. Some relevant mechanisms, such as state-only Medicaid for people who do not meet standard Medicaid categorical requirements, are addressed in Chapter 8.

Homelessness

Homelessness relates to eligibility barriers in two ways. First—and primarily—homeless people's access to HUD-funded shelter and housing is generally dependent upon their ability to meet the criteria of HUD's definition of homelessness. Conversely, homelessness itself or conditions related to homelessness may limit people's eligibility for other mainstream services and benefits.

A primary challenge for people in a number of the study communities is documenting and verifying length of homelessness in order to satisfy HUD's definition of homelessness. For example, homeless providers in Maine indicated that, because it is a largely rural state and most small communities do not have shelter systems, they have to find creative ways to verify how long a person has been homeless. Further, doubling up is very common in these areas because of the inclement weather and also because of family connections and a tradition of helping. This poses a problem, because doubling up is an exclusion criterion for the HUD definition of homelessness. These providers also find that many of the organizations they work with have different definitions of homelessness, making it more challenging for homeless people to access all of the services they need.

Homelessness limits access to a number of different mainstream benefits and services. In some cases, food stamps may be denied to people living in shelters if the shelters are providing meals. Homeless people cannot apply for food stamps when they are in respite care. The food stamp benefit is also suspended when recipients are in jail.
Study communities did not report mechanisms to directly address eligibility criteria related to homelessness. However, Chapter 7 covers a variety of mechanisms that

prioritize homeless people's access to the services they are eligible for according to existing criteria.

Family Size

The type and amount of benefits for which people are eligible is typically dependent upon family size and composition. For example, people must have a child in the household to qualify for TANF, and must be pregnant or have a child under the age of 5 to be eligible for the Women, Infants, and Children's supplemental nutrition program. Additionally, family size can prove a challenge for placing people in housing because it is often difficult to find appropriate sized units for larger families. As with many of the eligibility barriers, we did not encounter any mechanisms to address eligibility barriers posed by family size in our site visits.

Mental Health and Substance Abuse

Mental health and substance abuse histories, diagnoses, or lack thereof may pose a barrier to access to benefits and services. Access to mental health and substance abuse services may be partly or entirely dependent on diagnosis, leaving those without a diagnosis—or without a diagnosis recognized by relevant policy—with limited or no access to mental health or substance abuse care. While those who do have psychiatric disabilities and addictions may face additional challenges accessing other mainstream services as a result of discrimination, we consider these to be structural barriers, which are covered in Chapter 7. Study communities did not report any mechanisms to address diagnosis-limited access to mental health care.

Substance abuse can pose another kind of barrier to TANF receipt: In 50 percent of states, drug and alcohol screening, assessment, and treatment are required of TANF applicants. Applicants who screen positive are referred for assessment and treatment, and may be sanctioned if they do not comply.

Despite the lack of specific mechanisms to address eligibility barriers related to substance abuse and mental health, it is worth noting here that Housing First approaches and other low-demand housing models greatly reduce barriers to housing for people with long histories of homelessness and multiple disabilities, including psychiatric disabilities and substance abuse diagnoses. Such programs open supported, subsidized housing options to people who may not be able to meet substance abuse abstinence or mental health service compliance requirements of more traditional housing programs.

Health Insurance

Having adequate health insurance is critical to receiving necessary primary, behavioral and dental health services. Low and no cost medical and dental care, if available at all, tend not to be available in quantities that meet a community's demands. Eligibility for mental health and substance abuse services can be restricted based on type of health insurance. Colorado, for example, does not allow Medicaid to fund substance abuse treatment. Medicaid also may not cover comprehensive dental care. As noted in the

Categorical Requirements section, state-only Medicaid programs—such as the MaineCare program for people who do not meet Medicaid categorical requirements—are relevant to eligibility issues, but are described in greater detail in Chapter 8, as mechanisms that address lack of benefit capacity. Also relevant, and discussed in Chapter 8, is the provision of low or no cost health care.

Conclusion

Eligibility barriers are difficult to overcome, particularly as many result from federal policies that local decisionmakers are unlikely to be able to address. While some communities have been able to develop innovative ways to eliminate some eligibility barriers, such as Albuquerque's *hopeless appeal* and Denver's homeless court, most have not. Given the difficulty and complexity of changing policy, it is not surprising that study communities reported few mechanisms to address eligibility barriers, when compared to the number of mechanisms to address structural barriers or capacity barriers. The exceptions involve mechanisms that negotiate, change, or reinterpret eligibility criteria. In the communities studied, these examples tended to respond to criminal justice eligibility barriers.

CHAPTER 7: ANALYSIS OF THE SAMHSA HOMELESS FAMILIES PROGRAM DATA SET

From 1999 through 2006, the Centers for Mental Health Service and Substance Abuse Treatment within the Substance Abuse Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services funded a multi-site study of intervention programs for homeless families headed by mothers with a substance abuse and/or psychiatric problem. The study involved eight study sites across the country in which data were collected from mothers participating in a target intervention and mothers receiving services as usual, either in shelter or from another program.

One of the areas of data collection in the study involved families' receipt of a range of benefits and services, at baseline as well as over time. Together with a rich understanding of the programs, as well as the characteristics of families across multiple sites, the database from this study offers an opportunity to understand the extent to which certain types of benefits and services are more or less accessible to families, the factors that relate to receipt, and the extent to which families with specific needs are receiving some level of service to address these needs. Therefore, for the current study, the following questions were examined using the SAMHSA data base:

- What is the level of receipt of each benefit and service for this sample of families? How does the level change over time?

- What are the individual factors and program factors (controlling for study site) that relate to service receipt?

- What is the level of unmet need—either by self report or by independent measures of need (for example, mental health status; substance abuse problems) for specific types of health and related services and supports?

Through the examination of these questions, we are provided the ability to understand the relative level of receipt of various services, the services that are most accessible by families, and those that continue to be difficult to obtain.

With the exception of health services for children, this data set provides data on service receipt rather than access. Despite this limitation, there are advantages in including these findings in this report. For most services, receipt will likely be lower than access but can provide a reasonable proxy for access. Moreover, it is likely that the difference in the percentage of families having access to a services compared to those who actually receive the service are similar across behavioral health services. For income and health benefits, however, it is more likely that most families who have access to a benefit also follow through and receive the benefit as they provide core income and health supports, and many are linked together (for example, Medicaid and Temporary Assistance for Needy Families [TANF]).

The focus of the target intervention in each study site was a time-limited (that is, no more than a nine-month period of intensive services) intervention aimed at meeting the psychiatric, substance abuse, and/or trauma services needs of homeless women with children. The interventions were existing programs in the study site, but enhanced with funding from the study. All target interventions were intended to be multifaceted, involving a combination of services focused on mental health treatment, substance abuse treatment, trauma recovery, securing and maintaining housing, parenting skills, household and money management, and goal setting. Most of the target interventions involved some form of intensive case management, combined with other services and approaches (such as motivational interviewing). The remaining sites used more comprehensive service approaches, such as multi-systemic therapy and multiple services provided through a family health practice in a community health center.

Comparison services in most study sites referred to "services as usual"—typically involving shelter with a combination of onsite or community services. The comparison interventions were typically less intensive, yet also varied, representing what was considered services as usual in that particular setting.

Some of the target interventions provided services for as little as 4 months, others up to 12 months. Our examination of the receipt of services, therefore, examines change from baseline to three months, when most of the target intervention families were receiving the SAMHSA services. At the 15-month interview, target intervention families were generally no longer receiving those services.

Sample

Researchers reanalyzed data for 1,110 families from the treatment and comparison conditions in seven study sites (see Exhibit 7.1). Data were collected on families recruited from different portals of entry (for example, shelters, substance abuse treatment court) who were headed by women who were at least 18 years of age, the primary custodian of at least 1 child under the age of 16, and had experienced a level of problems warranting a DSM-IV Axis I mental health or substance abuse diagnosis in the past year (based on either the Mini International Neuro-psychiatric Interview or clinical interview). Although the original study had a broad definition of current homelessness (Rog et al. in development), the reanalysis for this study was limited to families who met the U.S. Department of Housing and Urban Development definition of homelessness—lacking a fixed, regular, and adequate nighttime residence. Doubled-up families or families living in temporary situations were not included in this analysis.

Exhibit 7.1: Homeless Families Intervention

Study site	Intervention	Comparison
Phoenix, Arizona (Randomized)	Enhanced Intensive Case Management, Motivational Interviewing	Shelter Treatment as Usual
Wake County, North Carolina	Intensive Case Management with Wrap-around Services	Traditional Case Management with Link to Services
Connecticut*	Intensive Case Coordination	Treatment as Usual
Westchester, New York (Randomized)	Family Critical Time Intervention And Housing Apartment Program	Shelter as Usual
Capital District, New York	Modified Critical Time Intervention	Services as Usual
St. Louis, Missouri	Multi-dimensional Family Assistance	Outreach Intensive Case Management
Worcester, Massachusetts	Comprehensive Family Health Practice	Treatment as Usual

**Target primarily substance abuse*

As Exhibit 7.2 indicates, the homeless mothers in the sample were on average 31 years of age and had two children. Race and ethnicity varied by study site, but across the study sites, families were predominately families of color. Nearly half of the mothers (44 percent) lacked a high school diploma or GED, and less than a fifth (17 percent) were employed at the time they entered the study. Less than a fifth (18 percent) were married, though there was some variability across study sites. The composition of this sample reflects that of the overall homeless population (Burt et al. 1999) as is displayed in the final column of Exhibit 7.2.

Exhibit 7.2: Homeless Mothers: Demographic Characteristics and Family Composition

	Total	CDNY	CT	AZ	MO	NC	WNY	MA	Burt et al.
n	1110	224	104	219	95	151	171	146	4,207
Average Age (SD)	30.5 (7.6)	28.3 (7.4)	32.1 (6.7)	31.3 (7.6)	32.7 (8.7)	31.1 (7.7)	31.3 (7.4)	28.5 (7.2)	--
Average number of children (SD)	1.8 (1.3)	1.9 (1.2)	1.1(1.2)	2.1(1.3)	2.0 (1.4)	1.4 (1.3)	2.3 (1.2)	1.7 (1.0)	--
Race (%)									--
Black	50.8	57.6	45.2	21.3	83.2	81.5	63.2	19.9	43
White	35.8	33.9	39.4	59.2	21.1	13.9	25.7	46.6	38
Hispanic	21.9	18.6	25.0	28.3	3.2	2.7	28.7	38.6	15
Other	11.0	10.3	4.8	19.2	10.5	6.0	11.7	8.9	4
Education (%)									
Less than high school diploma	43.6	43.8	49.0	46.6	43.2	40.1	38.6	44.5	53
High school diploma/GED	31.7	31.7	33.7	33.3	37.9	34.0	19.3	36.3	21
More than high school diploma	24.7	24.6	17.3	20.1	19.0	25.9	42.1	19.2	27
Currently employed (%)	17.4	23.2	11.5	12.3	14.7	27.2	17.0	12.3	--
Married (%)	17.8	24.6	8.7	22.4	8.4	19.6	17.5	11.7	23

Data Collection

Families were recruited for the study beginning in 2001/2002 (depending on the study site) and extending for an 18-month recruitment period. Data were collected at baseline, and at 3, 9, and 15 months after the baseline.

For this reanalysis, 93 percent of the families have a baseline and at least one follow-up. Sixty-eight percent have a complete 15-month data set.

The study team collected data exclusively from the mothers. Each mother participated in an in-person interview, providing information on herself, her family, and an index child (randomly selected from a child who lived with her or a child with whose behavior she was highly familiar). The baseline instrument had 13 domains and a combination of standardized and original instruments. The follow-up interviews covered the same domains, except for background history and demographics. Exhibit 7.3 outlines the domains covered and the instruments used.

Researchers also collected data for both the treatment interventions and the comparison interventions. The main intervention data were collected through a one time visit to each study site, augmented by documents and other contacts with the study site.

Exhibit 7.3: Instruments

Outcome Domain	Instrument	Measure	Scoring
Mental Health Symptoms	Brief Symptom Inventory (Derogatis 1993; Derogatis and Melisaratos, 1983)	Global Severity Index	• Possible Range = 0–100, normed at 50 • Higher scores = more symptomatic
Mental Health Functioning	Maternal Health - SF8 Mental Component Summary (Turner-Brown, Bayliss, Ware, and Kosinski, 2003; Ware, Kosinski, Dewey, and Gandek, 2001)	Mental Component Summary Scale	• Possible Range = 0–100, normed at 50 • Higher scores = better functioning
Drug/Alcohol Use	Addiction Severity Index (ASI) Composite – for both alcohol and drug subscales (McLellan, Kushner, Metzger, and Peters, 1992; McLellan, Luborsky, O'Brien, and Woody, 1980)	Alcohol Composite Summary Drug Composite Summary	• Possible Range = 0–1.0 • Higher scores indicate more substance use
Trauma Recovery	Posttraumatic Symptom Severity Scale (PSS) (Foa, Cashman, Jaycox, and Perry, 1997).	Total Symptom Severity Score	• Possible Range = 0–51 • Higher scores indicate higher trauma symptom severity
Maternal Health	Maternal Health SF8 (Turner-Brown, Bayliss, Ware, and Kosinski, 2003; Ware, Kosinski, Dewey, and Gandek, 2001)	Physical Component Summary Scale	• Possible Range = 0–100, normed at 50 • Higher scores = better health
Parental Functioning	Parent Questionnaire (adapted from Strayhorn and Weidman, 1988 Parenting Practices Scale)	Global Summary Score	• Possible Range = 0–4 • Higher score = better parenting
Child Outcomes	Child Behavior Checklist (Achenbach and Rescorla, 2001)	Total Problems Global T-Score	• Raw scores are normed/converted to T-scores: t-scores below 60 (normal range); t-scores of 60 to 63 (borderline range); t-scores above 63 (clinical range) • Higher scores = more behavioral/ emotional problems
Family Resources	Family Resources Scale (FRS) (Dunst and Leet, 1987)	Total Family Resources	• Possible Range = 1–5 • Higher scores indicate more resources
Residential Stability	Residential Follow-Back Calendar (New Hampshire – Dartmouth Psychiatric Research Center, 1995)	Percentage of Time Living in their Own House or Apartment	• Possible Range = 0–100

Analysis

Basic frequencies were conducted on the level of benefit and service receipt by families within and across the seven study sites. Frequencies were conducted on families' baseline receipt of services; for target intervention families, this was generally within two weeks of starting the target intervention, whereas there was a less definitive onset for families in the "services as usual" condition. Frequencies were also conducted on service

receipt at 3- and 15-month points after the baseline for all families, to assess the extent to which changes in receipt occurred.

Researchers conducted contrasts to assess the extent of reported "unmet need" for each type of service, as appropriate. In addition, for certain types of services, need was measured by an independent set of instruments and analyses were conducted to determine the level of service receipt for families meeting high levels of need.

The study team also used logistic regression models, examining the effects of site, type of intervention, and fidelity to program design on access to services.

Study Qualifications

In reviewing the findings, it is important to keep in mind the limitations of this analysis and data set. Some of these limitations pertain to the data set as a whole and some pertain to its inclusion in a study on benefit access. Overall, the data are from a subset of homeless mothers who have experienced mental health and/or substance abuse issues across seven different communities. Moreover, the families are participating in either a target intervention or a comparison "services as usual" intervention. Therefore, their rates of needs and receipt of services related to these issues, as well as related issues, are likely to be higher than homeless families as a whole. Moreover, because they are receiving some level of case management through their interventions at least for three months, rates of receipt of other services also are likely to be higher than for families at large.

In addition, there are a number of differences among the communities that are important to consider when reviewing the averages. Although families were selected using similar criteria across the seven sites, there were a number of significant differences among the study populations in the different communities. In addition, communities varied in the nature of the interventions offered, and were in states that also likely differed in the capacity of their benefit and service programs, such as TANF.
Finally, as noted above, our findings pertain to service and benefit receipt rather than access. These numbers provide a proxy for access, but are likely lower than the percentages of families who actually have access to the services but choose not to participate.

Thus, these limitations suggest restricted generalizability of the findings to homeless families overall or to specific communities. What the data do provide is a lens into the relative accessibility and receipt of a range of services and benefits, and opportunity to explore factors that improve or hinder receipt.

Descriptive Findings

Receipt of Benefits

What is the level of receipt of income benefits for this sample of families?

At baseline, across the seven study sites, a little over half the families reported receiving TANF or General Assistance (GA) within the previous 30 days. This finding is commensurate with that in the overall homeless population. Burt et al. (1991) found that 52 percent of their sample received Aid to Families with Dependent Children and 10 percent received General Assistance. In study sites where the percentage was lower, it tended to be offset by a slightly larger proportion of families working, as well as a large percentage of families without a source of income. Overall, approximately 8 percent were receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI). This percentage is consistent with, but slightly lower, than the percentage of homeless families (11 percent) identified as receiving SSI by Burt et al. (1999). Other sources of income primarily included alimony, child support, family, and/or parental contributions.

The majority of families (73 percent) received food stamps, with the highest percentages in Massachusetts and Missouri, as compared to 71 percent of the overall homeless population (Burt et al. 1991). For families in which the mother was pregnant or there was at least one child under five years of age, a little more than half (54 percent) were receiving supplemental food from the Women, Infants, and Children Program. For those families with a target child enrolled in school, 78 percent were receiving vouchers for free and reduced school lunches.

Families were less likely to receive subsidies for housing and daycare than other sources of income support and benefit. Less than one fifth of the families with a child under the age of five received daycare subsidies. This percentage varied considerably across the study sites, with as low as 6 percent of the families in the Connecticut sample to nearly a third of the North Carolina sample. These differences are likely due to sampling differences across the study sites, especially in the extent to which the families were looking for work or already working and in need of daycare.

Nearly half of the families were on the waiting list for a housing subsidy (including nearly all of the Worcester, Massachusetts sample), but only 8 percent currently had a subsidy. In the Worcester sample, families were in shelters that are contracted by the state's Department of Transitional Assistance (DTA) and were provided housing search services through the Central Massachusetts Housing Alliance, the local agency providing housing search and stabilization services to all homeless families through a contract with DTA.

When all three major benefit areas are examined (TANF or SSI/SSDI, food stamps, and housing subsidy) in combination, the data reveal, not surprisingly, that few families

received all three benefits, but the vast majority who received TANF or SSI/SSDI also received food stamps. Over 30 percent received food stamps alone.

Benefit Receipt Over Time

Examining the level of service receipt in the cross-site sample over time indicates that the rate of receipt of SSDI/SSI gradually increased but that the receipt of TANF/GA was less consistent, in part reflecting the extent to which the mothers entered the work force and perhaps in part to a reduction in the sample over time. The percentage of families without a source of income decreased slightly over time.

Across other types of benefits, housing subsidies showed the most steady increase in rate of receipt over the 15-month period, more than quadrupling in percentage though still providing support to only a third of the sample, with nearly half (48 percent) on the waitlist. Greater percentages of the sample also received daycare subsidies and school lunch vouchers at each time point, though in more modest gains than housing subsidies. Three fourths of the sample continued to receive food stamps after 15 months in the study.

Exhibit 7.4: Receipt of Benefits Over 15 Months

	Baseline	3 Months	15 Months
n	1110	948	810
Sources of Income in Past 30 days			
Earnings	18.8	27.5	37.7
Social Security Disability Income (SSDI)	3.9	4.4	6.5
Supplemental Security Income (SSI)	4.8	6.3	7.3
SSDI and/or SSI	7.9	9.8	12.8
U.S. Department of Veterans Affairs disability benefits or pension	0.1	0.2	0.1
Temporary Assistance for Needy Families (TANF)/General Assistance	51.5	63.0	43.7
Unemployment compensation	3.1	3.0	2.0
Other sources	33.2	26.5	34.5
No source of income	15.1	8.0	9.3
Benefit Receipt			
Food stamps	73.1	82.2	76.7
Women, Infants, and Children program[1]	34.8	37.7	35.6
Vouchers for school lunches[2]	54.3	61.4	63.8
Daycare subsidy[3]	15.3	20.6	23.3
Housing subsidy	8.2	19.2	33.0
On waiting list for subsidy	44.6	58.7	48.1
Combinations of Benefits			
TANF and food stamps	46.9	59.9	40.4
TANF, food stamps, and housing subsidy	4.2	12.9	16.1
SSDI/SSI and food stamps	5.3	7.1	9.4
SSDI/SSI, food stamps, and housing subsidy	1.1	2.3	3.6
Only food stamps	32.4	17.4	20.9

[1] Sample restricted to those who are pregnant or have a child under five years of age.
[2] Sample restricted to those whose target child is currently enrolled in school.
[3] Sample restricted to those who have a child under five years of age.

Receipt of Health Insurance

What proportion of mothers and children have health insurance?

Most (84 percent) of the mothers had health insurance, with the vast majority receiving Medicaid. The majority (90 percent) also had health care insurance for their children, again primarily through Medicaid. The percentage of mothers and children receiving Medicaid in this sample is higher than that found in the overall homeless population (those numbers are 61 and 73 percent, respectively) (Burt et al. 1999), however, it may be that these homeless mothers were more likely to need such services and, in turn, were more likely to be hooked into services prior to the start of the study. State insurance was the second most common source of insurance for children, whereas small percentages had private insurance.

How does the level of receipt change over time?

Receipt of health care insurance, specifically Medicaid, increased for both mothers and their children, especially from the baseline to three month timeframe. Less than 10 percent of the mothers and less than 5 percent of the children were without access to health insurance three months following baseline.

Exhibit 7.5: Access to Health Insurance

	Baseline	3 Months	15 Months
n	1110	948	810
Health Care Insurance			
Any source of health care	83.9	93.6	91.1
Medicaid	78.3	87.3	81.9
Medicare	1.5	1.4	1.7
Private insurance	4.3	3.7	5.4
U.S. Department of Veterans Affairs (VA) health care	0.4	0.4	0.5
Other insurance	2.7	2.9	2.8
Children's Health Care Insurance			
Any source of health care	89.9	96.5	95.4
Medicaid	82.3	90.4	86.4
Medicare	0.9	0.4	1.1
Private insurance	6.1	5.3	5.4
VA health care	0.2	0.2	0.4
State insurance	8.5	8.2	7.7
Other insurance	2.2	2.1	2.6

Receipt of Physical Health Services

What was the level of receipt of physical health services for mothers and their children in this sample of families?

Over 60 percent of the mothers reported having had a physical examination in the 12 months prior to the baseline interview, with a wide range of receipt across the study sites (the low being in Arizona). Similar percentages of the mothers reported having been seen by a gynecologist as well. In addition, of those who reported being pregnant at the baseline, 74 percent reported having had a prenatal visit during the pregnancy.

Similarly, for the children in the families, the majority (86 percent) had a regular doctor and nearly 75 percent had had an exam within the past 12 months. Again, as for the mothers, the lowest level of receipt of physical health services was in the Arizona site, at 51 percent.

Both mothers and their children had received less dental than health care over the last year, with less than half having seen a dentist. For mothers, the lowest level of receipt by far was in Arizona, with 18 percent of the mothers reporting they had had a dental care

visit in the last year. For children, the level of receipt was lowest in the Capital District of New York at 30 percent.

How does the level of access change over time?

Because good access to health services is generally considered having a regular doctor and having annual exams, the best comparison for changes in baseline receipt is receipt at 15 months (allowing for a 12 month period in which receipt is measured). For mothers, with the exception of the rates of prenatal visits for pregnant women, the proportion receiving physical and gynecological exams decreased over time. The dental exam rate remained low. For children, fewer were reported to have a physical exam in the 12 months prior to the 15 month interview, though the overwhelming majority (91 percent) of the children reportedly had a regular place of health care. This number is higher than reported for homeless and poor children overall (see *America's Youngest Outcasts: State Report Card on Child Homelessness,* 2009). It is not clear if mothers are including emergency clinics, other hospital clinics or mobile teams in response to this question. The percentage is high, and reflects either a heightened access for this group due to their engagement in services or an inflation of the responses due to referring to more emergency venues as regular care.

Dental exam rates remained low for the target children in the study as with their mothers. Some of the drop at 3 months must be due to the passage of time in relation to when an annual physical or dental exam would occur, especially given that they are back to higher levels at 15 months.

Exhibit 7.6: Receipt of Health Services

	Baseline	3 Months	15 Months
n	1110	948	810
Physical Health Services			
Had a dental exam w/in 12 months	37.1	17.1	30.7
Had a physical examination w/in 12 months	63.9	41.2	47.6
Seen by a gynecologist w/in 12 months	62.0	36.4	46.6
Pregnant	13.4	9.6	7.1
Had a prenatal visit during pregnancy	74.2	81.3	77.2
Children's Physical Health Services			
Had a dental exam w/in 12 months	40.1	23.9	37.3
Had a physical examination w/in 12 months	74.7	46.8	53.1
Has a regular doctor w/in 12 months	86.0	86.3	90.9

Receipt of Family Support Services

What was the level of receipt of housing, transportation, employment, parenting, and child care for this sample of families?

Across the study sites, receipt of housing services averaged 36 percent, ranging from a low of 1 percent in Missouri to a high of 55 percent in Massachusetts. Similarly, unmet

need for housing services averaged 43 percent, with the highest level in Missouri and the lowest in Massachusetts. The most common services were help in accessing housing subsidies and finding housing.

Fifty one percent of the sample received transportation services, with a little less than a fourth (23 percent) noting an unmet need for transportation assistance.

Approximately 15 percent of the families received child care services, most commonly help in finding child care assistance or receiving a child care subsidy. Despite the low levels of service receipt, only 12 percent of the families reported an unmet need for child care services. When the pool of families was narrowed to those families with children under five, the percentage of unmet need rose to 15 percent.

Services for parents varied across the study sites, with as few as 4 percent in the Westchester sample to nearly half (43 percent) in the Massachusetts sample. Overall, just shy of 20 percent received at least one parenting service. Across and within each study site, the most common service was parenting classes, followed by peer support. Twelve percent of the families across the study sites reported unmet need for parenting services.

Finally, less than a fifth of the families (18 percent) were receiving employment services, most commonly assistance in looking for a job and talking to someone about job training. A fourth of the families (25 percent) reported an unmet need for employment services. When the pool of families was narrowed to those families able to work and currently unemployed, the percentage of unmet need rose to 39 percent.

In sum, across this range of housing and support services, the largest unmet areas of need at baseline were for the most critical services to gain and maintain stability, with the need for housing services topping the list at 43 percent unmet need, followed by nearly a fourth of the sample indicating an unmet need for employment and transportation services each.

How did the level of access change over time?

Over the course of the 15 months families were interviewed, the unmet need for housing services decreased, despite their not receiving housing services. The decrease in unmet need may be due in part to the increase in housing subsidies received over time.

For transportation and child care services, the level of unmet need remained relatively constant; however, rates of service receipt dropped in both areas, especially child care services. For parenting services, the rates of both receipt and need dropped over time.

Finally, the rate of employment service receipt at 15 months was comparable to that at baseline, despite the decrease in unmet need. Again, as with housing, a greater percentage of families were engaged in the work force and thus less likely to be receiving services as well as having an unmet need for them.

In addition, families overall compared to adults have greater access to income benefits, at least on a temporary basis, and thus have concomitant less need for employment services and services that are required while working (such as transportation and child care).

Exhibit 7.7: Receipt of Housing Services

	Baseline	3 Months	15 Months
n	1110	948	810
Receipt of Housing Services			
Any housing services	36.3	32.4	20.9
Help in accessing a housing subsidy	21.7	21.4	13.8
Help finding housing	16.5	20.7	9.8
Help dealing with landlord	9.9	9.5	5.3
Help dealing with an eviction	7.2	1.2	1.9
Help maintaining utilities	8.0	4.4	5.3
Unmet need for housing services	42.6	28.4	23.8
Receipt of Transportation Services			
Transportation services	51.3	45.3	35.9
Unmet need for transportation services	23.3	21.9	20.9
Receipt of Child Care Services			
Any child care services	14.9	14.5	3.5
A child care subsidy	9.8	10.8	2.2
Help finding child care assistance	10.7	8.7	0.8
Help with child care transportation	6.6	4.7	1.4
Unmet need for child care services	12.3	11.0	13.2
Receipt of Parenting Services			
Any parenting services	19.9	23.1	11.6
Parenting classes	15.5	15.6	7.1
Peer support on parenting	10.1	10.3	4.0
Family counseling	5.9	6.4	3.0
Other parenting services	1.4	2.3	0.8
Unmet need for parenting services	12.4	6.9	5.7
Receipt of Employment Services			
Any employment services	17.5	23.1	14.4
Talked to someone about job training	11.0	15.6	8.5
Work skills and interests assessment	9.2	10.3	7.7
Help looking for a job	12.2	6.4	8.7
Training to keep a job	3.9	2.3	3.9
Other employment services	3.1	6.9	2.4
Unmet need for employment services	24.7	23.1	10.3

Receipt of Mental Health and Substance Abuse Services

What was the level of receipt of mental health and substance abuse services for mothers in this sample of families?

Across the study sites, 29 percent of the families received mental health services, with a low of 21 percent in Westchester and a high of 43 percent in the Massachusetts study site. Mental health counseling was the most common service received, followed by medication, crisis services, and case management. Across the study sites, 18 percent of the mothers reported an unmet need for mental health services.

When the mental health status of the mothers was taken into account (comprised of mothers scoring one or more standard deviations above the GSI norm or one or more standard deviations below the MCS norm) and service access was measured, the level of unmet need among this group was 57 percent.

A little less than a fourth of the families in the data set were receiving substance abuse services, but the proportion receiving a service varied greatly, in part due to variations in need across the study sites. Connecticut, with an emphasis on recruiting families with substance abuse problems, had the highest percentage of mothers receiving substance abuse services at 69 percent. All other study sites had significantly lower percentages of receipt, ranging from 12 percent to 35 percent. Within most of the study sites, outpatient substance abuse counseling was the most common service received, followed by case management. Self report of unmet need was low, at 5 percent across the study sites (Arizona was an outlier at 16 percent). However, when mothers' use of substances was taken into account (ASI-Alcohol composite score greater than zero and ASI-Drug scores greater than zero), the percentage of this group of families not receiving services was 14 percent.

How did the level of access change over time?

Over the course of the 15 months, the receipt of both mental health and substance abuse services increased slightly at 3 months and returned to the baseline level of rate at 15 months. Self-reported unmet need for mental health services dropped from 18 percent to 8 percent at 3 months and stayed at that level at 15 months. For substance abuse, the self-reported unmet need began at a low 5 percent but continued to drop at 3 and 15 months, at just below 3 percent and 2 percent, respectively.

Exhibit 7.8: Receipt of Mental Health and Substance Abuse Services

	Baseline	3 Months	15 Months
n	1110	948	810
Receipt of Mental Health (MH) Services			
Any MH services	28.7	35.8	27.0
Inpatient MH treatment	3.4	2.0	2.5
Treatment for a MH crisis	15.5	17.0	10.0
MH counseling	22.8	30.1	19.5
MH medications	18.0	20.5	16.5
MH case management	14.2	20.2	10.6
Other MH services	1.2	1.3	1.3
Unmet need for MH services (self-reported)	18.4	8.2	7.8
Receipt of Substance Abuse (SA) Services			
Any SA services	24.6	27.0	21.4
Inpatient SA treatment	8.5	5.9	2.8
Outpatient SA counseling	17.3	15.8	11.7
SA case management	15.7	15.9	11.0
Other SA services	2.5	1.5	1.4
Unmet need for SA services (self-reported)	5.1	2.8	1.7

Receipt of Children's Services

What was the level of receipt of services and support for children?

A number of questions were asked about services received by the target child[19] and whether there was unmet need for the services. As Exhibit 7.9 shows, medical services were the most commonly received services (25 percent), in line with the high level of receipt of physical health services noted earlier. Reported unmet need for medical services was low at 4 percent. Dental services were the second most commonly received services, received by 16 percent of the families across the study sites, but also reportedly needed by 22 percent of the children. Eight percent of the target children received mental health services, with an additional 12 percent of the children reportedly having unmet needs. The most common mental health services received were counseling and assessments. Less than a fifth of the children received school counseling and special education services (16 percent and 12 percent, respectively), and unmet need was 8 percent and 5 percent, respectively. Finally, less than 1 percent of the children received substance abuse services and less than 1 percent had unmet needs for the services.

[19] The target child was randomly selected from among the children between the ages of 1.5 years and 16 years and living with the mother at the time of the baseline interview. If no children within this age range were living with the mother, a target child was selected from among those that the mother was completely or fairly familiar with.

How did the level of receipt change over time?

The rate of receipt for children's services overall remained remarkably flat over the 15-month time period. Medical service receipt increased at three months, perhaps due to part of the study sample being in intervention programs (though most programs did not have child specific services). However, the rate returned to the baseline level at 15 months. Self-reported unmet need for medical services remained low at 3–4 percent. For dental services, there was a slight increase in service receipt at 3 months and 15 months, and a corresponding decrease in self-reported unmet need.

The rates of school services (special education, school counseling) stayed at level rates at all three time points, though the level of unmet need (below 10 percent on both) continued to decrease slightly. Rates of substance abuse service receipt and unmet need for children were at near 0 rates. Finally, receipt of children's mental health services increased slightly, with a similar decrease in unmet need.

Exhibit 7.9: Change in Receipt of Children's Services

	Baseline	3 Months	15 Months
n	1110	948	810
Children's Services			
Supplemental Security Income or Social Security Disability Income for child in past 30 days	8.3	7.7	9.4
Medical services	24.4	32.9	23.8
Unmet need for medical services	3.7	3.9	3.1
Dental services	16.1	21.0	23.3
Unmet need for dental services	22.4	16.3	13.4
Special ed services	12.1	12.5	12.4
Unmet need for special ed services	5.1	3.2	3.1
School counselor services	15.6	15.0	15.3
Unmet need for school counselor	7.5	5.4	3.1
Substance Abuse (SA) services	0.3	0.8	1.3
Unmet need for SA services	0.8	1.1	1.0
Children's Mental Health (MH) Services			
Any MH treatment	8.4	11.3	11.2
MH assessment	7.0	7.6	7.6
inpatient MH treatment	0.8	0.6	0.6
MH counseling	8.5	8.0	9.7
MH group therapy	2.5	1.6	3.0
MH services from emergency room	0.5	0.4	0.6
MH medications	3.9	3.2	4.5
Other MH services	1.2	1.1	0.8
Unmet need for MH treatment	12.0	8.1	7.1

Predicting Access to Services

Target Intervention Analysis

Target Intervention Measure

The type of target intervention tested and the nature of the study design varied across the seven study sites. Three study sites—Phoenix, Arizona; St. Louis, Missouri; and Westchester County—randomly assigned mothers to the target intervention (TI) or comparison intervention (CI). The other four—Connecticut; Worcester, Massachusetts; the Capital District, New York; and Wake County, North Carolina—each used a nonequivalent group design based on program participation in either a TI or a CI. In all study sites, the TI involved some form of time-limited, multi-faceted intervention. Most TIs offered some form of intensive case management, but combined that approach with other services in various settings. Some of the TIs provided services for as short as 4 months, others up to 12 months. Three TIs incorporated more comprehensive service approaches. TIs varied with their attention to substance abuse services, as described more completely below under the Program Ingredients description. The CI conditions were determined by the local study sites, and typically involved some form of "services as usual," involving shelter with a combination of onsite or community services.

Interpreting Odds Ratios from Logistical Regressions

We report odds ratios for logistic regression models. Odds ratios range from 0.00 to infinity, with 1.00 as the point at which the odds are considered equal (that is, the variable has no effect). In a logistic regression, an odds ratio greater than 1 (for example, 1.605) means the independent variable is positively associated with the dependent variable, and the larger the odds ratio, the stronger the association. Conversely, an odds ratio less than 1 (for example, .853) means the independent variable is negatively associated with the dependent variable, and the smaller the odds ratio, the stronger the association. Thus, an odds ratio of 6.00 is stronger than an odds ration of 2.00, but an odds ratio of .200 is stronger than an odds ratio of .800.

Target Intervention Results

Logistic regression models reveal that mothers in the target intervention group had lower odds of receiving child care services and child mental health services than mothers in the comparison intervention. Although the result is somewhat surprising, the target interventions generally were focused on the needs of homeless mothers, rather than their children. It is possible that the comparison interventions in one or more sites had some additional services for children. However, there was no effect of target intervention on other service receipt. Service receipt did vary across the various study sites, however. By and large, the study site by target intervention effects were not significant predictors of service receipt, with the exception of transportation services in Missouri and child care services in North Carolina. When examining the demographic variables, age was the most consistent predictor of service receipt. Older mothers were less likely to receive

TANF and food stamps and to have visited a doctor in the past 12 months, but they were more likely to receive substance abuse services and housing services, and to have children who received child mental health services. Mothers who were employed were less likely to receive TANF, as would be expected, and those with less than a high school diploma or GED had lower odds of receiving employment services and child mental health services. When examining the independent measures of need, we found that mothers who screened positive for drugs and those who had a history of drug use (measured by the proportion of their lives abusing drugs) were significantly more likely to receive substance abuse services. In addition, children who screened at a clinical mental health level of need were more likely to receive child mental health services. Across all measures however, the strongest predictor of service receipt at three months was receipt of those services at baseline.

Exhibit 7.10: Odds Ratios of Logistic Regression of Target Intervention on Service Receipt at Three Months (N=844)

	Temporary Assistance for Needy Families (TANF)	Food Stamps	Doctor's Visit	Any Mental Health (MH) Services
Target Intervention Group	0.98	0.88	1.07	0.75
Site Control Variables				
Propensity Score	0.80*	0.93	0.87	1.06
Site[1]				
Connecticut (CT)	0.34*	0.71	1.07	1.69
Phoenix, Arizona (AZ)	1.45	1.12	0.49*	1.11
St. Louis, Missouri (MO)	0.41*	0.64	1.71	1.91
Wake County, North Carolina (NC)	0.41*	0.41*	1.32	0.27*
Westchester, New York (WNY)	2.02	1.45	2.62**	0.83
Worcester, Massachusetts (MA)	1.33	1.29	1.12	1.86
Site * Group Interaction				
CT * Treatment Group	1.87	1.00	1.24	2.05
AZ* Treatment Group	0.70	1.47	0.67	1.96
MO* Treatment Group	1.37	2.04	0.48	2.56
NC* Treatment Group	1.08	1.17	0.44	3.22
WNY * Treatment Group	1.67	1.79	1.00	1.29
MA * Treatment Group	1.24	1.10	1.67	1.97
Demographic Characteristics				
Age	0.97**	0.97**	0.97**	1.02
White	0.97	0.59*	0.77	1.91***
Married	1.16	0.99	1.16	0.97
# of Children	1.12	1.15	0.87*	0.94
Education[2]				
Less than high school	1.06	0.97	1.20	1.17
More than high school	1.08	0.83	1.30	1.42
Employed	0.50**	0.84	1.15	0.71
Total Earnings	1.00*	1.00**	1.00	1.00
Service Receipt at Baseline				
TANF	5.21***			
Food Stamps		3.86***		
Doctor's Visit			1.56*	
Any MH Services				6.62***
Any Substance Abuse (SA) Services				
Any Housing Services				
Independent Measures of Need				
SF-8 Mental Health Scale				0.98
Global Severity Index				1.02
Experienced Childhood Trauma				1.52
Experienced Adult Trauma				1.12

[1] The Capital District, New York (CDNY) is the omitted category.
[2] High school diploma/GED is the omitted category.

Exhibit 7.10 continued

	Any SA Services	Any Housing Services	Any Transportation Services	Any Childcare Services
Treatment Group	1.15	0.89	0.75	0.34*
Site Control Variables				
Propensity Score	1.00	1.03	1.00	1.31
Site[1]				
CT	7.47**	0.26	1.19	0.51
AZ	4.95**	0.24**	0.92	1.42
MO	7.88**	0.41	0.58	1.00
NC	1.70	0.33*	1.23	0.20*
WNY	1.86	0.27*	0.59	0.82
MA	1.18	1.38	1.06	0.34
Site * Group Interaction				
CT * Treatment Group	0.48	3.90	1.00	0.00
AZ* Treatment Group	0.28	2.39	2.19	1.73
MO* Treatment Group	0.25	2.91	5.36**	1.51
NC* Treatment Group	1.23	1.98	1.10	8.09*
WNY * Treatment Group	1.10	1.67	1.31	0.98
MA * Treatment Group	1.71	1.12	1.34	2.11
Demographic Characteristics				
Age	1.04**	1.05***	1.01	0.97
White	1.33	1.00	0.96	1.26
Married	0.76	1.24	1.22	1.03
# of Children	0.82	1.14	0.86*	1.00
Education[2]				
Less than high school	1.13	0.86	0.97	1.69
More than high school	1.28	0.76	1.07	1.46
Employed	0.34*	0.88	0.73	1.60
Total Earnings	1.00	1.00	1.00	1.00
Service Receipt at Baseline				
TANF			2.26***	
Food Stamps				3.65***
Doctor's Visit				
Any MH Services				
Any SA Services	1.089***			
Any Housing Services		1.43		
Independent Measures of Need				
Positive Alcohol Screening	1.96			
Positive Drug Screening	81.27*			
Proportion Adult Life Abused Alcohol	1.17			
Proportion Adult Life Abused Drugs	3.35**			
Ever in Jail/Prison for Conviction		0.86		

[1] CDNY is the omitted category.
[2] High school diploma/GED is the omitted category.

Exhibit 7.10 continued

	Any Parenting Services	Any Employment Services	Any Child MH Services
Treatment Group	1.07	1.52	0.26*
Site Control Variables			
Propensity Score	1.00	1.07	1.00
Site[1]			
CT	0.85	0.75	0.00
AZ	1.87	2.70*	0.70
MO	3.84*	1.26	0.35
NC	0.72	1.35	1.06
WNY	0.40	1.10	0.39
MA	2.25	0.91	0.52
Site * Group Interaction			
CT * Treatment Group	2.12	1.09	
AZ* Treatment Group	0.50	0.48	1.26
MO* Treatment Group	0.70	1.51	5.87
NC* Treatment Group	2.21	1.10	1.39
WNY * Treatment Group	1.06	0.44	2.78
MA * Treatment Group	1.39	0.68	3.22***
Demographic Characteristics			
Age	1.01	1.00	1.04*
White	1.13	0.95	1.65
Married	1.00	0.67	1.95*
# of Children	0.92	0.90	1.14
Education[2]			
Less than high school	1.23	0.56**	0.42**
More than high school	0.76	1.08	1.03
Employed	0.71	0.64	0.50
Total Earnings	1.00	1.00	1.00
Service Receipt at Baseline			
Any Transportation Services			
Any Child Care Services			
Any Parenting Services	3.18***		
Any Employment Services		1.81**	
Any Child MH Services			11.62***
Independent Measures of Need			
Parenting Scale	0.87		
Child MH Problems at Clinical Level			2.64***

[1] CDNY is the omitted category.
[2] High school diploma/GED is the omitted category.

Program Ingredient Analysis

Program Ingredient Measures

The target interventions and the comparison interventions ranged in their emphasis on mental health services, as well as other service areas, both with respect to what was offered and the intensity with which it was provided. To describe how these various program components or "ingredients" differ between target and comparison intervention conditions and among the study sites, and to examine the extent to which variations in services relate to outcomes, program level data were collected on each target and comparison intervention. Data were collected through case studies in each project intervention location involving site visit interviews, focus groups, and document reviews.

Transportation and Financial Services

Transportation and/or financial services offered in the intervention received a score of (1) whereas no services provided in this area received a (0).

Health Services

Measures collected on health services included whether the intervention had designated physical health staff members and offered health services. These measures were summed into an ordinal measure with a range of 0–3. Sites that did not offer health services and had no health practitioners were given a score of 0. A low (1) score was given if a program offered health services. Medium (2) programs had only nurses on staff and provided health services. High (3) programs had nurses and doctors onsite and provided onsite health services.

Mental Health Services

The study assessed the presence of several mental health service ingredients, including whether the intervention had designated mental health staff members, psychiatrist(s) and/or psychologist(s), onsite mental health therapy/services, and mental health training for staff. These Program Ingredient measures were summed into an ordinal measure with a range of 0–3. Interventions scored 0 when no mental health services or training was provided onsite. A low (1) score was given if an intervention had two or fewer of the ingredients provided at a limited or low level. Medium (2) programs had designated staff, training, and some level of onsite services. High (3) programs had designated staff, training, onsite services, and some level of psychiatrist/psychologist onsite.

Substance Abuse Services

Substance abuse program ingredients included having designated substance abuse staff, having onsite substance abuse treatment or other services, and having staff training in substance abuse. The summary score ranges from 0–3. Programs scored 0 when none of these components were present. A low (1) score was given if a program only had a

designated substance abuse staff and/or staff received some sort of substance abuse training. Medium (2) programs provided limited onsite substance abuse services in addition to having designated substance abuse staff and substance abuse training for their staff. High (3) programs were similar to the medium program, but provided a full array of onsite substance abuse services. When a target or comparison program had more than one service delivery site, a program ingredients score was developed for each "sub site" and associated with the participants in that particular sub site.

Trauma Services

Trauma program ingredients included having onsite trauma recovery services and trained trauma services staff. The summary score ranges from 0–3. Programs scored 0 when none of these components were present. A low (1) score was given to programs that only had trauma-informed services. Medium (2) programs provided onsite services with a non-TREM model. High (3) programs had onsite services with a TREM model.

Housing Services

Housing program ingredients included having a housing specialist, offering transitional housing, providing other housing resources, and providing permanent housing resources. The summary score ranges from 0–3. Programs scored 0 when none of these ingredients were present. A low (1) score was assigned to programs with one of the aforementioned components. A medium (2) score was given to programs with two services and a high (3) score given to programs with three or more ingredients.

Parenting Services

Parenting program ingredients included offering parenting services onsite and offering family therapy onsite. Parenting services offered in the intervention received a score of 1, whereas no services provided in this area received a 0.

Employment Services

Employment program ingredients included offering job training or employment services. Programs without such services were given a score of 0. Programs with limited job-related services were given a score of 1 and programs with extensive job services and/or training programs were given a score of 2.

Children Services

Child program ingredients included offering children's services and having a child advocate on staff. The summary score ranges from 0–3. Programs scored 0 when none of these components were present. A low (1) score was assigned to programs with limited children's services. A medium (2) score was given to programs with limited children's services and a child advocate on staff. A high (3) score given to programs with extensive services and a child advocate on staff.

Program Ingredient Results

Case management case load size is the only tested program ingredient that related to differences in service receipt. Study site interventions that had case managers with higher case loads had lower odds of families receiving physical health services, substance abuse services, and child mental health services, yet higher odds of families receiving housing services. The various program ingredients did not affect the likelihood of receiving services, but there was a great deal of variation in service receipt between the various interventions. As in previous models, younger mothers and those with fewer children had greater odds of receiving a variety of services, including TANF and doctor's visits, while older mothers had greater odds of receiving substance abuse services and housing services. Independent measures of substance abuse need and mental health need increased the odds of substance abuse services for mothers and mental health service receipt for children, respectively. Once again, the strongest predictor of service receipt for most services at three months was receipt at baseline.

Exhibit 7.11: Odds Ratio of Logistic Regression of Fidelity Measures on Service Receipt at 3 Months (N=844)

	Temporary Assistance for Needy Families (TANF)	Food Stamps	Doctor's Visit	Any Mental Health (MH) Services
Program Ingredient Variables				
Caseload	.93	1.08	.83*	1.14
Services Offered				
Transportation/Financial Services	1.05	.73		
Health Services			1.02	
Mental Health Services				1.43
Substance Abuse Services				
Trauma Services				.96
Site[1]				
Connecticut (CT)	0.53	.69	1.35	1.05
Phoenix, Arizona (AZ)	1.24	1.50	.51**	.79
St. Louis, Missouri (MO)	0.59	.84	1.53	1.19
Wake County, North Carolina (NC)	0.46*	.49	.72	.46*
Westchester, New York (WNY)	2.97**	1.66	2.83*	.33
Worcester, Massachusetts (MA)	1.39	1.39	1.61	1.38
Demographic Characteristics				
Age	.98*	.98	.98*	1.03*
White	1.06	.60*	.77	1.89***
Married	1.26	.95	1.13	1.00
# of Children	1.05	1.09	.88*	.93
Education[2]				
Less than high school	1.01	1.00	1.26	1.12
More than high school	1.07	.81	1.22	1.32
Employed	.56*	.91	1.22	.75
Total Earnings	1.00*	1.00**	1.00	1.00
Service Receipt at Baseline				
TANF	4.75***			
Food Stamps		3.62***		
Doctor's Visit			1.69**	
Any MH Services				6.40***
Independent Measures of Need				
SF8 Mental Health Scale				.98
Global Severity Index				1.02*
Experienced Childhood Trauma				1.46
Experienced Adult Trauma				1.23

[1] The Capital District, New York (CDNY) is the omitted category.
[2] High school diploma/GED is the omitted category.

Exhibit 7.11 continued

	Any Substance Abuse (SA) Services	Any Housing Services	Any Transportation Services	Any Childcare Services
Program Ingredient Variables				
Caseload	.63**	1.31*	1.15	.78
Services Offered				
Substance Abuse Services	.73			
Trauma Services	1.51			
Housing Services		1.02		
Transportation/Financial Services			1.07	
Site[1]				
Connecticut (CT)	7.76***	.58	1.06	.32
Phoenix, Arizona (AZ)	3.36*	.27*	1.13	2.49*
St. Louis, Missouri (MO)	8.37***	.51	1.17	1.56
Wake County, North Carolina (NC)	4.25**	.61	1.01	.84
Westchester, New York (WNY)	4.38*	.29*	.66	.93
Worcester, Massachusetts (MA)	2.80	1.26	1.03	.73
Demographic Characteristics				
Age	1.04**	1.04**	1.01	.97
White	1.42	.99	.98	1.12
Married	.79	1.14	1.26	1.04
# of Children	.82	1.06	.87*	1.00
Education[2]				
Less than high school	1.09	.87	.98	1.75*
More than high school	1.24	.81	1.12	1.54
Employed	.36**	.81	.73	1.66
Total Earnings	1.00	1.00	1.00*	1.00*
Service Receipt at Baseline				
Any SA Services	10.08***			
Any Housing Services		1.45		
Any Transportation Services			2.34***	
Any Child Care Services				3.82***
Independent Measures of Need				
Positive Alcohol Screening	10.18			
Positive Drug Screening	105.80*			
Proportion Adult Life Abused Alcohol	1.34			
Proportion Adult Life Abused Drugs	2.98*			
Ever in Jail/Prison for Conviction		0.88		

[1] CDNY is the omitted category.
[2] High school diploma/GED is the omitted category.

Exhibit 7.11 continued

	Any Parenting Services	Any Employment Services	Any Child MH Services
Program Ingredient Variables			
Caseload	.79	1.00	.67*
Services Offered			
Parenting/Family Services	1.88		1.28
Employment Services		1.29	
Child Services			1.55
Site[1]			
Connecticut (CT)	1.15	.62	.98
Phoenix, Arizona (AZ)	.93	1.39	.47
St. Louis, Missouri (MO)	3.13**	1.25	1.16
Wake County, North Carolina (NC)	.45	1.25	.32
Westchester, New York (WNY)	.24*	.73	.58
Worcester, Massachusetts (MA)	1.91	.76	1.41
Demographic Characteristics			
Age	1.01	1.01	1.04*
White	1.07	.89	1.32
Married	.93	.62	2.30*
# of Children	1.00	.91	1.15
Education[2]			
Less than high school	1.17	.64*	.43*
More than high school	.74	1.12	1.04
Employed	.61	.64	.41*
Total Earnings	1.00	1.00	1.00
Service Receipt at Baseline			
Any Parenting Services	2.81***		
Any Employment Services		1.60*	
Any Child MH Services			11.56***
Independent Measures of Need			
Parenting Scale	.94		
Child MH Problems at Clinical Level			2.65***

[1] CDNY is the omitted category.
[2] High school diploma/GED is the omitted category.

Summary and Conclusions

Baseline receipt of services for homeless families in the SAMHSA study sites was highest for health insurance, physical health services for children, and food stamps—all at levels of over 70 percent of the families. In two of these areas, food stamps and health insurance, receipt continued to increase from baseline to the three month period. This is not surprising as this was a time when the majority of target intervention families (roughly half of the sample) were receiving target intervention services, and when even many of the comparison group families were likely receiving some level of services

through shelters and other homeless providers. Increase in service receipt from the baseline to the three month period was evident in most other service areas as well, including receipt of TANF and child care vouchers, a range of family support services, parenting services, employment services, mental health and substance abuse services for the mother, and child care services. Housing service receipt decreased over time, but was most likely due to the sharp and steady increase in housing subsidy receipt over the 15-month period. Mothers' receipt of physical health services and dental services stayed level across the 15-month time period. Whereas receipt of physical health services was relatively high at baseline and thus had less room to increase, receipt of dental services was among the lowest of services and also reflected the highest amount of unmet need among mothers and children.

The target interventions in the study sites did not predict service receipt, as one might expect. However, when the target intervention-comparison intervention variable was replaced by a range of program ingredients, the role of the case manager did emerge for some services (represented by case management case load size). Study site interventions that had case managers with lower case loads had greater odds of families receiving physical health services, substance abuse services, and child mental health services, yet lower odds of families receiving housing services. Because housing service receipt decreases over time for the sample and housing subsidies increase, it is possible that case managers with lower case loads had greater success in helping families obtain subsidies.

Other predictors of service receipt at three months related to the individual characteristics of the families. Age of the mother was the most consistent predictor of service receipt and varied in the direction of the relationship by service. Employment and education related to receipt of TANF and employment services, and the receipt of substance abuse and child mental health services were predicted by independent measures of the need for those services. Finally, there is continuity of services, with receiving services in a number of areas at baseline proving to be the strongest predictor of receipt of those services at three months.

In sum, it appears that as families remain in shelters, their receipt of a range of services generally increases over time, though the baseline level of receipt and the increase vary by geographic area. Case managers who have the time to work with families appear to make a difference in accessing some services, especially those that are also predicted by independent measures of need—substance abuse and child mental health services. Dental services is the area of unmet service need that seems to remain for almost a third of the mothers in the sample.

These findings, unfortunately, reflect much of what we have known about the service access and receipt of families from prior studies. Although absolute percentages may vary, the research over time has been consistent in the services that are most difficult to receive for example, dental services).

CHAPTER 8: CONCLUSIONS AND IMPLICATIONS

This study was conducted to:

- Document the types of mechanisms that communities have developed to maximize access to and receipt of mainstream benefits and services by homeless families and individuals.
- Identify the effects of local realities and practices of local homeless providers and mainstream benefit/services representatives on improved access.
- See if communities have been able to compensate for the loss of funding for services following from the U.S. Department of Housing and Urban Development's (HUD) shift in priorities for Supportive Housing Program funds toward housing-related activities, by finding service funding from other sources.

The study goals were addressed primarily through qualitative inquiry, conducting site visits, and analyzing responses to interviews with multiple key informants in each community. This inquiry was supplemented with analysis of existing quantitative data from the Substance Abuse and Mental Health Services Administration (SAMHSA) Homeless Families study, and from local and national data on people leaving HUD-funded programs as reported to HUD on those programs' Annual Performance Reports (APRs).

Documenting Access Mechanisms

Most low income people face one or more barriers that hinder their ability to enroll in benefits and services from mainstream public programs. When one is homeless, these barriers increase. The focus of our work in this study has been on understanding the various barriers to access faced by homeless people and identifying mechanisms that study communities have devised to overcome them, including community organizational structure. We identified three major categories of barriers—structural, capacity, and eligibility barriers. Structural barriers are problems that people have accessing benefits and services for which they are eligible. They differ from capacity barriers, which relate to lack of or limited availability of benefits or services, and from eligibility barriers, which restrict the types of people who qualify for mainstream benefits and services.

We found many mechanisms in study communities for overcoming barriers, and classified them into three categories—smoothing, changing, and expanding. The most widespread mechanisms involved *smoothing*—making it easier to apply for benefits or services or more likely that an application will be accepted. Smoothing mechanisms do not make more people eligible for a benefit or increase the supply of benefits and services. Changing mechanisms were the least common in our study communities; these mechanisms involve actual changes in policies or practices regarding eligibility, but do not increase the overall supply of benefits or services. For example, two study communities developed a mechanism to allow people with histories of felonies access to public housing and rent subsidies, but the overall number of subsidies did not change.

We found expanding mechanisms in most study communities, but with less frequency than smoothing mechanisms because they involve commitments of new resources. Expanding mechanisms are designed to increase the supply of supportive services and benefits, and sometimes housing, available to homeless people.

Previous chapters organized their presentation of findings by barrier and by types of mechanism used to overcome the barrier, but not by specific benefits or services. We took this approach in the interest of reducing repetition, because many barriers limit access to more than one benefit, and many access mechanisms are designed to function for several benefits at once. Nevertheless, the reader will want to know what communities are doing about *each* benefit as well as what mechanisms they use, so in this chapter we summarize our findings by benefit or service type in Exhibit 8.1. This organization lets the reader see which benefits are subject to widespread efforts to improve access and which ones are less likely to be included. Exhibit 8.1 also provides a quick overview of the type of mechanism (smoothing, changing, or expanding) that study communities are most likely to use to improve access (second column), and the issues that arise for particular benefits and services as communities try to put effective mechanisms in place (third column).

One can see in Exhibit 8.1 that most study communities have created at least some access mechanisms for the major federal entitlement programs (food stamps, Medicaid, Supplemental Security Income/Social Security Disability Income [SSI/SSDI], and pensions for veterans, shown in the top panel of Exhibit 8.1), and those that have General Assistance (GA) also work to improve access to that benefit. One can also see that smoothing mechanisms are by far the most common type, with no community succeeding in changing eligibility criteria for these programs and only two communities achieving some expansion of resources.

With respect to services that are not entitlements, including Temporary Assistance for Needy Families (TANF) (second panel of Exhibit 8.1), smoothing mechanisms are still the most common approach, but at least one study community, and often more, has been able to *change eligibility* and/or *expand capacity* for each type, except TANF and health and behavioral health care specifically for veterans. These expansions represent significant new commitments of local resources, along with occasional use of state resources. The more organized the study community—the closer its central organizing structure comes to creating a coordinated community response—the more likely it is to have been able to expand capacity for at least one nonentitlement service.

Exhibit 8.1: Summary of Findings Related to Specific Benefits and Services

Benefit or Service	Smoothing, Changing, or Expanding Mechanisms in Study Communities	Issues
Entitlements (no cap on how many people can receive if eligible)		
Food stamps	SMOOTHING—**Denver, Miami, Portland, Norfolk, Albany, Pittsburgh** (through simplified applications, waiver of face-to-face interview requirements, expedited access, outreach, outstationing, "pending" applications, and suspending rather than terminating benefits during institutional stays)	Cannot change eligibility; set at federal level. Can smooth application procedures and facilitate acquisition of needed documentation. Recent federal policy is pushing streamlined procedures that increase access
Medicaid	SMOOTHING—**Miami** (children, through Temporary Assistance for Needy Families [TANF] office, mentally ill offenders through Supplemental Security Income/Social Security Disability Income [SSI/SSDI] Outreach, Access, and, and Recovery [SOAR]); **Portland** (specialized SSI staff, consolidated application); **Denver** (consolidated application, outreach, benefit suspension for institutionalized persons); **Norfolk** (Homeless Action Response Team); **Albany** (outreach at hospitals); **Pittsburgh** (consolidated application, rapid enrollment in medical assistance managed care program) EXPANDING—**Portland** (MaineCare noncategorical eligibility); **Albany** (all General Assistance [GA] recipients eligible for state-funded Medicaid)	Cannot change eligibility for basic program; set at federal level. Can smooth application procedures and acquisition of needed documentation. Some states set up additional eligibility categories and pay for coverage entirely with state dollars. Among study communities, Maine and New York do this.
Medicare	No study community specifically mentioned trying to improve access to Medicare, but SOAR and other mechanisms to improve SSI access do the same for SSDI if it is relevant, so these mechanisms will also increase access to Medicare for anyone eligible for SSDI.	Depends on eligibility for SSDI, which most homeless people will not have the employment history to qualify for, or on age (65 and older).
SSI/SSDI	SMOOTHING—**Denver, Miami, Portland, Norfolk, Albany, Pittsburgh** (through SOAR or specialized staff in public or homeless agencies, including significant cooperation that has been developed with local Social Security Administration offices)	Issues same as Medicaid. SOAR and other mechanisms make a big difference for speed and success of SSI applications.
General Assistance	SMOOTHING—**Portland, Pittsburgh** EXPANDING—**Denver** (increased motel vouchers using General Assistance funds)	Many states do not have General Assistance; for those that do, eligibility thresholds and benefit levels are very low.
Veterans' disability benefits	SMOOTHING—**Denver, Miami, Portland, Norfolk, Albany, Pittsburgh**	Need honorable or general discharge, length of service, documentation is an issue, vets of older wars losing priority to newer vets.
Veterans' pension	SMOOTHING—**Denver, Miami, Portland, Norfolk, Albany, Pittsburgh**	
Other Benefits and Services (resources usually not sufficient to serve all eligible people)		
TANF	SMOOTHING—**Portland, Denver, Norfolk, Pittsburgh** (consolidated	Eligibility, length of receipt, requirements

Exhibit 8.1: Summary of Findings Related to Specific Benefits and Services

Benefit or Service	Smoothing, Changing, or Expanding Mechanisms in Study Communities	Issues
	applications, language lines, computerized search for documentation)	for participation, and sanctioning policy are set at state level, with little local flexibility to modify.
Health care	SMOOTHING—**All** (Health Care for the Homeless [HCH]), **Miami** (post-shelter linkage); **Denver** (priority at clinic, mobile unit); **Pittsburgh** and **Albuquerque** (co-location) EXPANDING—**Miami** (Homeless Trust purchase of health services), **Portland** (MaineCare for noncategoricals); **Denver** (new medical respite program)	State or local jurisdictions must commit resources; of study communities, only Portland (Maine) has expanded Medicaid eligibility through state-only funding.
Mental health services other than through Medicaid	SMOOTHING--**Miami** (purchase of services); **Norfolk** (Projects for Assistance in Transition from Homelessness [PATH] and Assertive Community Treatment [ACT] teams); **Albany** (single point of access, co-location); **Pittsburgh** (case management, provider coordination, co-location); **Albuquerque** (co-location) EXPANDING—**Miami** (Homeless Trust purchase of services, state and federal grants, county funds); **Denver** (new ACT team); **Pittsburgh** (new funds for behavioral health managed care entity)	Funding falls extremely short of need in all study communities.
Substance abuse treatment other than through Medicaid	SMOOTHING--**Denver** (PATH, Benefit Acquisition and Retention, and Homeless Outreach teams); **Albany** (single point of access); **Pittsburgh** (provider coordination) EXPANDING—**Portland** (HCH expansion, provider specialization); **Albuquerque** (new city funding for Sobering Center/single point of entry for substance abuse services)	Funding falls extremely short of need in all study communities.
Federal rent subsidies or public housing	SMOOTHING—**Portland, Denver, Norfolk** CHANGING—**Pittsburgh** (changed Moving to Work felony rehabilitation clause systemwide); **Albuquerque** (adjusted felony rules for one program's clients)	Far too few subsidies, waiting lists are extensive or closed, not all give priority to homeless households.
State/local rent subsidies	EXPANDING—**Miami** (for ex-offenders with mental illness); **Denver** (Road Home funds); **Portland** (access to state subsidies); **Albany** (two local housing trusts); **Pittsburgh** (Local Housing Options Team); **Albuquerque** (city funds to support housing first program)	Shows strong local commitment, but still too few.
Use of Community Development Block Grant and Home Investment Partnership for homeless-related housing	CHANGING/EXPANDING—**Denver, Norfolk, Pittsburgh**, **Portland** (similar resources from state housing authority/housing finance agency)	Rare nationally, so having four out of seven study communities allocating resources from these U.S. Department of Housing and Urban Development block grants to homeless-related residential programs reflects the consequences of high-level executive leadership on ending homelessness.

Exhibit 8.1: Summary of Findings Related to Specific Benefits and Services

Benefit or Service	Smoothing, Changing, or Expanding Mechanisms in Study Communities	Issues
Employment and training	SMOOTHING—**Denver, Norfolk** CHANGING--**Albuquerque** (Vocational Rehabilitation resources for women with criminal histories) EXPANDING—**Pittsburgh** (Homeless Children's Education Fund)	Federal performance standards may discourage some One-Stops from serving people with disabilities; pressure for people to be work-ready.
U.S. Department of Veterans Affairs (VA) health/ behavioral health care	SMOOTHING—**Denver, Miami, Portland, Norfolk, Albany, Pittsburgh**	Same as for VA cash benefits.

Evidence of Access to Benefits

Evidence regarding connections to mainstream services and benefits is generally incomplete. Ideally, one would want to track people as they first connect to the homeless system and follow them through until they are stably housed either in the community or in permanent supportive housing within the homeless system itself. One would want to know what income sources they had when they first contacted the system, and also what services (for example, housing stabilization, case management, mental health or substance abuse treatment) they might be receiving. Thereafter, one would want to know when they applied for and started receiving various cash and in-kind benefits (for example, SSI, Medicaid, food stamps), and likewise whether and for how long they received various supportive services. Unfortunately, none of the communities in this study, and probably few if any in the country as a whole, collect this information.

In discussions with local officials regarding access to data from the local homeless management information system (HMIS), we found that reports with the kind of information we were expecting are not available. These systems are not structured to collect or report the information that would be most useful for evaluation purposes. They do not necessarily enter a person into the system at first contact with a homeless provider, and some people are never entered. Information is most complete for income-related benefits because it is required by APRs; information on services (*for example,* for mental illness and substance abuse) is rarely present. Furthermore, information entered once is not routinely updated until a person leaves a program, so communities have only very limited information for current clients about the effectiveness of their efforts to assure access to mainstream services and benefits, either at a single point in time or over time. For people who stay in the system a short time, this absence of information might not be so bad, but for people who stay for months or years, as is the case for many residents of transitional and permanent supportive housing programs, it proved to be a significant problem for purposes of this study.

Because no study community had the right data for assessing improved access to services (Portland came the closest), we had to rely on information from APRs, which describe receipt of income from mainstream benefits at program entry and program exit for people leaving transitional and permanent supportive housing programs—often a long time after they initially contacted the homeless system. In addition, only four study communities (Miami, Norfolk, Pittsburgh, and Portland) were able to supply APR data.

We found evidence that individuals exiting HUD-funded programs in these four study communities were likely to be connected to income sources (SSI/SSDI, TANF, GA, food stamps, and employment) at rates for 2007 that exceed national rates for that year for people leaving similar programs. Among these benefits, the highest rates of enrollment were for food stamps (40 percent or more in three communities). The four study communities reported very different rates of SSI and SSDI receipt, ranging from 7 to 19 percent for SSI and from 3 to 11 percent for SSDI. For two communities, GA is at or

near0 while it is at 19 and 22 percent in two others. TANF receipt ranges from 1 to 23 percent in the four study communities with data.

The higher rates of enrollment in food stamps reflect the primary reality that basic eligibility is broadest for food stamps, and also the fact that many barriers to access have been reduced through structural mechanisms (for example, outreach, waiver of face-to-face meetings) described in Chapter 4. Variation in access to SSI/SSDI reflects the high barriers to access that are more likely to have been addressed, at least in part, by whether communities have trained staff in the SSI/SSDI Outreach, Access, and Recovery (SOAR) model. Variation in GA reflects the fact that many states do not have GA. We may speculate that variations in rates of access to TANF may reflect the extent to which communities have adopted mechanisms (*for example*, outreach) to overcome the barriers to this program, but they are equally likely to reflect the differential restrictiveness of TANF eligibility and application rules set by states. Across all programs, smaller communities, Norfolk and Portland, have much higher participation rates than the larger communities, Miami and Pittsburgh.

Rates of enrollment in Medicaid in the four study communities do not differ from national rates for people in similar programs. Within the four study communities these also vary widely, ranging from 4 to 24 percent at exit from HUD programs. Again, Norfolk and Portland have the higher rates. No data are available on rates of enrollment in services such as primary health, mental health, or addictions care, or in life skills development or employment supports.

In addition to the "hard" data we were able to assemble from study communities, many of those interviewed gave their perceptions that one or another mechanism had improved access. Examples include:

- Mainstream benefits workers at many Portland agencies who said that following the trainings, the applications they received were more accurate and more complete, with fewer applications from clearly ineligible people.

- Outreach workers in Denver's Homeless Outreach Collaborative talking about their increased ability to connect and follow through with many potential clients, their improved success at helping those clients get benefits, and their improved relationships with mainstream agencies, all of which contributed to Denver's documented reduction in street homelessness through placement in permanent supportive housing with the cash and noncash benefits necessary to keep people in housing.

- Testimony from many study communities that participating in SOAR training and negotiations with Social Security Administration (SSA) offices has greatly increased the proportion of applications for SSI/SSDI that are successful on initial application and greatly reduced the time to decision.

- Descriptions of how Norfolk's Department of Human Services streamlined and rationalized the way its various programs interacted with homeless families to

eliminate contradictory and counterproductive demands, and focus on ending families' homelessness first.

Data from the SAMHSA Homeless Families study, reviewed in Chapter 7, indicate generally high rates of participation for study families in Medicaid and food stamps (consistently above 70 percent) and TANF (between 44 and 63 percent), with much lower participation in other programs.[20] Patterns of participation for all three of these welfare programs, plus mental health and substance abuse services, were highest at the 3 month follow-up and then dropped off by 15 months after baseline, suggesting the influence of program help to get benefits that operated during the initial months after first program contact. Additional influences on later participation rates may include loss of eligibility (for example, for TANF, families may have exhausted their months of eligibility), new episodes of homelessness that resulted in benefit termination, and stabilizing to the point of not needing benefits any more. Some benefits that take longer to access showed a different pattern, however, increasing steadily over the course of the study. These included SSI and SSDI and housing and child care subsidies, all of which probably required assistance from case managers to access, but which have extended periods of application processing or wait listing. The only program characteristic that made a difference to the probability of benefit receipt was case load size, with smaller case loads generally resulting in clients being more likely to receive benefits.[21]

Population Differences

The populations under study are homeless single adults and homeless families. For both populations we sought to distinguish between access to mainstream benefits and services for those who also have disabilities and those who do not. In general, if access to a particular benefit or service is difficult for one population, it is difficult for all. For example, if barriers to access to food stamps are reduced or eliminated by adopting particular mechanisms in a community, the change should affect all populations equally. The exceptions occur when eligibility for a particular benefit or service is restricted to only one population or when some characteristic of the population interacts with a barrier.

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[20] These enrollment rates for SAMHSA Homeless Families participants are substantially higher than the rates for the same programs reported by the communities in the present study. Reasons include the fact that all SAMHSA participants were family households, and thus eligible for TANF, that enrollment in food stamps and Medicaid is usually done at the same time as TANF intake, and that average monthly TANF caseloads were 25 percent higher in 2000 (2.2 million families), when recruitment for the Homeless Families study was occurring, than in 2007 (1.67 million families) (accessed June 13, 2009 at (http://www.acf.hhs.gov/programs/ofa/data-reports/caseload).

[21] Data collection for the SAMHSA Homeless Families study did not include asking about the rationale behind service delivery strategies, whether any changes had occurred during the family intake period, or rationales for any changes that did occur. We cannot, therefore, know whether study programs thought strategically about how case load size might affect success in helping clients access benefits, or whether they set their case load size as a result of such thinking.

Benefits that are relevant to only one population include TANF, which is restricted to families; SSI/SSDI, which are restricted to persons with disabilities; and Medicaid, which is restricted to persons who receive TANF or SSI unless a state has its own indigent health insurance program. Further restrictions usually exist for each of these benefits related to income cutoffs and, for SSI/SSDI, the extent and duration of a disability and its type. It has historically been harder to qualify for SSI/SSDI with a mental than with a physical disability.

Access to benefits and services interacts with a characteristic of the population in the case of people affected by the complexity and length of applications, such as those who have learning disabilities, limited English proficiency, poor reading and writing skills, or serious mental illness, although there are certainly many exceptions among the disabled and nondisabled populations alike. All other things being equal, people with these issues will have a harder time applying for benefits, which is one reason for developing access mechanisms to help them get to and through the process.

The structure of a community's homeless assistance system may also affect access, if the system puts more resources into helping one, rather than another, type of household connect to services. For example, if a community provides central intake for currently homeless or at risk families, with assessment, case management, short-term housing, and other assistance to prevent or shorten the period of homelessness, but does not do so for single adults, then household type will interact strongly with access to benefits and services and ultimate receipt of the help a household needs.

Local Realities

We examined the independent effects that local realities and practices of local homeless providers and mainstream benefit and service representatives have on homeless individuals' and families' access to mainstream benefits and services. The entire report has identified many of the variations among study communities that affect homeless people's access to mainstream services. Two major factors are the availability of resources and the ways that communities organize themselves to address homelessness, which of course also interact with each other, generally following the idea that a stronger organization is able to generate more resources and develop more integrated and effective access mechanisms.

Resources

In Chapter 5 we described the consequences of resource availability or its absence on the ability of communities to expand program capacity in accord with documented need for benefits or services. These resources could be available because the community is in a generous state and local stakeholders know how to bring state resources into their community, or they could be absent because the state is among the poorest in the country or chooses not to support "welfare" functions. Local resources also come into play in several study communities, in the form of a self-imposed tax in Miami and Dade County, significant fundraising from multiple sources in Denver, strong foundation support in Pittsburgh and Allegheny County, or sophisticated drawing down of various federal and

state resources in most study communities. The experiences of study communities point to the importance of local context (state generosity, foundation resources) and organizing structure and skill (advocacy, resourcefulness) in developing the resources needed to address access issues. Of course, it is not usually easy to convince decisionmakers to commit resources to innovative approaches, so many study communities recognized the need to collect evidence of success and use it strategically to bolster commitments of existing resources and generate new commitments.

Organizing Structures

Most of the communities included in this study have strong central organizing structures. The structures vary in their placement within or outside of local government, organization, longevity, and scope, but it should be clear from the many examples throughout this report that having such a structure is extremely helpful in promoting improved access to mainstream benefits and services, as well as in many other ways. The study community with the least centralized structure, Albuquerque, is also the community in which access mechanisms are more likely to depend on informal relationships rather than institutional commitments, and in which the community itself has been least able to generate local resources. After discussing community responses to HUD's shift in funding priorities for its homeless-related resources, we return to the issue of organizational structures to analyze their presence and the way they have been able to affect access to mainstream resources.

Responses to Change in HUD Policy

In 2000, HUD adopted a policy of urging communities to use more of its Supportive Housing Program (SHP) resources to fund housing-related activities and less to fund services. HUD is the only federal agency that provides permanent supportive housing; many federal agencies provide services. HUD had previously given discretion to Continuums of Care (CoCs) to use HUD homeless funds on whatever mix of eligible activities they preferred. As a result, in 2000, nearly 60 percent of HUD homeless funds were used by communities for services such as daycare and drug treatment while the remaining funds were used for housing. With most of HUD's funds committed to renewals of existing projects, there was little money available for new projects and, with much of it going to services, little new housing was being created. Understanding this situation, Congress directed HUD to use more of its funds to create and sustain permanent supportive housing. In response, HUD created incentives in the Continuum of Care competition to encourage communities to use more of its funds for housing and less for services. It was argued that the services no longer covered by SHP funds could be funded instead by increasing the participation of program tenants in mainstream services. Competition rules for annual CoC funding applications also encouraged this direction. Through this encouragement, Continuums gradually shifted their emphasis toward creating more housing and accessing mainstream benefits programs to cover the services that were integral parts of the programs. Today (2009), about 66 percent of HUD competitive funding goes to housing and about 33 percent goes to services, which are concentrated more on case management and other core services that help keep people in housing, and less on activities that are the province of other federal agencies. This shift

and increased appropriations helped create over 40,000 new permanent supportive housing units since the new policy took effect.

Exhibit 8.2 shows how the seven communities in this study changed in response to this policy shift. For each community, the proportion of funds allocated to housing and services for the year 2001 and the year 2007 are shown (third panel), followed by the change in funding for each category as a proportion of 2001 dollars (fourth panel).

Exhibit 8.2: Changes in Allocation of U.S. Department of Housing and Urban Development Funding to Housing and Services

Community	Funds Allocated to Housing and Services				% Housing Funds		% Change in Funding	
	2001		2007					
	Housing	Services	Housing	Services	2001	2007	Housing	Services
Albany	1,061,768	795,433	1,696,651	644,347	57%	72%	+60%	-19%
Albuquerque	2,346,299	1,064,613	3,218,311	1,267,634	69%	72%	+37%	+19%
Metropolitan Denver	4,193,230	2,910,208	7,386,918	2,755,312	59%	73%	+176%	-5%
Miami-Dade County	6,963,330	6,998,459	13,061,931	10,334,852	50%	56%	+187%	+48%
Norfolk	1,659,439	781,477	1,667,750	761,086	68%	69%	+1%	-3%
Portland	832,581	558,962	1,727,027	862,360	60%	67%	+207%	+54%
Pittsburgh/Al. County	3,578,840	7,645,495	10,669,711	3,546,858	32%	75%	+289%	-54%

Four of the seven communities more than doubled their receipt of housing resources (capital and, mostly, rent subsidies) from the SHP, and one community (Pittsburgh) came close to tripling it, reflecting the increased resources available through the SHP thanks to larger congressional appropriations, as well as their own success in winning those resources through annual applications to HUD. Albany and Albuquerque also experienced substantial increases in SHP housing resources (60 and 37 percent, respectively). Only Norfolk remained essentially static in its SHP housing-related funding.

The same is clearly not true for SHP services funding, as shown in the last column of Exhibit 8.2. Services funding either increased considerably less than housing resources as a proportion of all SHP funding, or actually declined. Some declines were very small (3 and 5 percent for Norfolk and Denver, respectively), but Albany received 19 percent less services funding from SHP in 2007 as it did in 2001, and Pittsburgh received less than half the services funding in 2007 as it did in 2001. In the case of Pittsburgh, this change appears to be linked to the very low proportion of its SHP funds that were going to housing in 2001, and the very dramatic shift that occurred between that year and 2007—the largest shift of any study community, from 32 to 75 percent (third panel of Exhibit 8.2).

What Exhibit 8.2 does not show, because communities could not give us complete and reliable information about non-SHP funding for services, is the *total* amount of money

going to services, combining SHP and non-SHP funds. Only these figures could show the real capacity of communities to replace SHP service dollars with local funding for services. The figures we do have suggest that one of two things may have happened:

- People in temporary housing and permanent supportive housing could be getting a lot less by way of services in 2007 than they did in 2001, because there is less services funding on a per-unit basis and also because there is less services funding in an absolute sense, even if the number of housing units had not increased.

- Local resources could have been mobilized to replace the SHP funding that shifted from services to housing, at a minimum, and to provide an equivalent or increased level of supportive services to new housing units, at a maximum.

We know in the case of Pittsburgh that the county Department of Human Services (DHS) was able to shift contractual resources toward compensating for the reductions in services funding coming from HUD, and that foundation support also filled in some gaps, at least in the short term. We just don't know by how much, or whether the current services funding provides equivalent supports on a per-unit basis. We know that Denver has systematically raised money to cover the cost of services as part of implementing its Ten Year Plan (10YP), but again we do not know exactly how much locally-raised funding is being devoted to supportive services. We also know that some other study communities did not have the capacity to raise or shift resources, but again we do not know the extent of their current shortfall, nor do we know its effects.

In discussions of the change in HUD policy during site visits, community leaders described the following:

- Some communities are able to find additional resources to support new services (for example, Denver) or to substitute for the lost services funding (for example, Pittsburgh, which was able to replace at least some behavioral funding through DHS and foundation support).

- Some communities could not find additional resources and have been forced either to cut back or to forgo needed new services.

- Some communities have not changed their allocation of SHP funds between housing and services. Some were already devoting a high proportion of their HUD request to housing (Norfolk, Albuquerque), some were willing to accept the risk of a reduction in funding in the Super Notice of Funding Availability (SuperNOFA) process, and some relabeled basic services, such as housing stabilization, as operations funding. One interviewee who was the head of the CoC thought there was some kind of tacit approval of this strategy from HUD because no one was telling them that it "was wrong."

Thus the shift in HUD policy made little effective difference in some communities, while in others, a convergence of the HUD policy shift, perceived dependence on HUD

funding, and local circumstances appears to have led to a perceptible increase in efforts to maximize mainstream benefit access.

Of the three categories of barriers we have discussed, HUD's shift of SHP resources toward supporting more housing and fewer services affects capacity barriers most strongly, by reducing resources for specific services such as mental health and addictions treatment as well as the one-to-one supports that are needed to help people stabilize in housing and begin the process of increasing self-sufficiency. If the reduction in service resources on a per-person or per-unit basis also means that program staff have less time to spend on linking clients to mainstream benefits and services, the implication is that homeless people will get less help to overcome the widespread structural barriers described in Chapter 4, and thus will be less likely to receive benefits and services for which they are actually eligible. The more efficient and effective of the mechanisms described throughout this report will become even more important.

Even the communities in this study, with their relatively strong organizing capacity, have generally not completely replaced the service dollars that would have provided per-unit resources equivalent to what they received from HUD in 2001. The odds are that most other communities in the country have been about as successful as homeless people themselves in obtaining these resources in any systematic or reliable way.

Finally, there is the issue of a community's ability to find resources for the capital development and especially the operating aspects of supportive housing. If a community is able to obtain non-SHP funds to support the capital and operating costs of housing units—as Portland does with the help of MaineHousing, the state's housing finance agency; Miami-Dade County does with the support of several agencies that control housing resources; and Denver does with special fundraising—its HUD-specific portfolio will likely tilt more heavily in the direction of services funding. It may make sense to give these communities credit for their ability to fund housing and let them use a higher proportion of their SHP funds for services without being penalized in the competitive scoring of SuperNOFA applications.

Understanding the Importance of Organizing Structures

Throughout this report we have described many examples of the ways that communities work to increase homeless people's access to mainstream benefits and services. Can we go farther than this—farther than a list, however long—and draw some conclusions about likely effectiveness? We think the "four Cs" and change indicators frameworks presented in Chapter 1 give us the tools to do so. To reiterate, the "four Cs" are communication, coordination, collaboration, and coordinated community response. These are useful concepts in identifying the level of organizational commitment embodied in a mechanism to overcome barriers, with communication indicating the lowest level of commitment and coordinated community response indicating the highest level. The change indicators are power, money, habits, technology or skills, and ideas and values; observed changes in these indicators can reflect that a system or set of systems has really changed in ways that are likely to last.

Using the Four Cs to Categorize Access-Improving Mechanisms

The most minimal form of facilitating homeless people's access to mainstream benefits is a personal relationship between one case worker and one mainstream agency staff member. Such relationships certainly facilitate access to that mainstream agency's offerings for that case worker's clients, but they usually do not survive when one of the parties leaves his or her job, and new staff must "start from scratch," as we heard many times during site visits. Because this disadvantage of relying on personal relationships is quite large, during site visits we looked for mechanisms that had more staying power—that involved some *systematic* approach to improving access, often developed and sustained by the community's central organizing structure for ending homelessness.

Many mechanisms for improving access start by improving *communication* between those who have homeless clients needing a benefit or service and those in mainstream agencies who process applications. Arrangements such as Portland's systematic training programs are designed to establish and improve communication for many staff in many agencies simultaneously, thereby greatly improving effectiveness beyond what individuals can accomplish acting on their own. The community's commitment to repeat the process as often as needed addresses the issue of staff turnover and expands the communication to involve staff of both homeless-specific and mainstream agencies in learning about each other and making accommodations to smooth the process of benefit application and approval. The participation of mainstream and homeless agency directors in the decision to offer these trainings, reached through a committee of Portland's central organizing structure, puts the weight of agency policy behind the improved communication and coordination processes, and increases the odds that the changes will persist even when staff turnover means that new staff will occupy the street level positions in homeless and mainstream agencies.

Improving *communication* is also evident as a motivation for Project Homeless Connect in many of our study communities. Project Homeless Connect, a one-day event that most communities repeat once or twice a year, strives for extensive community involvement as a way to improve community members' understanding of homelessness and homeless people, at the same time that it works to link homeless people to benefits, services, and a wide variety of assistance that homeless people may not have known about or been able to access. Central organizing structures are responsible for staging Project Homeless Connect in most study communities.

Communication is the main level of engagement involved when homeless services providers use legal aid agencies to help clients get benefits. Basically, the provider knows someone who has already established communication with one or more mainstream agencies and links clients to that person. Albany uses a legal aid agency to help homeless clients qualify for welfare and other services; several other study communities use legal aid primarily to handle SSI/SSDI applications, and particularly appeals of an initial negative decision.

In study communities with strong central organizing structures, regular meetings of people engaged in similar or complementary activities also foster *communication* that often leads to new or revised procedures, approaches, or even programs. Several communities have regular meetings of outreach workers or teams that facilitate their work beyond the level of assisting individual clients. Health care workers comprise another group that meets regularly in some communities with resulting improvements in service delivery. In some study communities, 10YP committees continue to play active roles in community education and involvement and service development and delivery. Many people attested to the beneficial effects of these regular opportunities for talking together on their understanding of each other's capabilities and, ultimately, on their ability to better serve clients and connect them to benefits.

Most mechanisms reported in this study operate at least at the level of *coordination*, which cannot happen until good communication has been established among all relevant participants. All of the outreach, co-location, and outstationing mechanisms described in earlier chapters involve *coordination* between at least two agencies; often more agencies are involved. Multi-agency teams and multi-service centers represent *coordination* to the extent that they facilitate access to benefits and services that each agency offers but do not change basic things about their own agency such as eligibility, duration of benefits, what benefits will cover, and the like. Albuquerque's St. Martin's Hospitality Center, Albany's Sheridan Hollow Drop-In Center, Denver's St. Francis House, Portland's Preble Street Drop-In Center, and Miami's Homeless Assistance Centers are examples of co-location and outstationing. St. Martin's Hospitality Center and several Pittsburgh providers, being mental health providers as well as homeless assistance providers, are examples of coordinated service delivery related to mental health.

The level of *collaboration* involves joint goal-setting, planning, and implementation by two or more agencies that commit to adjusting their policies and practices as needed to meet the needs of shared clients, or clients who should be shared because they need the services of all participating agencies. At the level of two agencies, one homeless and one mainstream, we can see the simplest form of *collaboration* in Albuquerque, where the local housing authority has agreed to waive some of its restrictions related to criminal history for clients of one agency, Crossroads, if the clients can demonstrate their involvement in rehabilitation. A broader example on the same theme occurred in Pittsburgh, where the housing authority agreed, under the aegis of its new Moving to Work program, to expand eligibility for homeless people with criminal histories if they could show their involvement in rehabilitation. The first is agency-specific and resulted from the negotiations of two agencies; the second is communitywide and resulted from community discussions orchestrated by the central organizing structure of how to remove specific barriers to a valuable mainstream resource for all homeless people with criminal histories.

Most examples of *collaboration* in this study evolved with the support and assistance of community organizing structures that themselves demonstrate extensive *collaboration.* As the examples in Chapter 3 demonstrate, having a strong central organizing structure, especially one with the ability to generate some of its own flexible resources, is the surest

way to design, implement, and support collaborative mechanisms. Among these mechanisms in study communities are Denver's Homeless Outreach Collaborative, Miami's Criminal Mental Health Project, and Norfolk's Homeless Action Response Team for families.

Finally, the central organizing structures of several study communities achieve the level that may be called a *coordinated community response*. Portland's Emergency Shelter Assessment Committee brings together all relevant players, including state and federal agencies, to assure that the community's homeless assistance system functions as smoothly as possible and achieves the goals of preventing homelessness or ending it quickly. Its two and a half decade history supports its highly cooperative way of operating, whether the task is to identify remaining issues and gaps or implement solutions. Miami's Homeless Trust also benefits from a long history of accomplishments, and recently negotiated a memorandum of agreement with many mainstream agencies that ties them into working with the homeless system in a more integrated way. Denver's Road Home mobilizes housing and service resources from many public and private sources, coordinated and facilitated by the mayor's office, to fulfill a highly articulate and detailed plan to end homelessness in Denver in 10 years. All three use data strategically for feedback to improve performance and also to keep the community informed of progress and maintain high levels of community support.

The point has already been made in Chapter 3 that a strong central organizing structure helps move a community's overall response to homelessness from the pre-communication level through improving communication and coordination. These transitions are in the service of making the real changes in the policies and operating procedures of multiple agencies that constitute collaboration and ultimately a *coordinated community response.* They are far less likely to happen in communities without a central organizing structure or where a structure exists but it is weak and missing many important stakeholders.

Using Change Indicators to Assess Whether a Mechanism Represents a Real Shift in Policy and Practice

Changes in *power* toward the goal of ending homelessness by many means, improving access to mainstream benefits among them, is evident in several study communities, especially those that have come relatively recently to the ending homelessness goal. The two best examples are the mayors of Denver and Norfolk, whose commitment has helped create strong central organizing structures and substantial progress. Other examples of dramatic policy changes following the commitment of people in power include:

- The restructuring of Pittsburgh's Department of Human Services under a new director more than a decade ago and the consequences in the department's ability to integrate activities across programs and to respond fruitfully to changing circumstances.

- The spread of the Crisis Intervention Team approach to policing and evolution of the Criminal Mental Health Project that grew out of the dedication of a circuit court judge and the support of the mayor of Dade County.

Changes in *money* applied to the task of improving access to mainstream services are documented throughout this report. The investment in outreach made by the Homeless Trust in Miami and Denver's Road Home are obvious examples. Others include Miami's arrangements for assuring health care during and after a stay at a Homeless Assistance Center, Portland Health Care for the Homeless's expansion to incorporate substance abuse treatment services into its treatment options, Pittsburgh's shift of Department of Human Services resources to cover behavioral health service needs of homeless people, Norfolk's use of state and then local resources to rapidly re-house homeless families, and Denver's creation of a Homeless Court to reduce the access barrier of having criminal warrants.

Changes in *habit* are evident in many of the accommodations that public agencies in study communities have made to facilitate access. These include outstationing eligibility workers, accepting applications over the phone or online, changing agency operating procedures to set aside one or more days just to process applications from homeless people or flagging applications from homeless people for expedited processing, simplifying application documents and procedures, working together to facilitate SSI applications, coordinating across programs doing the same thing (for example, central coordination of outreach activities), using computerized access to verify identity or eligibility, and the like.

Changes in *technology or skills* are also widely apparent in the way that many mechanisms operate. SOAR is a widespread example of the effects of training on increasing the success of SSI applications. Use of Crisis Intervention Team approaches, supported by widespread training of police officers throughout Dade County, brought new skills to bear on how to avert violence during incidents arising from mental health crises and assure that people get connected to appropriate services. Training in eligibility requirements and application procedures improved the ability of many caseworkers throughout Maine to link their clients to mainstream benefits. New computerized universal applications for welfare benefits, and sometimes other services, are being used in many communities. The consolidated application in one study community covers at least 10 mainstream programs, letting applicants enter data once and assessing the information to determine all the programs for which the person is eligible. Language lines bring the advantage of being understood to mainstream agency clients who may speak as many as 30 or 40 different languages.

Changes in *ideas and values* are essential for sustaining changes in the long term. Several important new ideas that drive program development are evident in study communities. First and foremost is the idea that communities can actually end homelessness rather than just manage it. This is the idea that underlies the push for communities to create and carry out 10YPs, all of which are designed to end either chronic homelessness or all homelessness in the foreseeable future. The goal of ending

homelessness represents a paradigm shift in community response to homelessness that has led to very different behaviors and practices in many areas of the country (Burt et al. 2004). Six study communities have 10YPs and Albuquerque has a 5 Year Plan, but there are dramatic differences in the extent of community investment in fulfilling these plans, even among the seven communities included in this study. Clearly, adopting a new idea without accompanying changes in power and money cannot do as much as when all three go together.

A change in ideas and values that often accompanies the drive to end chronic homelessness is a community's recognition that it must offer housing to people who have been homeless a long time, have numerous disabilities, and are the visible street presence of homelessness that the public mostly knows, but that these people are not likely to accept housing if they must first become clean and sober and, if relevant, compliant with psychiatric medications. What has become clear through the experience of many communities, plus research evidence, is that most of the target population will ultimately accept housing that is low barrier and that operates on the principle of "help them get housed first; nothing can be resolved while they are still on the streets." This low barrier "housing first" approach is probably the most important mechanism, nationally, for expanding eligibility for housing to people with mental illness, addictions, or both. All seven study communities have at least some projects that follow this model; some (Denver, Miami) have invested heavily in this approach, with direct effects in reductions in street homelessness. Once in housing, this model works to connect its formerly homeless tenants to appropriate care and treatment of all kinds, as well as to housing.

It is rare for the five indicators of system change to occur in isolation. In general, the more indicators present after a community has been working to end homelessness for a while, and the stronger and more interconnected they appear to be, the higher the odds that changes in the community's approach to homelessness are real and that they will likely be long lasting.

Implications

Ending homelessness will not occur without housing opportunities for individuals and families who are now homeless. However, housing alone is often not sufficient. There must also be supports, particularly mainstream benefits and services. Without these supports, some individuals and families will not move successfully into permanent housing, nor will they be able to retain that housing. While HUD's primary mission as an agency is to assure access to housing, it has also recognized a need to assure availability of supportive services. Those supports are more likely to be available under the following conditions.

First, whether or not a community has a 10YP, it will need an organizational structure for addressing changes in the policies and practices of homeless assistance programs and public agencies so that access to benefits continues and improves. A community organizing structure that focuses primarily on deciding how best to allocate HUD funds, such as a narrowly focused Continuum of Care committee, does not usually address

issues of access to mainstream benefits, let alone develop mechanisms appropriate to improving access. Community organizing structures that are more effective for this purpose will embody the principles discussed above and in Chapter 3.

Second, communities should look for mechanisms to improve access that show some evidence of effectiveness in other communities. This report has described a great many mechanisms that demonstrate the creativity and commitment of communities to ending homelessness. There is no shortage of appropriate ideas.

Third, communities should make far greater efforts to assure that the promise of HMIS is fulfilled. The homeless management information systems in the seven study communities do not appear to be structured in ways that give coordinators and program managers essential information in a timely manner. Although they nominally cover emergency shelter programs, they do not require enough information to document service receipt at first contact with the homeless assistance system, nor do they record what happens thereafter. They do systematically collect the information required for APRs, because continued funding depends on it, but that information is not very helpful for answering this study's research questions, nor for providing feedback to communities themselves about how well they are doing at benefit linkage and whether any changes undertaken to improve access are working. As a result, communities have no way to systematically determine how well they are doing with respect to assuring access to mainstream benefits and services, and where there are gaps that need to be addressed.

Over the past decade, to assure the availability of resources to create new permanent supportive housing, HUD has promoted a policy in which it encourages communities to reduce their allocation of HUD funds to services in favor of expanding their use to develop housing and provide operating funds for new and existing units. This has left some study communities relatively unaffected, but for others it has created difficult choices with respect to funding existing service commitments or needs for new services. Given legislative directives and its own departmental priorities, HUD is not at present free to return to a policy that offers greater flexibility. Rather than continue with the current situation, in which the U.S. Department of Health and Human Services (HHS) has grappled with mechanisms to assure access to its benefits and services for homeless people, it might be better for Congress to augment the resources of the McKinney-Vento Act to support certain well-defined core services. These funds could be administered by HHS with the explicit directive that they be offered to communities in an integrated manner through HUD's current Continuum of Care application process, or given to HUD to integrate into that application process for its transitional and permanent supportive housing grants. Either arrangement would greatly simplify the lives of homeless service providers as well as greatly benefit homeless individuals and families. The trade-off for communities would be that they would be expected to adopt both an organizational structure and new mechanisms that assure greater access to mainstream benefits and services, as well as the capacity through HMIS to effectively evaluate their efforts. HUD could provide incentives to communities to plan the introduction of such mechanisms and fund structures and services that support this direction.

Appendix A

Miami-Dade County

Miami is the largest of Dade County's 35 municipalities and the center of homeless services, with the cities of Miami Beach, Hialeah, and Homestead also featuring prominently in the service system. The total population of Dade County was 2,402,208 as of 2006 and was growing at a rate of roughly 30,000 per year, a trend that is expected to continue in the coming years (Miami-Dade Department of Planning and Zoning n.d.). Tourism is a critical industry in the community, and has been a factor in local concerns about homelessness and, more importantly, a significant resource for the ensuing response.

Miami-Dade County	
Continuum of Care total population[1]	2,402,208

Community Characteristics		
	SSI as % median income[2]	18%
	1br FMR = %SSI[2]	150%
Homeless Population[3]	Total # people homeless	4392
	# in households w/ children	1229
	# households w/ children	347
	# households w/o children	3132
	# chronically homeless	407
	# with MH diagnosis	865
	# with SA diagnosis	1047
	# veterans	253
	# with HIV/AIDS diagnosis	96
	# DV victims	205
	# unaccompanied youth < 18	68

Demographics[1]		
	% Hispanic	61
Race	% American Indian/Alaskan Native	1
	% Asian	2
	% Black/African American	21
	% Native Hawaiian/Pacific Islander	0
	% White	78
	% speaking English < "very well"[4]	35
Age	% < 19	27
	% 20 – 24	7
	% 25 – 44	28
	% 45 – 64	24
	% > 65	14

[1]2006 estimated US Census data, except where noted

[2]Cooper, Korman, O'Hara and Zovistoski, 2009

[3]2007 point-in-time count

[4]2006 American Community Survey

Poverty is more prevalent in this Continuum of Care than in the nation generally, with 16.6 percent of Dade County residents and 27.0 percent of those in the City of Miami falling below the poverty line, as opposed to 13.3 percent nationally (U.S. Census Bureau, 2005-2007). Market housing is not affordable for residents with low incomes: A Supplemental Security Income (SSI) check covers only about 67 percent of the one-bedroom FMR, with nothing left over for living.[2] The supply of subsidized housing is not adequate to the need, and there has been widespread community concern about delayed and discontinued affordable housing development projects under the direction of the

Miami-Dade Housing Authority, currently in U.S. Department of Housing and Urban Development (HUD) receivership due to financial mismanagement (HUD August 7, 2007).

The county's population is culturally and linguistically diverse. Over 61 percent of residents are Hispanic. Following English, the most commonly used languages in the community are Spanish and Creole. Nearly 35 percent of the area's residents are not fluent English speakers.[4]

Site Selection Rationale

Two primary mechanisms drove our initial interest in Miami: the Miami-Dade County Homeless Trust (HT) and the county's food and beverage tax (FBT). Created in 1993, the Homeless Trust is the hub of the community's homeless services system. In addition to developing and implementing the community's Homeless Plan, advising the County Board of Commissioners on matters related to homelessness, and serving as convener and administrator of the Continuum of Care, the Trust is charged with administering the proceeds of the FBT and other resources flowing into the community to address homelessness. The FBT adds a 1 percent tax to all transactions in restaurants with a liquor license that gross $400,000 or more a year. In its most recently completed fiscal year the Trust had a budget of about $40 million, with $12 million derived from the FBT, $20 million from HUD, and the balance from state and private resources. To date, Homeless Trust accomplishments include increasing the number of emergency, transitional, and permanent supportive housing beds by 769, 1,815, and 2,072, respectively, and reducing the number of homeless people on the streets from roughly 8,000 to 1,347. The majority of the community's benefit- or service-specific mechanisms may be attributed at least in part to the planning and coordination provided by the Trust, along with the resources provided by the FBT.

Brief History

Twenty years ago, the Miami-Dade County community had a much larger and much more visible homeless population. Estimates of the exact size of the population in the late 1980s and early 1990s vary, but many are in the range of 8,000, roughly seven to eight times the number of emergency beds available in the community at the time, according to the community's Homeless Plan. There were large encampments in parks and under highways, and homeless people were often arrested for eating and sleeping in public places (National Coalition for the Homeless n.d.), actions that ultimately led to a class action lawsuit that was decided in favor of the homeless plaintiffs.

Around this same time, the County created a Task Force on Homelessness. The Task Force made a number of recommendations, including creating the FBT and the public-private partnership of the Homeless Trust to administer the money and run the entire county response to homelessness. An independent board of directors sets policy and works with HT staff to carry out strategies and plans. The state legislature passed a law

enabling Florida counties to establish tax mechanisms such as the FBT to create dedicated funding streams for local homeless services.

The immediate goal of the Homeless Plan and the Homeless Trust was to reduce street homelessness through Homeless Assistance Centers (HACs) and transitional housing beds. Two HACs were developed, and in the years since, over 70,000 people have used their services. The Homeless Trust began a shift to *ending* chronic or street homelessness through permanent supportive housing (PSH) in 1997, but moved more completely to that orientation in 2004 with a plan to create and complete 100 new PSH units each year. Through this shift, however, the Homeless Plan has continued to provide the central vision for the community's efforts. Miami-Dade County's 2006 10 Year Plan to End Homelessness (10YP) is considered an update to, rather than a replacement of, the Homeless Plan.

In the late 1990s, then-governor Jeb Bush established a state-level homeless task force and charged it with developing a statewide plan to end homelessness, in line with the federal push on state and local governments from the Interagency Council on Homelessness. The resulting statewide plan contains many recommendations that coincide with strategies Miami-Dade County pursues. With the authority of the statewide recommendations behind them, county advocates have been quite successful at securing state funding for relevant Miami-Dade County programs.

Structure of Community Coordination

Miami-Dade County's most important benefit and service access mechanism is the Homeless Trust itself, as a central organizing, planning, and administering body. The Trust works to identify gaps and barriers and uses its flexible FBT resources to fill those gaps, often on a pilot basis until data can be assembled to document effectiveness. Almost all of the community's more specific mechanisms originate in the Trust and its resources. The Trust has also been very successful in getting local and state funding for continuing mechanisms that began as pilot projects, especially where criminal justice and mental health domains converge.

The Trust consists of a 27-member board that guides the work of the Trust staff. Many board members also take active roles in promoting homeless services and developing structures to end homelessness. The Trust itself does not provide services, but instead contracts with 30 community providers and maintains a public-private partnership with the Community Partnership for the Homeless (CPH). CPH is a nonprofit agency that developed and now operates the community's Homeless Assistance Centers (described in more detail below).

Homeless Assistance Centers & Outreach

In the Dade County Community Homeless Plan, the HACs were envisioned as the point of entry into the system and the providers of temporary care. One of the HACs is located in downtown Miami and the other in Homestead, a city of roughly 32,000 (U.S. Census 2006) about 35 miles southwest of Miami. In addition to emergency shelter and meals, the HACs serve as one-stop shops, providing or linking residents to a wide variety of

services that homeless people require, including public assistance, SSI/Social Security Disability Income application assistance, U.S. Department of Veterans Affairs benefits, job services, and legal services. Dental care, substance abuse and mental health services, and primary health care are provided onsite through a partnership with Jackson Health System.

The Homeless Trust also created and funded three programs to provide outreach, including referral to the HACs. One of these programs serves the City of Miami, one serves Miami Beach, and the third serves the balance of Dade County. The outreach teams' work with homeless street people includes relationship-building, engagement, and assessment of needs, particularly needs for shelter, treatment, or crisis intervention. A 24-hour, toll-free homeless helpline connects single adult callers to the appropriate outreach team, and families to Camillus House, one of the community's major homeless assistance organizations. The Trust funds another major provider, Citrus Health Network, to serve as the coordinating center for outreach efforts throughout the county. There are five Citrus outreach teams, one of which is devoted to coordination efforts with the City of Miami and City of Miami Beach outreach programs. Citrus is contacted regarding any person whose chronically homeless status is believed to involve a psychiatric disability.

Jail Diversion Programs

Spearheaded by Judge Steve Leifman, Miami-Dade County's Eleventh Judicial Circuit has developed jail diversion programs for people with psychiatric disabilities, most of whom were homeless before arrest or would be homeless once released. These programs are referred to collectively as the Criminal Mental Health Project (CMHP), and include a communitywide pre-arrest diversion program based on the Crisis Intervention Team (CIT) model and a post-arrest diversion program at the Miami jail.

The post-arrest program diverts people to one of the County's 10-plus Crisis Stabilization Units, which then facilitate connections to housing with services and treatment. This program, which has been in existence for about eight years, has historically sought to improve the community's response to people with psychiatric disabilities who are arrested on misdemeanor charges. Within the past year, the program was expanded to include those arrested for low-level felonies. Some of those involved in the post-arrest diversion program also benefit from the community's gap funding, which pays for housing and services during the SSI eligibility determination period, with the understanding that retroactive SSI payment will be applied to the costs incurred. Citrus Health Network provides many of the post-arrest diversion services.

The diversion programs are credited with making a sizeable reduction in misdemeanor recidivism among people with psychiatric disabilities (from 70 percent to 20 percent), and with allowing Miami to close an entire wing of its jail. Currently, the CMHP has 11 full-time staff, including a full-time CIT trainer, social workers who assist in case management, two supervisors who provide oversight and research, and four full-time peer specialists, all of whom have experience with both the criminal justice and mental health systems. The peer specialists are a key component as they are integral to helping service consumers feel safer and more comfortable.

Memorandum of Agreement

In June 2008, the community implemented a memorandum of agreement (MOA) among the Housing Trust, the Eleventh Judicial Circuit, state and local departments of corrections, Florida Department of Children and Families, Jackson Memorial Hospital, and local foster care and mental health organizations. The MOA establishes commitments to change public agency operating procedures in two ways. First, mainstream agencies committed themselves to developing new and/or more effective linkages to the homeless assistance system for any clients of theirs who are in a housing crisis or find themselves homeless, so their homelessness may be prevented or ended as soon as possible. This change involves developing and expanding mainstream service providers' knowledge of the full range of what the homeless assistance system offers. The most important locations/time points for this improved linkage are when clients are about to be discharged from a public institution—from foster care, psychiatric hospitalization, substance abuse treatment, or jail—but other opportunities also exist, such as the point when people *enter* such institutions, if their stay is likely to be short.

The second change the MOA calls for is the creation of three new housing specialist positions to develop resources beyond those found in the homeless service system, and to link people referred via the mainstream service system to these new housing resources. For example, in the mental health service system, the housing specialists work to find housing for people being discharged from the community's crisis units, and do the same for youth aging out of foster care. This structure had been among the elements called for in Miami-Dade County's 10 Year Plan and had also been picked up as a priority initiative through the work of the county-appointed Community Affordable Housing Strategic Alliance. At the time of this report, the housing specialists had been functioning for a little over one month; in their first month they placed 179 people into services and housing, including 14 who were placed at least initially within the homeless system.

List of Interviewees

- **Camillus House, Inc.** - Gloria Barbier (Vice President, Institutional Advancement), Karen M. Mahar (Chief Operating Officer, Special Assistant to the President), Fred Mims (Director of Direct Care Ministry), and Michelle Rodriguez (Homeless Prevention Program Manager)

- **Citrus Health Network, Inc.** - Nathalia Calabrese (Adult Case Management Administrator), Gloria Picart (Independent Living Supervisor), and Manuel Sarria (Administrator of Adult Homeless Programs)

- **City of Miami Homeless Assistance Program** (Homeless Outreach) - Jacquelyn Epson (Outreach Supervisor), Natalia Figueroa (Office Manager), and Sergio Torres (Administrator)

- **Community Partnership for Homeless** (Homeless Assistance Centers) - Luis Binet (Center Manager), Alfredo K. Brown (Deputy Director), Burney Burke

(Housing Developer), Lokaranjit Chalasani, M.D. (Psychiatrist), Emilio M. Espino (Program Services Manager), Trev. B. Flowers (Director of Community Relations), Juan M. Gollaz (Case Manager), Carolina Mejia (Case Manager), Jackie Master (Nurse Practitioner, Miami HOPE), Jose R. Marmolejo, Ph.D. (Director of Program Services), Michael Pastrana (Case Manager), Armando Rodriquez (Housing/Job Developer), and H. Daniel Vincent (Executive Director)

- **Florida Agency for Persons with Disabilities -** Migdalia Diaz-Prado (Operations and Management Consultant)

- **Florida Department of Children and Families ACCESS, Central Service Center -** Marianela Amador (Program Administrator), Alfredo Avendaño (Intake Case Manager), Tamara Chemaly (Economic Self-sufficiency Specialist), Octavio Rosquete (Clerk), and Jose Silva (Economic Self-sufficiency Specialist)

- **Florida Department of Children and Families ACCESS, Opa-Locka Service Center -** Esther Nobakhare (Supervisor) and Rosie Rodriguez (Economic Self-sufficiency Specialist)

- **Florida Department of Children and Families Substance Abuse and Mental Health Program Office -** Cylenthia D. Baldwin (Operations and Management Consultant Manager), Deborah G. Dummitt, Ph.D. (Adult Mental Health Program Administrator), Silvia M. Quintana (District Program Supervisor), and Michele Sweeting (Operations and Management Consultant Manager)

- **Health Care for Homeless Veterans -** La'Shon Black (HUD VASH), Shelia Leroy (Grant and Per Diem), Gina Queen (Miami-Dade Outreach), Christian Rodgers (Administrative Support), Dan Robbin (VISN 8 Coordinator), Cherry Smart (Coordinator), and Rodly St. Villien (Broward Outreach)

- **HOPE in Miami Beach -** Ernie Earth (Identification Project)

- **Miami-Dade County Homeless Trust -** Ronald Book (Board Chair), Gonzalo DeRamon (Housing Committee Chair), Judge Steven Leifman (Finance Committee Chair), and David Raymond (Executive Director)

Denver

The City of Denver is the largest municipality of the 13-county Denver Metropolitan Area and is the most developed in terms of homeless services. According to the 2006 Census estimates, Denver City's total population stands around 566,974, 50 percent of which is white (non-Hispanic), 10.6 percent is African American, and 34.8 percent consider themselves of Latino or Hispanic origin. The 2005 American Community Survey (ACS) shows that 82 percent of those who are 25 years or older have a high school diploma and 36 percent have a bachelor's degree or higher. Nine percent of the population is under 5 years of age, and 10 percent are over 65. The median age in 2006 was 35 years old.

Denver	
Continuum of Care total population[1]	2,546,470

Community Characteristics		
	SSI as % median income[2]	16%
	1br FMR = %SSI[2]	106%
Homeless Population[3]	Total # people homeless	8698
	# in households w/ children	5249
	# households w/ children	1994
	# households w/o children	2933
	# chronically homeless	412
	# with MH diagnosis	1029
	# with SA diagnosis	1315
	# veterans	708
	# with HIV/AIDS diagnosis	123
	# DV victims	563
	# unaccompanied youth < 18	73

Demographics[1]		
	% Hispanic	35
Race	% American Indian/Alaskan Native	2
	% Asian	4
	% Black/African American	12
	% Native Hawaiian/Pacific Islander	0
	% White	84
	% speaking English < "very well"[4]	15
Age	% < 19	26
	% 20 – 24	6
	% 25 – 44	34
	% 45 – 64	23
	% > 65	11

[1]2006 estimated US Census data, except where noted

[2]Cooper et al, 2009

[3]2007 point-in-time count

[4]2006 American Community Survey

The 2004 Census estimates indicate that the area median income for households reached around $41,000, compared to $50,165 for the state of Colorado. Denver's estimated poverty rate for 2004 was higher than the state's by a full 5 percentage points, with 15.2 percent living below the poverty line.

Specific to the City and County of Denver, in the year the Denver's Road Home began (2005), 4,444 homeless persons were counted in the Homeless Point in Time count. By the 2007 count, that number was down to 3,954 homeless persons, representing a drop of 11 percent in 2 years. According to the 10 Year Plan (10YP), 942 chronically homeless

people were estimated to be in Denver County at baseline (2003-2005). This number had shrunk 36 percent, to 602 chronically homeless individuals, by the 2007 count.

Community Selection Rationale

The existence of a central organizing structure, Denver's Road Home, within the mayor's office, strongly influenced our selection of Denver as a study community. Over the last three years, Denver has garnered national attention for its 10 Year Plan to End Homelessness and unique system of support for homeless services. Led primarily by Mayor Hickenlooper and the Denver's Road Home office, a series of committees address the issues and goals enumerated in Denver's 10YP, using a highly coordinated and goals-driven approach. With both local public and private support, but very little state support in terms of resources, Denver provides an example of targeted resource allocation with a special emphasis on mainstream benefit receipt for homeless people. The city has taken on significant responsibilities surrounding the elimination of homelessness while also bringing in more private service providers, including those that are faith-based, and raising a substantial amount of private funding.

Brief History

Prior to 2004, the Metro Denver Homeless Initiative ran the Continuum of Care, which included Denver and the six surrounding counties, while the Colorado Coalition for the Homeless (CCH), a nonprofit agency, operated the majority of the city's homeless services. With the election of Mayor John Hickenlooper, however, community members and members of the City Council saw an opportunity to expand the local government role in homeless services.

In 2004, the mayor gathered a group of 43 representatives from local government, nonprofits, philanthropic organizations, and the homeless population to form the Denver Commission to End Homelessness, with the charge to create and publish the city's original 10 Year Plan to End Homelessness. The Commission split into seven subcommittees with specific tasks, which took commentary from approximately 350 community members and blended it to define a set of goals for Denver's homeless system. In 2005, Mayor Hickenlooper released Denver's 10 Year Plan to End Homelessness, titled *Denver's Road Home*. Since the 10YP's passage, the subcommittees have met to discuss issues and to bring recommendations before the broader Commission. In May 2007, the Commission approved an update, or "status report," of the 10YP, which adjusted goals and reported on the plan's overall progress.

The 10YP also established the Denver's Road Home Office (DRH) within the mayor's office, consisting of four staff located at the Department of Human Services who cover housing, mainstream benefits, employment, and programs. The office's director is a mayoral appointee; however, the position is funded solely by foundation resources. DRH is charged with implementing Denver's 10YP by raising and distributing homeless funds in partnership with the Mile High United Way—Denver's fiscal agent for the 10YP.

Denver's 10YP puts heavy emphasis on sharing responsibility for funding. The Denver Commission to End Homelessness estimated the plan would cost $46.1 million to fully implement, and charged the 13-member Committee on Fundraising, part of the Mayor's Homeless Commission and led by the Director of DRH, to raise the needed funds. The mayor came up with a strategy to make the funding effort a community process with heavy community support. "He wanted to have everyone invest." The goal has been to get 50 percent public, 25 percent corporate, and 25 percent private funding. According to interviewees, the mayor successfully lobbied for foundation support, asking for an expansion of what they were already giving. Foundations agreed, with the understanding that as the city rolled out the initiative they would wean off foundation and corporate dollars.

Colorado Support

Denver has very little in public housing money from the state. Part of the paucity of funding comes from a Tax Payer Bill of Rights amendment (TABOR) that restricts revenue growth for the state, and thus limits the funds available for homeless-related programs. In short, TABOR ensures that, if there is a surplus in the state budget, the state cannot pass new taxes or increase existing taxes without a vote of the people. Statutory spending limits put a cap on state spending, mandating that any increases will be no more than 6 percent of prior years, after taking into account inflation. Colorado makes no state money available for homeless programs. This state picture played a large role in the mayor's push for more private support.

In an effort to counteract the lack of state support, the City Council, in August 2008, approved spending $20 million of public funds for homeless housing as a reinvestment measure, using savings generated from the reduction of the city's chronic homelessness. DRH hopes to use the funds to produce over 200 new units of permanent supportive housing, using a Housing Assistance Program model similar to Section 8 long-term leases—that is, a specific property has the subsidies attached to its units, and the subsidies stay with the units as tenants move on—or a similar arrangement sometimes done with sponsor-based assistance, in which an agency leases apartments with the subsidies, and tenants come and go.

Structure of Community Coordination

The DRH acts as an umbrella organization for Denver's part of the metropolitan Continuum of Care. DRH's seven committees meet monthly. Each committee addresses an aspect of the 10YP, focusing on evaluation, community awareness (dissemination of information), fundraising, resource allocation, implementation, employment, and the broader Continuum of Care. This structure makes DRH a strong mechanism for expanding, changing, and smoothing access to mainstream benefits, with its ability to raise funds in the private sector, bring the provider community together, and advocate for policy changes. Services under the 10YP are funded by the DRH office through its resource allocation committee. In all, DRH funds over 27 homeless programs run by 19 agencies and providers throughout the city, and leads all efforts to implement and fund the 10YP. The DRH continuum includes over 80 agencies and providers. DRH Requests

for Proposals (RFPs) are used to solicit programs and activities that further the Plan's recommendations; no money is spent on programs unrelated to the goals enumerated in the 10YP. Grant periods usually last a year; grantees are monitored regularly to make sure they are using the resources to meet 10YP goals. Depending on how a program is performing, DRH will pull or increase funding—sometimes even in the middle of a grant period. The Colorado Coalition remains Denver's largest service provider and receives most of its resources from the U.S. Department of Housing and Urban Development.

Outreach and Engagement:

The Denver Outreach Collaborative is an association of homeless outreach groups operating in the City of Denver. In an attempt to provide more coverage and less overlap in both case management and outreach, DRH put out an RFP to bring together and coordinate existing public and private outreach groups. There are, in total, 20 outreach workers in the collaborative—6 from Urban Peak, 6 from St. Francis House, 6 from CCH, and 2 police officers funded by DRH. In addition, the collaborative has 4.5 full-time case managers and 3 full-time dispatch workers. The city gives a million dollars toward the grants, with another $400,000 coming from the downtown business improvement district and CCH. CCH coordinates the project, holding meetings monthly; however, each group has its own manager. In addition, the city runs a central dispatch to coordinate and disperse the teams. Reportedly, phones are staffed seven days a week from 6 a.m. to 10 p.m. Interviewees stressed the importance of the collaboration, noting its comprehensive approach: "Our Denver Street outreach collaborative can …follow people through the whole system so we don't have to drop people when they leave a shelter. That is key." Additional outreach workers and programs are run through Denver Health, the Stout Street Clinic—an indigent care provider, and the Mental Health Center of Denver.

Benefit Acquisition and Retention Programs

Programs working to assure benefit receipt for homeless people are prevalent in Denver. Several organizations have formed unique relationships to facilitate the application and retention process. For instance, case managers from different agencies are trained in Supplemental Security Income (SSI)/Social Security Disability Income (SSDI) Outreach, Access, and Recovery and doctors at the local indigent care clinic worked out specific agreements for completing homeless persons' SSI applications. Perhaps the best example is the Benefit Acquisition and Retention Team (BART). Staff at the Denver Social Security Administration (SSA) office lauded BART, run by the Colorado Coalition for the Homeless, as one of the most successful teams for getting homeless people Aid for Needy and the Disabled, SSI, and SSDI. Using a total of 4.5 full-time case managers to process claims, the BART team members are experts at putting together disability applications. Over the last four years, the team established a relationship with the SSA office in which BART provides accurate and complete applications marking them as "BART Claims," and, in turn, the SSA office expedites the approval process. This relationship is reinforced by monthly planning and feedback meetings hosted by CCH and attended by SSA regional and field office managers, the Colorado Disability

Determination Services (DD), SSA's Office of Disability, Adjudication and Review (SSA's appeals organization), and BART staff.

List of Interviewees

- **Colorado Coalition for the Homeless -** Louise Boris (Vice President of Programs), Jennifer Perlman (Manager of Quality Improvement), and Heather Beck (Community Resources and Outreach Program Manager)

- **Colorado Department of Human Services** - Tracy D'Alanno (Unit Manager)

- **Denver Cares -** Mark Wright (Director) and Audrey Vincent (Nursing Director)

- **Denver Department of Human Services** – Nan Morehead, Nicole Hoard, Bismilla Harjhoon (Program Case Manager), George Cassidy (Veterans Service Officer), Patrick Coyle (Housing Coordination), Jerene Peterson, and Deborah Ortega

- **Denver Rescue Mission -** Steve Walkup (Vice President of Programs), Brad Hopkins (program Director), Tom Levitt (Program Director), Ashley Berner (Case Manager), and Angela Nelson (Case Manager)

- **Denver's Road Home** - Jamie Van Leeuwen (Project Manager)

- **Denver University -** Katie Symons

- **Fundraising Committee -** Donna Boreing (Chair)

- **Mental Health Center of Denver –** Kara Theel (Program Manager) and Chris Christner (Project Coordinator)

- **Metro Denver Homeless Initiative** - Jean Tutolo (Director)

- **Office of Economic Development** - Liz Ojeda (Manager of Operations) and Nancy Rider (Business Development Associate, Homeless Initiative)

- **OMNI -** Jim Adams-Burger (President) and Katie Page (Analyst)

- **Resource Allocation Committee -** Barb Grogan

- **Social Security Administration** - Don Ketcham (Executive Officer)

- **St. Francis Center** - Missy Mish (Housing Outreach Director) and Carla Slatt-Burns (Case Worker)

- **Urban Peaks -** Kay Ramachandran (President), Kendall Rames (Clinical Site Manager), and Shawn Hayes (Case Manager)

Pittsburgh/Allegheny County

The Pittsburgh/McKeesport/Penn Hills/Allegheny County Continuum of Care (CoC) serves all of Allegheny County, with a total estimated 2006 population of 1,223,411. Pittsburgh is the primary population center and the center of the homeless services system in the county, with a secondary services center in McKeesport, a city of 24,040 lying roughly 14 miles southeast of Pittsburgh. The area's economy and population have been largely driven by the rise and collapse of the steel industry. At 312,819, Pittsburgh's 2006 population is less than half of its 1950 U.S. Census population. Both Pittsburgh and McKeesport are continuing to lose population. Pittsburgh's population represents a drop of about 15 percent from its 1990 U.S. Census population of 369,879, whereas McKeesport had roughly 2,000 (about 8 percent) more residents in 1990 than in 2000. A number of our interviewees told us that young people tend to leave the community, while older residents tend to stay. Interviewees also described Pittsburgh as a city of neighborhoods. While this characteristic offers many benefits to the city's residents, there are also drawbacks. For example, several interviewees observed that relatively distinct racial and cultural lines of demarcation, along neighborhood lines, continue to characterize the city.

Pittsburgh/Allegheny County	
Continuum of Care total population[1]	1,223,411

Community Characteristics		
	SSI as % median income[2]	19%
	1br FMR = %SSI[2]	89%
Homeless Population[3]	Total # people homeless	1380
	# in households w/ children	479
	# households w/ children	177
	# households w/o children	901
	# chronically homeless	143
	# with MH diagnosis	334
	# with SA diagnosis	433
	# veterans	201
	# with HIV/AIDS diagnosis	26
	# DV victims	75
	# unaccompanied youth < 18	4

Demographics[1]		
	% Hispanic	1
Race	% American Indian/Alaskan Native	1
	% Asian	3
	% Black/African American	14
	% Native Hawaiian/Pacific Islander	0
	% White	84
	% speaking English < "very well"[4]	2
Age	% < 19	24
	% 20 – 24	7
	% 25 – 44	24
	% 45 – 64	28
	% > 65	17

[1]2006 estimated US Census data, except where noted

[2]Cooper et al, 2009

[3]2007 point-in-time count

[4]2006 American Community Survey

Housing in the community is relatively affordable, but the one-bedroom fair market rent (FMR) is still roughly equivalent to a Supplemental Security Income check, and the community does not have sufficient subsidized or affordable housing stock. A few recent changes have put an additional strain on the existing resources, including the closure of a number of personal care facilities following concerns about the quality of housing they offered, a recently completed HOPE VI project in Pittsburgh's Hill district, and the closure of nearby Mayview State Hospital, which is currently underway. None of these changes are without clear benefits; they are raised here simply as events that could or will increase the demand for affordable housing and supportive services. It should also be noted that the opinions of those we spoke to seemed divided as to whether the HOPE VI project did actually displace low-income residents. Additionally, the community was one of only two nationally that saw a decrease in FMR (Seattle being the other) over the past year. While this decrease may reflect greater housing affordability for the general population, for many with Section 8 certificates it made finding housing more difficult and even jeopardized housing stability among some already housed (that is, some voucher holders had to leave their apartments because they no longer fell within the rental guidelines). One positive outcome of the FMR decrease, however, was the community's ability to increase the number of vouchers provided, given the decrease in cost of each voucher.

Site Selection Rationale

County-level integration and cooperation made Allegheny County an attractive candidate for study inclusion. The Allegheny County Department of Human Services (DHS) serves as the Pittsburgh/McKeesport/Penn Hills/Allegheny County Continuum of Care lead. Homeless services are situated within the Office of Community Services (OCS), one of five DHS program offices. Having multiple program offices under one county agency provides the ability to look at the overlap among offices and allocate resources as needed, and facilitates a highly coordinated, communitywide effort. For example, although OCS is the bureau responsible for homeless services, other DHS offices experience a need for housing, and most play a significant role in the system serving people who are homeless.

DHS is a key member of the Allegheny County Homeless Advisory Board, formerly the Allegheny County Homeless Alliance. Established in 2003, the Advisory Board is the public-private partnership responsible for the oversight of the CoC and the community's 10 Year Plan to end homelessness (10YP). The Advisory Board's membership also includes other Allegheny County government entities; Pittsburgh, McKeesport, and Penn Hills government entities; a wide range of mainstream and homeless services provider organizations; and local foundations. Staff support for the Advisory Board is provided by OCS.

An unusually strong community of major, private foundations exists in Pittsburgh, and has played a significant role in Allegheny County's homeless service system. In addition to generally providing additional funding streams, foundation money supports projects that would be difficult to fund through public money.

Like all Pennsylvania counties, Allegheny County receives Pennsylvania State Homeless Assistance Program (HAP) and Human Services Development Fund (HSDF) funding. Both HAP and HSDF are administered through the Pennsylvania Department of Public

Welfare (DPW). Counties have considerable flexibility in the use of these funds, and are expected to design a spending plan that is responsive to their own communities' needs and existing funding gaps. Including federal, state, county, and foundation sources, DHS receives a grand total of about $19.3 million to fund housing and support services for homeless individuals and families.

Brief History

The current configuration of DHS developed out of a mid-1990s effort to streamline the Allegheny County government. As part of this initiative, in 1997, the county consolidated six former departments, including the Department of Child Welfare, under the umbrella of the newly formed DHS. The recently appointed Director of Child Welfare, Mark Cherna, was named as the DHS Director, and has held this position ever since. As he was appointed at such a formative point in DHS history, Mr. Cherna had a unique opportunity to actually put the department together. Department members consider this situation to be a factor in the department's subsequent success, along with the consistent leadership that Mr. Cherna has provided in the years since the redesign. Mr. Cherna was able to retain the selection committee that had been assembled to conduct the search for a new Child Welfare Director (his previous position), and to use this group as a sort of "kitchen cabinet" as he assumed his new position. The foundation community also was a key player in backing Mr. Cherna's decision to consolidate the departments, and their support helped to avoid any wrangling among agencies. The redesign was driven by the needs of children and families, but OCS was able to establish homelessness as a priority area for the new department.

The community developed its CoC in the early days of HUD's adoption of the approach. It has proven highly beneficial in terms of drawing down both HUD and, more recently, behavioral health funding. The department's structure is credited with some of that success, as is the highly engaged provider community.

Driven largely by the Advisory Board, Allegheny County's 10YP was released in July 2005. The Advisory Board has been making significant progress in moving some portions of the 10YP forward, and DHS has worked to keep the Board invigorated by recruiting new members regularly from other parts of the community (for example, safety, university).

The HUD funding prioritization of housing activities over services marked a major turning point in the community. DHS worked with this requirement through a combination of creative cost and funding shifting, foundation support, and adjustment to resource loss. The department's unified structure was a major factor in its ability to shift costs and funds internally in the department. The foundation community was able to supply $3 million for three years to help with the shift; these funds were evenly split between services and capital.

Structure of Community Coordination

The base of the Allegheny County system serving homeless people is the DHS structure and its relationship to the community's providers; the foundation community is another relatively unique feature of that system. These two components are described below.

DHS Structure and Provider Community Cooperation

Today, Allegheny County's homeless service system continues to benefit from considerable integration among DHS program offices, and the engagement of key players from each of these offices. There are five program offices within DHS: OCS; the Area Agency on Aging; the Office of Children, Youth, and Families; the Office of Behavioral Health; and the Office of Mental Retardation and Developmental Disabilities. The Office of Behavioral Health receives the community's Projects for Assistance in Transition from Homelessness funds and, generally speaking, that office's provider organizations are also OCS providers. Similarly, OCS works closely with the Area Agency on Aging on matters of mutual concern, such as issues related to the community's personal care boarding homes. In addition to its inter-program office collaboration, OCS collaborates with the County's Department of Economic Development and with the City of Pittsburgh, both of which receive Emergency Shelter Grant funding. OCS itself is composed of four bureaus: Family and Community Services, Employment and Training Services, Hunger and Housing, and Outreach and Prevention. Each OCS bureau meets quarterly with members of its provider networks. Hunger and Housing quarterly meetings are oriented to providing technical assistance, reviewing homeless management information system trends, and discussing implications of these trends for U.S. Department of Housing and Urban Development (HUD) funding.

Inter-office integration of housing and homeless issues has also been facilitated by the appointment of a housing coordinator who works across DHS. Mr. Cherna felt there was a need for housing DHS-wide and sought funding from the foundations for a half-time person to examine the system. In addition to leading a number of projects described in the mechanisms sections, the housing coordinator's current responsibilities include chairing a committee on housing for transition-age youth, staffing the Homeless Advisory Board, and chairing the Allegheny County Local Housing Options Team (LHOT). LHOT, composed of representatives from funders, developers, housing authorities, and other mainstream and homeless service providers, meets monthly and works to support the development of new housing options for local residents in need of affordable and accessible housing.

Positive working relationships between DHS and the community's provider agencies have also been a critical mechanism for ensuring provider agency access to resources. These relationships have been fostered by both informal and formal means. A number of homeless service organizations' executive directors have formed a workgroup, using foundation funding. This group works with Mr. Cherna to help keep DHS informed of the issues facing the community's provider agencies. A number of provider agency interviewees identified their relationship with OCS—and OCS staff accessibility—as a major asset to providing services to homeless people in the community.

DHS planning is supported by a data warehouse that draws from 27 sources of data, including sources both internal and external to the department (for example, DPW, county jail, juvenile probation). The project began in 2001, again with support from the foundation community, and with a focus on early childhood. Today, the system allows DHS to consider patterns of shared clients, or people receiving services from multiple systems, as well as patterns of costs of serving these clients. This has led to planning for changes that reduce costs, improve services and outcomes, or both. The systemwide knowledge the warehouse facilitates has also positioned DHS well in terms of leveraging additional foundation funding.

Foundation Support

As described above, the community's foundation resources are unusually strong, and include Heinz Endowments, the R.K. Mellon Foundation, and the McCune Foundation. Foundations have served a variety of central roles in the homeless and mainstream service systems. DHS has been working to develop a central repository for foundation and other private funding. While there isn't currently a functioning repository external to the county system, the Continuum of Care Supportive Service Fund has served as an interim workaround, providing both match funding and resources for funding "gaps" in the system since 2006. Additionally, availability of foundation funding has freed some providers up from using fee-for-services revenues as HUD match funds.

In addition to serving as a critical mechanism of service expansion, foundation support has been used to smooth access to services in a variety of ways. At the government and policy level, foundations provided gap funding created by the HUD shift in priorities. As described earlier, foundation support has allowed DHS to develop and staff the current housing coordinator position, has made the provider organizations' executive directors' workgroup possible, and has supported the data warehouse. Individual providers also use foundation support to increase services or service efficiency. For example, the House of the Crossroads, one of the community's substance abuse service providers, used foundation support to launch an examination of the ways that the agency was and could integrate their services with those of others in the provider community.

List of Interviewees

- **Allegheny County Housing Authority** - Jack McGraw (Assistant Director of Development)

- **Allegheny County Department of Economic Development** - Cassandra Collinge (Assistant Manager, Consumer Programs)

- **Allegheny County Department of Human Services** - Chuck Keenan (Housing Coordinator), Michael Lindsay (Housing Program Administrator), Bill Thomas (Senior Evaluation Specialist, Office of Information Management), and Reginald Young (Deputy Director, Office of Community Services)

- **Bethlehem Haven** - Theresa Chalich (902 Clinic Coordinator), Sabrina Chapman (Shelter Case Manager), Sara Dix (Program Coordinator Project Employ), Nicolya Hall (Residential Manager, Shelter), Lois Mufuka Martin (Executive Director, Bethlehem Haven), Theresa Orlando (Director of Miryam's), and Holly Sonney (902 Clinic Case Manager/Outreach Worker)

- **Greater Pittsburgh Community Food Bank** - Georgette D. Powell (Community Outreach Coordinator)

- **Health Care for the Homeless** - April Arsenault (Administrative Coordinator), Anita DeChancie (Nurse Coordinator), Iris M. Kurka (Case Manager), Shannon Chrissis (KIDSTART Coordinator), and Jennifer Williams (Director)

- **Homeless Children's Education Fund** - Joseph F. Lagana, Ed.D. (Founder)

- **House of the Crossroads** - Larry DeMarzo (Executive Director)

- **Housing Authority of the City of Pittsburgh** - Richard Morris (Director, Resident Self-Sufficiency Department)

- **Operation Safety Net** - Stephanie A. Chiappini (Program Manager) and Linda M. Sheets (Program Director)

- **Pennsylvania Department of Public Welfare, Allegheny County Assistance Office** - Michael L. Boyle (Director of Program and Administrative Services), Richard G. Cunningham III (Assistant Executive Director), Janice L. Gladden (Executive Director), Karen L. Randolph (Director of Communications), and Inez Titus (Staff Assistant)

- **Pittsburgh AIDS Task Force** - Kathi Boyle (Executive Director), Darrell Phillips (Director of Housing and Client Services), Meghan Schwab (Case Manager), and Patricia Wohlfarth (Case Manager)

- **Primary Care Health Services Supportive Housing Network** - Eartha Sewell (Program Director)

- **Veterans Leadership Program of Western Pennsylvania** - Annette Romain (Director of Programs and Development) and Ronald Zola (former Executive Director)

- **Western Psychiatric Institute and Clinic** - Susan Coyle (Clinical Administrator, Ambulatory Initiatives)

- **Womanspace East** - Danielle Hunt (Emergency Shelter Case Manager), Heather Ochman (Transitional Housing Case Manager), Lottie Reed (Program Director), and Francene Ross (Bridge Housing Program Case Manager)

Albuquerque

Albuquerque is the largest urban area in New Mexico, with nearly 26 percent of the state's total population. In 2006, the city's population was 493,438 and the metropolitan statistical area population was 504,949. The population is growing, with a 12.6 percent increase between 2000 and 2006. Albuquerque is located in Bernalillo County, which has a 2006 population of 615,099, and residents have access to mainstream services through state, city, and county sources. The city is more prosperous than the rest of the state, with 14.1 percent of households below the poverty line, compared to 16.7 percent for the entire state (2004 data). Even so, the City of Albuquerque has 60,000 households with a housing cost burden (paying more than 30 percent of income for housing).

According to the 2006 American Community Survey, Albuquerque is a racially and ethnically diverse community. Nearly 30 percent of households report speaking a language other than English at home, and nearly 12 percent of the population is foreign born. The median household income (2006 inflation adjusted) is $43,021, and the median family income (MFI) is $55,295. Both of these economic indicators are higher than statewide data (New Mexico median household income = $40,629; MFI = $48,199).

Albuquerque	
Continuum of Care total population[1]	493,438

Community Characteristics		
	SSI as % median income[2]	19%
	1br FMR = %SSI[2]	94%
Homeless Population[3]	Total # people homeless	1276
	# in households w/ children	455
	# households w/ children	147
	# households w/o children	771
	# chronically homeless	159
	# with MH diagnosis	52
	# with SA diagnosis	169
	# veterans	132
	# with HIV/AIDS diagnosis	17
	# DV victims	224
	# unaccompanied youth < 18	22

Demographics[1]		
	% Hispanic	44
Race	% American Indian/Alaskan Native	5
	% Asian	3
	% Black/African American	3
	% Native Hawaiian/Pacific Islander	0
	% White	65
	% speaking English < "very well"[4]	10
Age	% < 19	27
	% 20 – 24	7
	% 25 – 44	30
	% 45 – 64	24
	% > 65	12

[1]2006 estimated US Census data, except where noted

[2]Cooper et al, 2009

[3]2007 point-in-time count

[4]2006 American Community Survey

In 2007, the New Mexico Coalition to End Homelessness (NMCEH) conducted a survey with a sample of homeless persons on the streets and in shelters in Albuquerque. The

majority of survey participants were male (70.5 percent). The majority of survey participants were 40 or older (64.2 percent). The majority of survey participants identified as either white (36.7 percent) or Hispanic (28.1 percent). Sixty-eight percent of participants were single individuals, while 20 percent had children in their household. Almost half (47 percent) of survey participants were originally from New Mexico.

The lack of affordable housing is a significant barrier to ending homelessness for a significant number of participants (39 percent could not find an affordable place, 46 percent reported needing help finding an apartment they can afford). Nearly half (42 percent) of respondents had incomes below $750/month.

The 2007 Point in Time count, in January 2007, involved two separate counts: a count of the sheltered population and a count of the unsheltered population on the night of January 24, 2007. The sheltered population included people staying in emergency shelters and transitional housing. The unsheltered population included people who slept in a car, movie theater, park, public space, street or alley, tent, abandoned building, under a bridge, the foothills/mountains, etc. The following provides a summary of the results:

Albuquerque 2007 PIT Count				
	Emergency Shelters	Transitional Housing	Un-sheltered	Total
# of households w/children	24	100	23	147
# of persons in households w/children	71	312	72	455
# of households w/o children	402	204	165	771
# of persons in households w/o children	402	204	215	821
Total PERSONS	473	516	287	1,276

Source: Results of a Survey Conducted of People Experiencing Homelessness in Albuquerque, September, 2007, NMCEH.

Site Selection Rationale

The primary mechanism that drove our interest in Albuquerque was their history of working together as a community to create real opportunities for people to exit homelessness. The use of the housing first approach and the incorporation of homeless service provider agencies as "outposts" of the mainstream service delivery system were intriguing.

Brief History

The NMCEH coordinates the Continuum of Care (CoC) planning process. In New Mexico there are two Continuum of Care regions: the City of Albuquerque and the balance of the state. NMCEH has offices in Albuquerque, Santa Fe, and Las Cruces and the Albuquerque Continuum of Care activities are managed by Lisa LaBrecque, Policy and Advocacy Director, NMCEH.

The New Mexico Coalition to End Homelessness was founded in the year 2000 by a group of nonprofit agencies and the New Mexico Mortgage Finance Authority. This

statewide coalition coordinates the efforts of the member provider agencies to end homelessness and manages the Continuum of Care process as noted above. The Coalition has both individual and agency members. Members elect the Board of Directors annually and the Board oversees the operations of the Coalition. The Albuquerque community is represented by four NMCEH Board members. The Coalition has membership meetings every other month beginning in January, and Board meetings every other month beginning in February. The Coalition currently employs four full-time staff.

Structure of Community Coordination

The Albuquerque Continuum of Care planning process is conducted by a Steering Committee composed of provider agencies and City of Albuquerque representatives. The leadership of the Continuum comes from within the provider community. The providers have a history of working together to meet the needs of homeless persons, and are functioning within a larger state context of restricted access to services and budget cuts. At the time of the site visit, the Behavioral Health Collaborative, which controls mainstream behavioral health services, had experienced a severe budget shortfall. A key service component, Comprehensive Community Supportive Services, has been restricted to six hours per client per month. This is a significant problem for providers, who struggle to help people with significant mental health problems end their homelessness and achieve recovery. The system is too thinly funded to achieve these goals, according to key providers in the Continuum of Care.

Within this context, it is not surprising to find that successful access to mainstream services is the result of service providers pushing hard to find ways to make these systems more responsive.

Co-Location

St. Martin's Hospitality Center is a day shelter that provides meals and a safe place for homeless people to be during the day. It also offers the opportunity to connect with other service providers. In interview, Lee Pattison, Executive Director, stated that mainstream service agencies have a routine presence. Specifically, the food stamps program, the U.S. Department of Veterans Affair benefits, New Mexico AIDS services, behavioral health services, and the public housing authority (PHA) have regular outreach at St. Martin's. Also, St. Martin's hosts a monthly service coordination meeting attended by case managers and outreach workers from within the CoC. St. Martin's provides meeting space for cross-agency training—the specific example offered was training on how to obtain Supplemental Security Income (SSI) benefits, provided by the State Health and Human Services agency. Finally, St. Martin's receives funding *as a mainstream service agency* to provide behavioral health services. This includes psychiatric services, outreach and case management, and medications for individuals who have been successful in obtaining benefits. The fact that this agency functions within the mainstream system, and that those staff are upstairs from the day shelter, has smoothed access to behavioral health services.

Permanent Housing

Crossroads for Women is a provider agency within the Albuquerque Continuum of Care system that provides housing, mental health, case management, life skills education, and vocational assistance to women who are homeless and suffering from mental illness and substance abuse disorders. This agency identified a PHA policy that was a barrier to women in their program. Most of the women served by Crossroads have a felony conviction and, in 2005, the PHA issued new rules that prohibited housing for anyone with a felony conviction, and eliminated exceptions based on substance abuse histories and substance abuse recovery. Crossroads called a meeting with PHA and were told that the only chance for women in their program was to file a "hopeless appeal." Crossroads completes an appeals packet, describing the Crossroads program, and about 90 percent of the appeals are successful—women are deemed eligible for housing assistance. Elizabeth Simpson, the Executive Director of Crossroads, believes this "work around" would not have been created if Crossroads had not simultaneously submitted a set of legal documents that examined the new rules, and made the case that a complete and permanent ban from public housing assistance is inconsistent with federal laws.

Vocational Rehabilitation

In January 2001, Crossroads for Women began to build a network of supporters within mainstream services agencies focused on helping these women, many with criminal records, improve job skills and obtain jobs. Partners included representatives from the State Department of Health and the State Office of Vocational Rehabilitation. A memorandum of understanding (MOU) was executed at the state level that addressed the needs of persons with mental illness in need of vocational rehabilitation services. This MOU paved the way for the development of a specific process that results in women with criminal records and significant disabilities being funded for vocational training. Elements of the change include a full-time vocational counselor employed by Crossroads for Women, the State Department of Health completing a Vocational Assessment Profile (VAP) for each woman referred, the State Department of Vocational Rehabilitation assigning one office to be the single point of contact for receiving VAPs from Crossroads and enrolling women for services, and women receiving Supportive Employment Services from Crossroads. In interview, Lisa Simpson stated that 90 percent of the women accepted into this program have been employed.

Identification

Albuquerque Health Care for the Homeless, St. Martin's Hospitality Center, and the New Mexico Coalition to End Homelessness worked with the New Mexico Motor Vehicles Department (MVD) regarding the requirement for a street address for legal identification. After a period of outreach and negotiation, MVD now accepts P.O. boxes as sufficient for individuals coming from within the Continuum of Care, and will issue a legal identification card. MVD created an alternative ID card which someone could get using a much longer list of documents to prove identity, identity number, and residency. Under the new rules that MVD created, a homeless person would have been unlikely to obtain a

regular ID because the list of acceptable documents was so narrow. Currently the alternative ID card can be used for everything that a regular ID can be used for.

List of Interviewees

- **Albuquerque Health Care for the Homeless** - Jennifer L. Metzler (Co-Executive Director)
- **Catholic Charities** - Carol Tonikha
- **Crossroads for Women** - Elizabeth E. Simpson (Executive Director)
- **New Mexico Coalition to End Homelessness** - Lisa LaBrecque (Policy and Advocacy Director)
- **St**. **Martin's Hospitality Center** - S. Brooks Bedwell (Assessment, Intake and Client Services Program Manager), Karen Navarro (Client Advocate), and Lee G. Pattison, Ph.D. (Executive Director)
- **Supportive Housing Coalition of New Mexico** - John Ames (Director, Housing First)

Albany and Albany County

The Albany Continuum of Care (CoC) serves all of Albany County, with a total estimated population of 297,556 as of 2006. The City of Albany is the population center of the area, and also the center of the homeless and mainstream services systems. Housing in the area could be considered relatively affordable for people with moderate income. As elsewhere, however, the housing market is not accessible to people with low incomes. In 2008, the fair market rent for a one-bedroom apartment was equal to 98 percent of the value of a Supplemental Security Income (SSI) check (Technical Assistance Collaborative, 2009). While New York State does offer general cash assistance through the Safety Net program, those in the program do not receive enough funds to meet even modest market rents.

Albany and Albany County	
Continuum of Care total population[1]	297,556

Community Characteristics		
	SSI as % median income[2]	18%
	1br FMR = %SSI[2]	98%
Homeless Population[3]	Total # people homeless	619
	# in households w/ children	223
	# households w/ children	68
	# households w/o children	394
	# chronically homeless	68
	# with MH diagnosis	151
	# with SA diagnosis	233
	# veterans	63
	# with HIV/AIDS diagnosis	32
	# DV victims	61
	# unaccompanied youth < 18	39

Demographics[1]		
	% Hispanic	4
Race	% American Indian/Alaskan Native	1
	% Asian	5
	% Black/African American	13
	% Native Hawaiian/Pacific Islander	0
	% White	83
	% speaking English < "very well"[4]	4
Age	% < 19	25
	% 20 – 24	9
	% 25 – 44	27
	% 45 – 64	26
	% > 65	14

[1]2006 estimated US Census data, except where noted

[2]Cooper et al, 2009

[3]2007 point-in-time count

[4]2006 American Community Survey

Site Selection Rationale

Provider cooperation is cited as the hallmark strength of the Albany system serving homeless people. As the organizing entity for Albany's CoC, the Albany County Coalition on Homelessness (ACCH) has played and continues to play a central role in fostering and maintaining cooperation. Interviewees described ACCH as being helpful in identifying problems and solutions on a communitywide basis. ACCH meets on a monthly basis, with the primary goals of coordinating the community's resources and

identifying and remedying needs or gaps in the systems serving homeless people. Interviewees described these meetings as productive, and indicated that they help to move things forward outside of grant season. The membership mix (both executive directors and line staff) was noted as helpful.

New York is a relatively generous state with respect to benefits and services, as evidenced by, among other things, liberal Medicaid benefits, a relatively extensive public mental health system, and SSI supplements for people with certain disabilities. General Assistance cash benefits (GA) are offered in New York and have historically been greater than those provided by most other GA-offering states (Gallagher et al. 1998). State generosity promotes many of the Albany programs described in this section.

Brief History

ACCH was initially convened in 1996. Since that time, staff support for ACCH has been provided by CARES, Inc., a local organization dedicated to serving people with HIV/AIDS. ACCH membership includes representatives of Albany County and City government offices, homeless and mainstream service provider organizations, community groups, faith-based organizations, and current and formerly homeless people. Members may be appointed or invited, or may volunteer to join.

In 2004, a number of ACCH members became interested in developing a 10 Year Plan to End Homelessness (10YP) within the community. These efforts were endorsed by the County Executive and the Albany Mayor, and an advisory group was convened in November 2004. From the start, the group's goals included addressing the needs of homeless families and homeless/runaway youth, as well as homeless single adults; working committees on the needs of each of these subpopulations were formed shortly after the advisory group was convened. The plan development process also included a series of focus groups with homeless adults, families, and youth, and a half-day conference involving all committee members and other community members. The 10YP was finalized in October 2005.

Structure of Community Coordination

As noted above, ACCH plays a central role in the organization and cooperation of the community's services for homeless people. Other key components of the system are described here.

Albany County Department of Social Services

The community's financial assistance programs are administered by the Albany County Department of Social Services (DSS). In addition to Temporary Assistance for Needy Families (TANF) and related employment services, food stamps, and Medicaid, DSS administers Safety Net, the community's general cash assistance program (formerly Home Relief). New York is among the roughly 50 percent of states that require drug and alcohol abuse screening, assessment, and treatment for welfare benefit applicants (Urban Institute n.d.). DSS workers conduct screening and refer those who screen positive to the Albany County Department of Mental Health (DMH) Central Management Unit for assessment, level of care and employability determinations, referral to treatment providers, and monitoring of individuals mandated to participate in treatment.

There is a strong administrative commitment to facilitating access to benefits and to addressing homelessness. Provider interviewees spontaneously attested to this commitment and indicated that it has made an impact at the ground level. DSS is involved in ACCH meetings, and a representative of the Commissioner's office chairs the community's 10 Year Plan Housing First Committee.

New York State's primary mechanism for reimbursing emergency shelters is the DSS-administered Temporary Assistance program (not to be confused with TANF). Those applying for shelter eligibility generally come to DSS via Homeless and Travelers Aid Society (HATAS) as part of the centralized intake system described below, although they occasionally come directly to DSS and are then referred to HATAS upon determination of eligibility. HATAS recently began maintaining onsite staffing at the DSS main office. People seeking shelter outside of business hours apply for DSS approval on the next business day, and DSS grants retroactive shelter reimbursement, if the applicant is otherwise determined eligible.

Albany County Department of Mental Health

The Albany County Department of Mental Health is responsible for developing and coordinating the community's mental health housing, an increasingly broad set of programs. These are contracted housing programs; DMH works to generate interest in the local provider community, and offers support through HUD and New York State Office of Mental Health funds. A number of mental health and homeless service providers currently hold DMH housing contracts, including Rehabilitation Support Services, Inc., Clearview Center, Catholic Charities, HATAS, and Capital Area Peer Services.

DMH also leads the Albany County Single Point of Access/Accountability (SPOA), a major mechanism for the coordination of mental health and homeless service provision in the community. SPOA meets ever other week to coordinate and allocate resources in relation to individual consumers' needs; among these tasks is the establishment of housing priorities for homeless people with mental health needs. Meetings include

representatives of DMH, mental health and homeless service providers, Capital District Psychiatric Center (CDPC), and Albany Medical Center.

The Patient Services Coordinating Committee was formed by DMH in the interests of better responding to people who were using a disproportionate amount of the system's resources, but were not receiving the services and supports that they needed. The group's goal is to help consumers access a unique package of services, specific to their individual needs. In addition to provider agency representatives, the group includes DSS representatives.

Centralized Intake: Homeless and Travelers Aid Society (HATAS)

The Homeless and Travelers Aid Society of the Capital District is a homeless services provider that is funded by DSS to perform a centralized intake function for Albany's homeless services system. To fulfill this role, HATAS facilitates shelter admission and eviction prevention. The organization has standard business hours but its on-call assistance is available after hours and on weekends. The centralized intake process is undergoing a period of restructuring; during our site visit, this function was being re-bid, and HATAS was not the only agency pursuing the new contract. HATAS was awarded the contract, but the centralized intake funding mechanism has changed. While it was originally supported by CoC funds, it will now be funded through DSS, and new performance criteria are in place as a result of this shift. This funding is a combination of TANF funds through the New York State Flexible Fund for Family Services and Albany County administrative dollars.

HATAS is also one of four community partners receiving New York State Homeless Intervention Program (HIP) funding; the other three partners are Interfaith Partnership for the Homeless (described below), Legal Aid Society of Northeastern New York, and United Tenants, a local nonprofit organization that focuses on housing conditions and tenants' rights. Administered on a statewide basis by the New York State Office of Temporary and Disability Assistance (OTDA) and locally by DSS, HIP is intended to assist both individuals and families in either retaining or securing and maintaining permanent housing for a 12-month period.

In addition to the above services and functions, HATAS operates case management and advocacy services for victims of domestic violence, Shelter Plus Care funding, payeeship services for SSI/Social Security Disability Income (SSDI) recipients referred from DMH, a housing subsidy for people with disabilities who are living in shelters, and a transition team for people discharged from CDPC as well as for aging-out youth.

Interfaith Partnership for the Homeless

The Interfaith Partnership for the Homeless was originally founded by a group of area churches in 1984. Originally, the organization was primarily concerned with providing a safe place for homeless people to sleep; the shelter it created has grown over the years, necessitating two moves. The most recent of these occurred in 2004, when the

organization completely rehabilitated a building in Albany's Arbor Hill neighborhood using funds from the Homeless Housing and Assistance Program (a competitive program administered by New York State OTDA). This building now houses Interfaith's offices and its 30-bed emergency shelter.

In addition to the shelter, Interfaith operates the Sheridan Hollow drop-in center, located within the same block. The call for the Sheridan Hollow drop-in-center originated in the 10YP, as committee members identified a need for a single location providing access to a wide range of services, such as mailboxes, showers, and case management. Today the drop-in center provides all of these services; many other area providers also have co-location arrangements with Interfaith via Sheridan Hollow (see mechanisms for further details). At the time of our visit, Interfaith was also developing a permanent housing program and a single room occupancy program. The organization had also recently joined HATAS, Legal Aid, and United Tenants in providing Albany's HIP-funded services.

List of Interviewees

- **The Addictions Care Center of Albany, Inc.** - David Cornish (Program Director) and Shari Noonan (Executive Director)

- **Albany County Department of Mental Health** - Susan Hornacek Daley (Associate Director of Administration) and Melissa Harshbarger (Housing Specialist)

- **Albany County Department of Social Services** - Linda Doyle (Program Coordinator), Alice Geel (Assistant Director of Social Service Programs), Anna Marie Massaro (Managed Care Coordinator), Beth O'Neil (Assistant Director, Employment Division), and Patty Smith-Willsey (Director, Adult Services)

- **Albany Housing Coalition, Inc.** - Glenn E. Read (Director of Veteran Services) and Joseph P. Sluszka (Executive Director)

- **ARISE** - Tom McPheeters

- **Capital City Rescue Mission** - David Poach (Intake Coordinator)

- **CARES, Inc.** - Joel Holl (Housing Placement Specialist), Linda Glassman (Executive Director), and Allyson Thiessen (Homeless Information Coordinator)

- **Catholic Charities of the Diocese of Albany** - Deborah Damm O'Brien (Executive Director), Thomas Coates (Housing Office Director of Operations), and Molly Malone (Senior Case Manager)

- **Clearview Center, Inc.** - Judy McLaughlin (Sherman Street Project Director)

- **Equinox, Inc.** - Kathy Magee (Director of Domestic Violence Services)

- **Homeless and Travelers Aid Society of the Capital District, Inc. -** Ira Mandelker, Ph.D. (Executive Director) and Joanne Zubris (Emergency Services Manager)

- **Hospitality House Therapeutic Community, Inc.** - Lauren Guest (Road to Recovery Specialist) and James W. Jeffreys, Ph.D. (Clinical Director)

- **Interfaith Partnership for the Homeless** - Brigitte Emanuel (Program Director), Kathy Leyden (Program Director), and Janine Robitaille (Executive Director)

- **Legal Aid Society of Northeastern New York, Inc.** - Lillian M. Moy (Executive Director) and Wendy Wahlberg (Deputy Director)

- **Rehabilitation Support Services, Inc.** - Mary Ellen McGowan-Brown (Program Director)

- **St. Catherine's Marillac Family Shelter** - Louisa Marra (Program Director)

- **St. Peter's Addition Recovery Center** - Robert J. Doherty (Executive Director) and Stephen M. Lape (Program Manager)

- **United Tenants of Albany** - Maria Markovics and Roger Markovics

Norfolk

According to census estimates, Norfolk's population totaled 229,112 in 2006, making it Virginia's second largest city, behind Virginia Beach. The population is divided fairly evenly between whites and blacks: 48.8 percent and 45.3 percent, respectively, with small numbers of other groups. In 2006, those under age 18 represented 26 percent of the population, and those over 65 represented 10.2 percent. The median family income (MFI) in 2006 stood at $44,127, well short of the state MFI of $66,886. Norfolk's poverty rate (18.5 percent) almost doubled the state rate (9.5 percent), and while 78 percent of the 25+ population have a high school degree, only 19.6 percent have a BA or higher—again, well short of the percentage for the state, 29.5 percent.

Norfolk has the second largest population of naval retirees and is the location of the largest naval base in the world. The city's major industries, not surprisingly, are defense contracting (ship building), cargo shipment, and coal shipment. Its major corporations include Norfolk Southern, Landmark Communications, Dominion Enterprises, FHC Health Systems, Portfolio Recovery Associates, and Blackhawk Products Group. Many of interviewees mentioned that business played a supportive role in the city's homeless efforts. As an example, Landmark recently made a $75,000 grant for permanent supportive housing furniture.

Norfolk	
Continuum of Care total population[1]	229,112

Community Characteristics		
	SSI as % median income[2]	17%
	1br FMR = %SSI[2]	123%
Homeless Population[3]	Total # people homeless	540
	# in households w/ children	113
	# households w/ children	40
	# households w/o children	427
	# chronically homeless	97
	# with MH diagnosis	57
	# with SA diagnosis	95
	# veterans	109
	# with HIV/AIDS diagnosis	13
	# DV victims	42
	# unaccompanied youth < 18	0

Demographics[1]		
	% Hispanic	4
Race	% American Indian/Alaskan Native	1
	% Asian	4
	% Black/African American	47
	% Native Hawaiian/Pacific Islander	0
	% White	51
	% speaking English < "very well"[4]	3
Age	% < 19	30
	% 20 – 24	12
	% 25 – 44	28
	% 45 – 64	20
	% > 65	10

[1]2006 estimated US Census data, except where noted

[2]Cooper et al, 2009

[3]2007 point-in-time count

[4]2006 American Community Survey

Norfolk's 2008 PIT identified a total of 502 homeless people, with 139 individuals in families and 363 single adults. Of the 502, 61 people mentioned that they were currently living on the street, 80 were in transitional housing, and 361 were residing in an emergency shelter. Subpopulations are broken down in Exhibit 1.

Norfolk Homeless Point in Time Subpopulations, 2008	
Subpopulations	Homeless Individuals
Chronically homeless	78
Mentally ill	67
Substance abuse	96
HIV/AIDS	7
Domestic violence	61
Physically disabled	69

Source: Norfolk Homeless Management Information System

Thirty-four percent of the population was identified as female and 66 percent as male. African Americans made up 67 percent of all those counted, while whites accounted for 17 percent; 6 percent were unknown. A total of 75 individuals, or 15 percent, were veterans.

Community Selection Rationale

Norfolk's Homeless Action Response Team (HART) and the city's Office to End Homelessness (OEH) provided the initial reasoning for our community visit. Since the creation of HART in 2004, Norfolk has received national attention as a model for homeless services intake mechanisms. The HART team primarily serves homeless families that are documented residents of Norfolk, providing links to mainstream benefits, services, and housing; it also serves homeless singles coming into the Department of Human Services (DHS), although only families are mandated to enter the system through HART. A year after HART started, Norfolk set up the Office to End Homelessness to ensure timely and sound implementation of their 10 Year Plan (10YP). The Office provides a link from the mayor's office to the broader homeless system, guaranteeing both a central contact and continued involvement from the city's senior leadership.

Brief History

In early 2004, Mayor Paul Fraim and the Norfolk City Council announced the creation of the Commission to End Homelessness, a 26-member group made up of both public and private partners. The initial purpose of the group was to deliberate and produce a "Blueprint," or Norfolk's 10 Year Plan to end homelessness. Utilizing local stakeholders and the Norfolk Homeless Advisory Committee—a group that, in December 2003, put out a report on the gaps in Norfolk's homeless system—the draft identified 19 areas of the Norfolk homeless system that needed to be developed, centering around case management, employment and support, and housing strategies.

In concordance with the plan, Mayor Fraim established the Office to End Homelessness in May 2005 and appointed its Director, Katie Kitchin. OEH was and is in charge of ensuring best practices and the implementation of the 10YP. It is widely regarded as *the* link from the various homeless initiatives to the mayor's office. In addition to her role at OEH, Ms. Kitchin also serves as an executive member of the Homeless Consortium Board – the oversight committee for the city's Continuum of Care.

In 2007, there was a critical reduction in available resources for homeless services distributed by DHS and HART that resulted from the state's more restrictive interpretation of the Comprehensive Service Act (CSA). The CSA law, passed in the early 1990s, allowed pooling of state agency funds, subject to a local match requirement (set at 25 percent for Norfolk), to support family preservation and prevention of foster care and other out-of-home placements. Previously, DHS made extensive use of CSA funds to prevent and end homelessness, following the rationale that homelessness leads to family dissolution and increased foster care placement for children. Because of Norfolk's large and unexpected usage, the state mandated that all cases using CSA funds go before a review board (the Norfolk Interagency Consortium) with strict new interpretations on what the funds could be used for. Norfolk had been the most liberal and generous jurisdiction in the state in making use of CSA funds, spending close to $600,000 through HART in 2006; at the time of this visit, HART was receiving far less for 2008.

Structure of Community Coordination

Norfolk's Homeless Consortium is made up of seven committees and taskforces that oversee various aspects of the city's system. The committees cover topics ranging from the broader Continuum of Care to homeless management information system development, single adult services, health care, employment, and central intake. Each committee or taskforce consists of representatives from local agencies involved in homeless services. The entire Consortium meets monthly while individual committees schedule their own meeting times.

As mentioned, the Office to End Homelessness plays a critical role in coordinating Norfolk's homeless services effort, even beyond its director's role on the Consortium's board. OEH is charged with identifying service gaps, developing new resources, assessing existing programs, and facilitating communication between various arms of the Continuum of Care. In that sense, it is a mechanism for smoothing, expanding, and changing access to mainstream benefits for the homeless. Multiple interviewees mentioned that OEH was integral in steering public dollars, like Home Investment Partnership program and Community Development Block grant funds, into the homeless system, and that the mayor provided invaluable support. OEH is used as a mechanism to ensure mayoral involvement and also highlights the importance of creating a high-level, central contact position for the city, especially in larger community efforts surrounding the delivery of benefits and services. As an example, OEH is in charge of bringing together all of Norfolk's homeless providers and homeless people under one roof twice each year, through its Project Homeless Connect. Interviewees continually noted the

success of the program, both in serving the homeless people who attended the events, and in providing an opportunity for representatives of organizations that serve the homeless to get acquainted with each other and build bonds of friendship. The importance of informal social connections across organizations was cited as a key contributor to the effectiveness of Norfolk's approach to homelessness, as was the ongoing support of Mayor Fraim and the existence of OEH.

Service provision for homeless people is distributed across a broad spectrum of public and private efforts. While DHS plays a central role in mainstream agency support for the city's homeless, other key agencies include Norfolk's Redevelopment and Housing Authority, the Veterans Administration, and the Virginia Employment Commission One-Stop. All are oriented to meeting the needs of homeless people. Mental health and substance abuse services are almost exclusively provided by the Community Service Board, an independent quasi-governmental agency that provides both mainstream and homeless-specific services (Project for Assistance in Transition from Homelessness [PATH], Housing First). In addition, through the homeless consortium and OEH, the city's mainstream agencies work with over 19 private homeless service providers.

Central Intake and the Homeless Action Response Team (HART)

Central Intake is a key focus of Norfolk's 10YP plan, and an updated family intake process has been successfully created and developed by DHS and OEH through HART. The approach to serving single adults is less well coordinated, but moving in similar directions. The HART team, located within the DHS office, serves as the single point of entry for all homeless families and some singles. Through a memorandum of agreement between DHS, three local shelters, and local providers, HART links homeless families and singles to shelters and mainstream benefits while also providing in-home services for families. Homeless families can go to the DHS office or they can call in through the Norfolk Hotline. From the HART background document: "After an initial screening, all families presenting with a housing crisis undergo an assessment using Structured Decision Making (SDM™), a research-based tool which determines whether families are at low, moderate, high, or very high risk of child abuse and neglect." Today, the city publishes a 24-hour hotline, staffed by HART and local shelters and all shelters refer incoming families to the HART team. For singles, there is no central intake, but for those coming into DHS, services and referrals are provided by HART.

List of Interviewees

- **ACCESS Housing and Norfolk's Homeless Consortium -** Stacie Walls-Beegle (Director)

- **Community Services Board -** Delsa Fauconier, Suzanne Davis, Renee Jackson (Case Manager), Shana Baum (Case Manager), Brenda Wise (Director of Administration), Pamela Davis (PATH Case Manager), Duane Miller (PATH Case Manager), and Jackie Schaede.

- **Department of Human Service/Homeless Action and Response Team (HART)** - Jill Baker, Program Manager

- **DHS Benefits Team** - Alicia Bazemore and Ken Walker

- **Health Care for Homeless Veterans -** Martha Chick-Ebey (Community Outreach)

- **Housing Broker Team** - Mike Taylor and Jill White

- **Norfolk Redevelopment and Housing Authority** - John Kownack (Program Services Director)

- **Office to End Homelessness** - Katie Kitchin (Director)

- **One-Stop and Virginia Employment Commission -** Kurt Clemons (Veterans Representative). Kim Staley, Melvin Clemons (Veterans Representative), Hosey Burgess, (Workforce Services Supervisor), and Nancy Stephens (Operations Manager)

- **Park Place Clinic -** Dr. Subir Vij (Medical Director) and Yvonne Price (Case Manager, Outreach)

- **The Planning Council -** Jill White (Housing Specialist) and Michael Taylor (Housing Specialist)

- **Salvation Army -** Heidi Grass (Case Manager) and Larry Ryan (Substance Abuse Counselor)

- **Second Chances and Harbor House -** Cynthia Thompson (Acting Director) and Michael Marshal (Program Specialist)

Portland

According to census estimates, Portland's population totaled 64,249 in 2006, making it Maine's most populous city. Caucasians are the predominant race, making up 92.8 percent of the city's population. The percent of the population in 2006 that was under 18 was 21 percent, and 13.9 percent were over 65.

The median household income in 2005 was $40,500, compared with the state of Maine's median household income which was at $42,801. Portland's poverty rate is at 9.7 percent. 88.3 percent of Portland's population have earned at least a high school degree, and 38 percent have a BA or higher.

Portland is Maine's cultural, social and economic capital. It is also the principal city of the Portland–South Portland–Biddeford, Maine Metropolitan Statistical Area, which includes Cumberland, York, and Sagadahoc counties. Tourists are drawn to Portland's historic Old Port district along Portland Harbor, which is at the mouth of the Fore River and part of Casco Bay, and the Arts District, which runs along Congress Street in the center of the city.

Portland	
Continuum of Care total population[1]	64,249

Community Characteristics		
	SSI as % median income[2]	16%
	1br FMR = %SSI[2]	124%
Homeless Population[3]	Total # people homeless	741
	# in households w/ children	294
	# households w/ children	110
	# households w/o children	438
	# chronically homeless	44
	# with MH diagnosis	121
	# with SA diagnosis	72
	# veterans	44
	# with HIV/AIDS diagnosis	1
	# DV victims	18
	# unaccompanied youth < 18	0

Demographics[1]		
	% Hispanic	2
Race	% American Indian/Alaskan Native	1
	% Asian	4
	% Black/African American	3
	% Native Hawaiian/Pacific Islander	0
	% White	93
	% speaking English < "very well"[4]	3
Age	% < 19	21
	% 20 – 24	8
	% 25 – 44	36
	% 45 – 64	21
	% > 65	14

[1]2006 estimated US Census data, except where noted

[2]Cooper et al, 2009

[3]2007 point-in-time count

[4]2006 American Community Survey

In Portland, there were a total of 741 homeless people according to the 2007 point-in-time count. This total included 110 households with children and 438 households without children. Of the 741 people, 121 had mental health problems, 72 had substance

abuse problems, 18 were victims of domestic violence and 44 were veterans. 52.1 percent of the population was identified as female and 47.9 percent as male.

Maine has a statewide plan to end homelessness, to which the different regions and cities contributed. Portland does not have its own separate plan to end homelessness, but it has a long history of other homeless-related plans. Maine's plan to end and prevent homelessness was created by a diverse group of stakeholders from the Statewide Homeless Council and the three Regional Homeless Councils. It is considered a work in progress designed to continually involve everyone working to end homelessness in Maine.

The plan provides a blueprint for meeting the needs of all homeless or at-risk populations over the years by taking action steps to end and prevent homelessness. The plan to end homelessness is a statewide effort with homeless service providers and stakeholders working through each Regional Homeless Council and the Statewide Homeless Council to meet the goal of ending homelessness in Maine. Stakeholders may provide input through the Regional Homeless Councils or by contacting any member of the Statewide Homeless Council.

The plan has several goals. One focuses on the front end, using outreach to help people having a housing emergency to stay in their homes and emergency shelters to provide safety while promoting rapid re-housing with adequate supports to increase the odds that people will be able to retain their new housing. Another goal is to ensure an adequate supply of appropriate housing and rental subsidies to support rapid re-housing and stability. The next goal is to ensure that physical, mental, and chemical health needs of homeless people are met to allow long-term stability and success. The last goal is to ensure that issues underlying homelessness are addressed and that linkage to an effective, on-going support system is securely in place.

Site Selection Rationale

The primary mechanism that drove our initial interest in Portland was the Continuum of Care (CoC) that had long been established in Portland. The Emergency Shelter Assessment Committee is a structure of the CoC. Early in the 1980s the city of Portland and the United Way formed a task force to examine the growing phenomenon of homeless families and develop ideas for how to address it. One task force recommendation was for a permanent body to address homeless-related concerns; ESAC was formed in response to this recommendation. ESAC was charged with developing approaches to dealing with homelessness in the community, focusing initially on family homelessness but ultimately broadening its purpose to include all homelessness.

ESAC focuses specifically on issues that pertain to Portland's homeless population. ESAC also establishes standards of care and performance at shelters and reviews shelters against these standards on a regular basis. It is able to anticipate issues, troubleshoot barriers and roadblocks, strategize for the smoothest way to introduce new practices, and create subcommittees to address particular planning issues. The group looks at program

utilization statistics every month, discusses changes, and, if there appear to be problems, tries to figure out what to do.

In 1996, when HUD started the Continuum of Care (CoC) approach for applying for federal SHP funding, the Portland City Council designated ESAC to serve as the governing entity for the city's CoC Homeless Assistance Grant Program. As part of the annual CoC planning and prioritizing process, which ESAC organizes every year, ESAC established a CoC Priorities Committee that reviews project performance and quality and assigns priority scores to applications being proposed for the city's SuperNOFA submission. The Priorities Committee reviews each HUD grantee to make sure it is fulfilling the terms of its proposal and grant. Any provider that is seriously out of compliance risks getting a low priority score and thus potentially not getting HUD funding for the coming year. ESAC includes state representatives from MaineHouse and DHHS who are integral to its leadership and activities. ESAC controls the membership of the Priorities Committee to make sure that members charged with establishing priority scores have no conflicts of interest with service providers submitting proposals.

Brief History

For a long time, Portland went its own way dealing with homelessness while the rest of its county (Cumberland) was not part of its plans. The players in neighboring York County knew the players from Cumberland County and interacted in state-level activities, but there was no official coordination with homeless-related activities. In 2006, as part of statewide organizing around homelessness, Cumberland and York Counties were asked to work together as one of three Regional Homeless Councils. This Region I council was the last of the three to get organized because Portland was already organized, being its own CoC and having an array of plans in place for where it wanted its system to go and how it wanted to use available resources and new ones as they came along or could be raised. The DHHS director for Region I helped bring the two counties together beginning in June 2005. After a steering committee came up with plans and a decision-making structure that satisfied the concerns of both counties, the Region I Council was formed. It has responsibility for planning and also for prioritizing the use of state homeless resources within its two counties. ESAC focuses specifically on issues that pertain to Portland's homeless population,

Most of the Portland-specific structures and programs existed before the Region I Council started. Some predate the 1987 McKinney Act, but they and the Portland governance structure now participate in the regional process and are benefiting from it. In addition to changes in ESAC, a good example of the benefits of regionalizing is the new position devoted to homelessness prevention for families in crisis in the small towns in Cumberland County outside of Portland, which is supported by the first-ever money that the county has ever committed to a homeless-related function. By connecting families to mainstream resources that help to keep them in their homes, the person in this new position helps keep families in their home communities and prevents them from moving to Portland to get assistance.

Structure of Community Coordination

The City of Portland has long been its own CoC and has a long history of activism related to homelessness. Some of its structures, such as the Emergency Shelter Assessment Committee (ESAC), date back to the early days of awareness that homelessness was here to stay in the latter part of the 20th century, not just a blip caused by the 1981-82 recession. For a long time, Portland went its own way and the rest of its county (Cumberland) was not part of its plans. Nor was there coordination with homeless-related activities in neighboring York County, although all the players knew each other and interacted in state-level activities. Portland was the first entity in Maine to have any type of homeless plan or structure to deal with homelessness.

In 2006, as part of statewide organizing around homelessness, Cumberland County, including Portland, and York County were asked to work together as one of three Regional Homeless Councils. This Region I council was the last of the three to get organized because Portland was already organized, being its own CoC and having an array of plans in place for where it wanted its system to go and how it wanted to use available resources and new ones as they came along or could be raised. The DHHS director for Region I helped bring the two counties together beginning in June 2005. After a steering committee came up with plans and a decision-making structure that satisfied the concerns of both counties, the Region I Council was formed. It has responsibility for planning and also for prioritizing the use of state homeless resources within its two counties.

Most of the Portland-specific structures and programs that we visited for this project existed before the Region I Council started, and some predate the 1987 McKinney Act, but they and the Portland governance structure now participate in the regional process and are benefiting from it. In addition to changes in ESAC a good example of the benefits of regionalizing is the new position devoted to homelessness prevention for families in crisis in the small towns in Cumberland County outside of Portland, which is supported by the first-ever money that the county has ever committed to a homeless-related function. As described in more detail below, by connecting families to mainstream resources that help to keep them in their homes, the person in this new position helps keep families in their home communities and prevents them from moving to Portland to get assistance.

Trainings

With the increased emphasis on helping clients access mainstream services, ESAC began organizing trainings given by mainstream service providers for shelter directors and case managers/line workers to attend. The goal is to teach people how to access mainstream services. Trainings have been done on GA, TANF/ASPIRE (Welfare-to-Work), rental subsidies including RAC and RAC+ (two programs offered by MaineHousing, the state housing authority), SSI/SSDI, energy assistance (LIHEAP), VA, MaineCare, SCHIP, and food stamps, and also one by Shalom House on accessing Shelter plus Care. Mainstream service agency staff say they can see the evidence of trainings in the referral source and quality of applications they receive. ESAC and mainstream agency staff work

together to identify training needs, and try to schedule a training when an agency is receiving a large number of "inaccurate" or "inappropriate" applications for its benefits. Agency staff also note a decline in inappropriate these applications following a training. Following trainings ESAC could see positive results in terms of increased applications and approvals. An additional benefit of the trainings is that they offer an opportunity for case managers to develop personal relationships with mainstream service providers.

SSI/SSDI Coordinator

The City of Portland funds a position (held by Julie Glassock) that is specifically responsible for helping people qualify for SSI/SSDI. Ms Glassock is very successful at this endeavor for a number of reasons. She spends a lot of time with potential applicants to get great detail up front about their illnesses, treatment, and work histories. She develops trusting relationships with clients and they disclose information to her that they may not otherwise reveal on applications. She also uses her office address as a mailing address for all of these applications so that she can stay on top of the claims and requests from SSA (for more information, etc.) do not get lost or ignored. These two components together establish continuity of contact (with applicants and with the SSA office.) As a result, Portland's primary allowance rate is much higher than the national average (~42 percent in Portland versus ~30 percent nationally). From July 1, 2007 through May 2008, 83 of the applications Ms. Glassock filed received awards, 40 at initial decision and the rest on review. About 80 percent of the people Ms. Glassock meets with, submit applications.

Geographic Location

The Portland shelters are very good at referring people to the State DHHS office in part because they are (geographically) located so close to one another. Shelter staff can walk out the door and point to the DHHS building or, if necessary, they can walk people there directly. At one point in time the DHHS office was going to be moved to the outskirts of town but they were able to prevent this move, in part, because their location close to the shelters is so important to their clients.

Language Line & Refugee Services

Portland is a center for refugees, particularly from Somalia and the Sudan, but DHHS has dealt with people speaking more than 20 different languages. In earlier years families from both of these countries, plus secondary refugees seeking to join family, were settled in Portland. One time Portland was at capacity and asked a shelter in Lewiston if it could accommodate some newly arrived Sudanese families. Since that time, most of the Sudanese gravitate to Lewiston, but Somalis and refugees from other countries still settle predominantly in Portland.

List of Interviewees

- **Catholic Charities Maine -** Arian L. Giantris (Director, Refugee and Immigration Services)

- **Family Crisis Services -** Heather Treadwell (Residential Services Team Leader)

- **Maine Housing -** Cindy Namer (Manager, Homeless Initiatives)

- **Milestone Foundation, Inc. -** Linda Janson (Director of Operations)

- **MAPS Shelter Services -** Peter Rand and Meg Ward

- **People's Regional Opportunity Program -** Maurice E. Geoffrey, Raenae Moore, and Mary L. Perry

- **Portland, Maine Health and Human Services Department -** Ron Bansmer (Assistant MaineCare Program Manager), Todd Beaumier (Representative Payee, Social Services Division), Linda Dinsmore (Human Services Counselor, Social Services Division Family Shelter), Robert Duranleau (Director, Social Services Division), Douglas S. Gardner (Director), Aaron Geyer (Senior Human Services Counselor, Social Services Division), Julie Glassock (Human Services Counselor, Social Services Division), Terry Hamilton (Program Administrator, Office of Integrated Access and Support), Angela Havlin (Human Services Counselor, Social Services Division, Oxford Street Shelter), Riga Hourigan (Human Services Counselor, Adult Services), Abeir Ibrahim (Human Services Counselor, Social Services Division), Pamela McNally (Support Services Supervisor, Social Services Division Oxford Street Shelter), Josh O'Brien (Shelter Director, Social Services Division Oxford Street Shelter), Regina Phillips (Program Coordinator, Social Services Division Refugee Services), Sean Sheerins (Human Services Counselor, Social Services Division, Oxford Street Shelter for Men), and Jeff Tardif (Family Services Supervisor, Social Services Division)

- **Preble Street** - Jon Bradley (Assistant Director), Susannah Fuentes (Day Shelter Services Coordinator), Sally Hoyt (Employment Case Manager), Rob Paritt (Employment Services Case Worker), Mark R. Swann (Executive Director), Maria Tripp (Logan Place Coordinator), and Amanda Wells (Women's Shelter Coordinator)

- **Shalom House -** Melany Mondello (Statewide Subsidy Coordinator) and Kyra Walker (LAA Housing Subsidy Coordinator)

- **Social Security Administration -** Robert Clark (Public Affairs Specialist)

- **Spring Harbor Hospital** - Nancy Ashbaugh and Cynthia Kunkel

- **U.S. Department of Veterans Affairs** - Susan L. Whittington (Homeless Veterans Grant and Per Diem Liaison)

APPENDIX B – Site Visit Protocols

Homeless People's Access to Mainstream Services

System Overview Questions for Coordinators/System Administrators

INTRODUCTION

Thank you for taking the time to talk with us today. We're [*INTERVIEWER NAMES*] from [*AHP/URBAN INSTITUTE/WESTAT*] and [*AHP/URBAN INSTITUTE/WESTAT*], respectively. We're working on a HUD-sponsored study of factors affecting homeless people's access to mainstream services and benefits. [*COMMUNITY NAME*] was chosen as a study site, and we're interested in talking to you as someone who is in a position to reflect on overall community strategies and approaches to increasing mainstream access. We're interested in learning from you about the thinking behind how your community has tackled the issue of bringing mainstream benefits and services into play to end people's homelessness, sustaining them in housing once they regain it, and preventing other people from becoming homeless.

While our final report will include a list of everyone that we interview, we won't cite your comments verbatim or attribute specific statements to you by name. The only potential exception to this rule would occur if you tell us about a program that we end up highlighting as an illustrative program. Should this occur, we would send the final text of the highlight to you for your sign-off before including it in any report.

Overall Community Organization to Address Homelessness

1. Please describe the **ways your community is organized to address homelessness**. By this I mean the CoC and any other committees, task forces, councils, coalitions, training or cross-training structures, advocacy structures, or anything else currently working on some aspect of serving homeless people or ending homelessness.

2. [*GET ALL THE NAMES – DRAW THEM—MAKE A PICTURE*.]

GRAPHIC DEPICTION OF COMMUNITY ORGANIZING STRUCTURE FOR HOMELESSNESS

[*CAN INCLUDE RELATIONSHIP TO STATE/COUNTY/CITY ENTITIES, IF RELEVANT*]

Public Agency Responsibilities for Mainstream Benefits and Services

3. In your community which agency is responsible for each of the following benefits/services [*SHOW LIST A, GET NAMES AND BEST CONTACT FOR EACH AGENCY]*

Strategies/Overall Community Approach to Increasing Access

4. Please tell me how your community has been thinking about assuring that homeless people get the mainstream services they need?

    a. Do you have an overall approach—something that guides you in deciding what needs to be done and who needs to be involved? If yes, please describe.

    b. Can you tell me something of the history of your approach/these strategies?

        i. When did you start trying to improve access? What were your first approaches?

        ii. Does a person's location on the streets, in ES, in TH, or in PSH make a difference for your community's approach or strategy for helping him/her get benefits? What differences?

        iii. Have your strategies changed/developed since early on? If yes, from what to what? Why? Who was involved in pushing for these changes? Making them work?

        iv. How did/do you decide what strategies might be the most effective? What changes are under your control locally? What state or federal policies or practices you might be able to influence?

        v. Who were/are the key people involved in the work to increase access?

        vi. What was the effect on your community's efforts to increase mainstream access of HUD's shift in emphasis to put more of its money into housing rather than services.

Entities with specific access focus

5. Do any of the entities you described earlier have a particular focus on increasing mainstream access and/or assuring that people keep their benefits or stay connected to services once access is assured? If yes, which one(s)? Then ask, for each:

    a. What does it do? What are its responsibilities with respect to increasing access?

    b. Who/what participates in its activities to increase access? What are their roles/what do they do to assure access and continuing services/benefits?

        i. Which mainstream service agencies (e.g., human services, social services, TANF, Medicaid, health care, mental health, substance abuse, HIV/AIDS, veterans)?

ii. Which mainstream housing agencies (e.g., housing authority, housing finance agency, housing trust fund, housing/economic/community development agency)

iii. Provider and advocacy groups?

iv. Consumers and other individuals?

c. [*GET ANY INFORMATION ON HISTORY SPECIFIC TO THIS COMMITTEE/ENTITY THAT WOULD ADD TO WHAT WE ALREADY KNOW ABOUT THE DEVELOPMENT OF ACCESS MECHANISMS IN THIS COMMUNITY*.]

Challenges

6. What do you see as the biggest challenges to increasing access to mainstream services for homeless people? Please describe how they have influenced your community's approaches, and also its successes?

   a. Type of household—family/single adult

   b. Disabilities—do specific types of disabilities or individual barriers make a difference?

   c. Sheer availability or amount of a resource, or its limited or reduced availability?

   d. For means-tested benefits that provide ongoing income, subsidy, or services, such as GA, TANF, food stamps, Medicaid, SSI, what are the most important factors affecting your strategies?

      i. Probes: eligibility restrictions, level of government, relationships with local government office staff, prior history of cooperation (or lack thereof), ability to influence relevant politicians, rigor of the application process, etc.

   e. For services, such as mental health care, primary health care, substance abuse treatment, employment-related assistance, child-related services, what are the most important factors affecting your strategies?

      i. Probes: level of government, relationships with local government office staff, prior history of cooperation (or lack thereof), ability to influence relevant politicians, etc.

   f. As far as you are aware, does a person's or family's homelessness, *per se*, pose a challenge to accessing mainstream services, over and above what a poor housed person or family would face?

      i. If yes, please describe.

      ii. As part of this question, does a homeless person's "location" within the system of homeless services make a difference to the ease or difficulty of mainstream service access? E.g., is it easier or harder to connect people staying in ES, vs. people in TH or PSH. If yes, please describe the differences.

Perceptions of success/evidence of success

7. Please tell me how your community tells itself whether its efforts to improve mainstream access are succeeding?
    a. Do you have a formal approach—HMIS or some other data system?
        i. If yes, please describe. Would this data system serve as a reliable source of information on the extent to which homeless people access mainstream benefits and services? If so, for which benefits and services? Do you regularly produce reports? How many years back to these reports go? [*GET THE DATA SHOWING SUCCESS AND REQUEST REPORTS IF APPLICABLE.*]
    b. I'd also like your impressions about which strategies seem to work best, and your reasons for saying so.
    c. Also, could you give me your impressions of factors that make a difference for whether or not your efforts will succeed?
        i. Issues with the specific benefit or service—are some easier than others?
        ii. Issues with household type (singles vs. families)?
        iii. Issues with client characteristics such as disability, criminal record, victimization, prior failure at particular services or programs?
        iv. Issues with a person's location on the streets, in ES, in TH, or in PSH?
        v. Issues with a person being local or coming from another community or another state?
        vi. Issues with documentation for immigrants? For other people?

Specific Mechanisms for Increasing Access to Mainstream Services

8. Please tell me all the different approaches that your community is using to increase access. Once I have a general idea of what these mechanisms are, we can decide which ones we should visit and I can get contact information, etc. to set up our visit.
9. We're interested in ***ANY*** approaches, including those that might have evolved among one or two providers. We've thought about the following types of mechanisms, but feel free to add any as we go along.
10. First, tell me about any mechanisms that **make it easier to apply or to have an application accepted** (smoothing), such as mainstream outreach to homeless service locations (putting a VA or mental health worker on site at homeless programs once a week), creating a unified application for several benefits programs, creating a multi-agency team, co-case management, trainings to increase mutual knowledge among caseworkers in homeless assistance and mainstream agencies, etc.

a. What mechanisms does your community have/use to make it easier to apply or have an application accepted?

B.[MAKE LIST, GET CONTACT NAMES, PHONE, EMAIL, ETC.

i. FOR EACH ONE, GET A BRIEF DESCRIPTION OF WHAT IT IS AND WHERE IT FITS IN THE OVERALL STRATEGY/APPROACH, INCLUDING THAT IT DOESN'T FIT BUT IS JUST OFF ON ITS OWN.]

11. Second, tell me about any **changes in eligibility or the eligibility process** that you have been able to establish, including actual changes in agency policy, expanded eligibility criteria, presumptive eligibility, relaxing or modifying some documentation rules, etc

    a. Have any mainstream agencies in your community made any changes in eligibility for receipt of a benefit or service? If yes,

    b. Make a list. Get names and contact info for who would be best to talk with about each.

    c. Then for each one, get a brief description of what it is and where it fits in the overall strategy/approach, including that it doesn't fit but is just off on its own.

12. Third, I'd like to know about **expanding or shifting resources** to get more supportive services to homeless people, including new money (e.g., new document recordation fee that gets used to pay for services), more money added to existing categories or line items, or new programs for particular homeless people, set-asides, shifts in priorities for who gets a benefit, etc. Also include new grants or contracts to homeless providers for supportive services, "whatever it takes" funding streams, etc.

    a. Has your community developed any of these expansions/additional resources?

    b. If yes, what is it/are they?

    c. Make list, get contact names, phone, email, etc.

        ii. For each one, get a brief description of what it is and where it fits in the overall strategy/approach, including that it doesn't fit but is just off on its own.

Do you have anything else you would like to add?

Anything that is on the horizon but not yet in practice?

Any threats to existing mechanisms, or mechanisms that have already died due to reduced funding or support?

In addition to yourself, who else should we be talking with to get the overall picture of your community's approach to increasing access to mainstream resources? Could you give me names, contact info, and the person's unique perspective on these issues?

[IF ADMINISTRATOR IS PRIMARY SOURCE FOR COMMUNITY] **We will send you our descriptions of the programs or activities in your community before we submit our reports to HUD. You'll have the opportunity to approve our descriptions at that time, and to review them with anyone else in your community for clarification. Thank you for your time and information. You have been extremely helpful.**

[IF ADMINISTRATOR IS SECONDARY SOURCE FOR COMMUNITY] **We will send [PRIMARY SOURCE NAME] our descriptions of the programs or activities in your community before we submit our reports to HUD. S/he will have the opportunity to approve our descriptions at that time, and may also choose to share them with you or others in your community. Thank you for your time and information. You have been extremely helpful.**

Mainstream Agency Staff

INTRODUCTION

Thank you for taking the time to talk with us today. We're [*INTERVIEWER NAMES*] from [*AHP/URBAN INSTITUTE/WESTAT*] and [*AHP/URBAN INSTITUTE/WESTAT*], respectively. As you're probably already aware, we're working on a HUD-sponsored study of factors affecting homeless people's access to mainstream services and benefits. [*COMMUNITY NAME*] was chosen as a study site, and we've talked with [*ADMINISTRATOR(S)]* at *[ORGANIZATION NAME(S)*] to identify specific mechanisms by which that's happening in your community. We're interested in talking to you about homeless people's access to [*PROGRAM NAME*]'s services, and about any other things you are involved with to help homeless people get mainstream services.

While our final report will include a list of everyone that we interview, we won't cite your comments verbatim or attribute specific statements to you by name. The only potential exception to this rule would occur if you tell us about a program that we end up highlighting as an illustrative program. Should this occur, we would send the final text of the highlight to you for your sign-off before including it in any report.

QUESTIONS

Basics

1. Date of interview
2. Interviewer(s)

Respondent Role

3. Community
4. Name, title, contact info – [*GET CARDS*]
5. Agency (and division, if appropriate)
6. Program name – e.g., Social Security, The Center for Behavioral Health, etc.
7. Client types – singles only, adult men only, families only, pregnant teens only, recovering substance abusing families only, etc.
8. Specific role (e.g., director, manager/supervisor, eligibility tech, bene counselor, etc.)
9. Of the consumers you work with, what proportion are homeless?

Relevant benefits and services

10. [*SHOW R* LIST A] Which of these mainstream benefits and services does your agency provide? *[IF R INDICATES FOUR OR FEWER BENEFITS, FOR QUESTIONS 11-17 ASK R ONLY ABOUT THESE. IF R INDICATES MORE THAN FOUR BENEFITS AND SERVICES, ASK R:*]

a. Are any of these benefits and services accessed through the same process? *[IF R INDICATES THAT THE INDICATED BENEFITS AND SERVICES ARE ACCESSED THROUGH FOUR OR FEWER PROCESSES, GROUP THE BENEFITS BY PROCESS AND PROCEED THROUGH ITEMS 11-17 IN REFERENCE TO EACH GROUP. IF R INDICATES THAT THE BENEFITS AND SERVICES ARE ACCESSED THROUGH UNIQUE PROCESSES - OR MORE THAN FOUR PROCESSES - ASK R:*]

b. Which four benefits or services do you help people get most often? *[ASK R ONLY ABOUT THESE*]

Basic information about each benefit or service that R works with/on

Okay, I'd like to start with getting some basic information about eligibility criteria, the application process, and a few other things about each of the benefits and services your agency provides.

11. For each mainstream benefit or service mentioned in Q10 that is included in our scope, could you tell me:

    a. For those not already enrolled, how does the application process work for this benefit? What do clients/providers have to do/provide/fill out? Where do you have to go?

    b. What type of assistance do you provide to help people enroll? Anything specific to homeless people?

    c. Who else helps homeless people access your services? What type of assistance do they provide?"

    d. Once the application is in, how long does it take for your agency to make a decision? If this involves any additional steps, what are they, or what could they be?

    e. What are the biggest challenges or barriers that any poor person or family would face in establishing eligibility for this benefit/service?

    f. Are there any challenges or barriers that are particularly difficult to overcome because the applicant is **homeless,** as well as being poor?

    g. What might cause a person to lose the benefit/service?

    h. How do you reach out to insure homeless people are receiving benefits or know about the availability of benefits? Do you get referrals from local homeless providers?

Who else works on access for this benefit?

12. Does anyone at your agency specifically help homeless people apply for this benefit?

13. Have you, and anyone else who works on access for this benefit, given any

special training to help homeless client's and homeless service providers get through the process faster, or with more success? If yes, please describe?

14. Do you, or anyone who works on access for this benefit, work closely with anyone at local shelters or homeless service providers to move these applications along faster, or more effectively? If yes, please describe.

Changes in access for/availability of this benefit/service

A number of our questions relate to mechanisms that your community is using to increase access. When we use the term "mechanisms" we're referring to any approaches your community is using. These include:

- **activities that are intended to *make it easier to apply or to have an application accepted* (smoothing), such as starting mainstream outreach to homeless service locations, creating a unified application for several benefits programs, creating a multi-agency team, co-case management, trainings to increase mutual knowledge among caseworkers in homeless assistance and mainstream agencies, etc,**
- ***making changes in eligibility or the eligibility process*, including actual changes in agency policy, expanded eligibility criteria, presumptive eligibility, relaxing or modifying some documentation rules, and**
- ***expanding or shifting resources* to get more supportive services to homeless people, including new money more money added to existing categories or line items, or new programs for particular homeless people, set-asides, shifts in priorities for who gets a benefit, etc.**

15. For your homeless clients, has access to/availability of this benefit/service increased, stayed level, or decreased during the last five years?
    a. *If increase:* What mechanisms, either in the state, the service system, or your agency has helped to increase access/availability? More/new funding? What barriers were removed or neutralized with these mechanisms?
    b. *If level:* What mechanisms, either in the state, the service system, or your agency has helped to maintain the level of access/availability?
    c. *If decrease:* Why has access/availability declined? Funding cuts? Changes in regulations? Additional eligibility barriers?

"Typical" benefit packages

16. What mainstream benefits would you say a "typical" homeless single is eligible for?

    a. If the answer would differ depending on whether you're talking about someone in ES vs. someone in TH or PSH, then what would be typical of someone in ES? In TH? In PSH?

17. What mainstream benefits and/or services would you say a "typical" homeless

family is eligible for?

a. If the answer would differ depending on whether you're talking about a family just applying for or in ES vs. someone in TH or PSH, then what would be typical of someone in ES? In TH? In PSH?

Strategies when a person/family may qualify for more than one benefit/service

18. What screening do you/does your agency do to determine the benefits and services a person/family may qualify for?

    a. Does everyone coming to your agency get this screening? If not, how decide who gets it?

    b. Is there a special preference for homeless individuals?

    c. What happens if a person needs a benefit or service but you don't think s/he will qualify for it?

19. Are there any types of benefits or services that you know will take longer to get? If yes, how do you prioritize trying to get people these benefits?

20. Does your agency work with other local agencies to link people up with services? Does your agency work with other local service providers?

R's Involvement with special mechanisms

21. Are you involved with any special mechanisms to improve homeless people's access to mainstreams services?

[*GIVE EXAMPLES YOU KNOW ARE HAPPENING IN THIS COMMUNITY. ASK FOR OTHERS]*

For each mechanism that R is involved with:

22. [*GET THE NAME OF THE MECHANISM. TRY TO BE CONSISTENT IN NAMING THESE THINGS, SO WE ALL KNOW WE'RE TALKING ABOUT THE SAME THING.]*

23. *[ASK R TO SHOW YOU WHERE THE MECHANISM OR MECHANISMS S/HE WORKS WITH FITS INTO THE OVERALL STRUCTURE OF THE COMMUNITY RESPONSE TO HOMELESSNESS THAT YOU GOT FROM THE OVERVIEW PERSON/PEOPLE. LOCATE IT SPECIFICALLY ON THE GRAPHIC WE HAVE OF THE COMMUNITY ORGANIZING STRUCTURE. ASK R TO CONFIRM THE ACCURACY OF THE GRAPHIC FOR THE PART OF THE SYSTEM THAT S/HE IS FAMILIAR WITH.*]

GRAPHIC DEPICTION OF COMMUNITY ORGANIZING STRUCTURE FOR HOMELESSNESS

[*can include relationship to state/county/city entities, if relevant*]

[*FOR THESE INTERVIEWS, THIS BOX WILL BE FILLED IN WITH THE PICTURE YOU GOT FROM THE OVERVIEW PERSON/PEOPLE YOU INTERVIEWED*]

24. [*FROM R'S PERSPECTIVE*], what is it?
25. What is [*R'S*] role in making the mechanism work?
26. What does it do? How does it work?
27. How is it paid for? What funding streams support it?
28. [History—Do a brief check to see whether the R agrees with the description of history we got from the admin level; what else s/he might want to add.
    a. Find out specifically whether the mechanism was created in response to HUD's shift of resources out of services, or, if it predates that HUD change, whether it was modified/beefed up in response to same.]
29. Who is involved? Any other mainstream programs, in which agencies? Homeless service providers?
30. How is it going?
    a. [*GET NARRATIVE OF HOW IT HAS BEEN RECEIVED, WHETHER THE MAINSTREAM AGENCY PEOPLE SEEM TO LIKE IT, WHETHER IT HAS HAD SIGNIFICANT CHALLENGES TO OVERCOME AND HOW IT HAS DONE THAT (IF IT HAS), ETC.*]
    b. [*GET EVIDENCE OF SUCCESS (MORE PEOPLE RECEIVING), INCLUDING FROM AGENCY DATABASES, HMIS AND APRS.*]

[*ONCE YOU HAVE THE INFORMATION FROM QS 21-30, CLASSIFY THE MECHANISM: DOES IT APPEAR TO BE A SMOOTHING, ELIGIBILITY, OR EXPANSION MECHANISM, OR HAVE ELEMENTS OF ONE OR MORE OF THESE MECHANISMS? GIVE EXAMPLES TO JUSTIFY YOUR CLASSIFICATION*.]

- **Smoothing—**anything that makes it easier to apply or to have an application accepted (.e.g., outreach, unified application, multi-agency team, co-case management, trainings, etc.
- **Changes in eligibility**—actual changes in agency policy, expanded eligibility criteria, presumptive eligibility practices, relaxing or modifying some documentation rules, etc.
- **Expanding or shifting resources** to get more supportive services to homeless people, including new money (e.g., new document recordation fee that gets used to pay for services), more money, or new programs for particular homeless people, set-asides, shifts in priorities for who gets a benefit, etc. Also includes new grants or contracts to homeless providers for supportive services, "whatever it takes" funding streams, etc.

31. **Challenges**—What do you see as the biggest challenges to increasing access to mainstream services for homeless people? Please describe how they have influenced the ways you try to help people get mainstream benefits and services?

a. Type of household—family/single adult

b. Disabilities—do specific types of disabilities or individual barriers make a difference?

c. Sheer availability or amount of a resource, or its limited or reduced availability?

d. Other barriers? Transportation? Documentation?

Depending on the agency:

a. [*FOR AGENCIES GIVING MEANS-TESTED BENEFITS THAT PROVIDE ONGOING INCOME, SUBSIDY, OR SERVICES, SUCH AS GA, TANF, FOOD STAMPS, MEDICAID, SSI*] what are the most important factors affecting your ability to provide homeless people with services?

   i. Probes: eligibility restrictions, transportation, documentation, level of government, relationships with local homeless providers, prior history of cooperation (or lack thereof), ability to influence relevant politicians, rigor of the application process, etc.

b. [*FOR AGENCIES GIVING SERVICES SUCH AS MENTAL HEALTH CARE, PRIMARY HEALTH CARE, SUBSTANCE ABUSE TREATMENT, EMPLOYMENT-RELATED ASSISTANCE, CHILD-RELATED SERVICES*], what are the most important factors affecting your ability to provide homeless people with services?

   i. Probes: level of government, transportation, documentation, relationships with local homeless providers, prior history of cooperation (or lack thereof), ability to influence relevant politicians, etc.

c. As far as you are aware, does a person's or family's homelessness, *per se*, pose a challenge to accessing benefits provided by your agency or other local agencies, over and above what a poor housed person or family would face?

   i. If yes, please describe.

   ii. As part of this question, does a homeless person's "location" within the system of homeless services make a difference to the ease or difficulty of mainstream service access? E.g., is it easier or harder to connect people staying in ES, vs. people in TH or PSH. If yes, please describe the differences.

32. **Perceptions of success/evidence of success**—Please tell me how your agency tells itself whether its efforts to improve access for homeless clients is succeeding?

a. Do you have a formal approach—HMIS, your own agency database, or

some other data system?

i. If yes, please describe. –also [*GET THE DATA SHOWING SUCCESS*].

b. I'd also like your impressions about which strategies seem to work best, and your reasons for saying so.

c. Also, could you give me your impressions of factors that make a difference for whether or not your efforts will succeed?

i. Issues with the specific benefit or service—are some easier than others?

ii. Issues with household type (singles vs. families)?

iii. Issues with client characteristics such as disability, criminal record, victimization, prior failure at particular services or programs?

iv. Issues with a person's location on the streets, in ES, in TH, or in PSH?

v. Issues with a person being local or coming from another community or another state?

vi. Issues with documentation for immigrants? For other people?

Do you have anything else you would like to add?

Anything that is on the horizon but not yet in practice?

Any threats to existing mechanisms, or mechanisms that have already died due to reduced funding or support?

We will send [*PRIMARY SOURCE NAME*] our descriptions of the programs or activities in your community before we submit our reports to HUD. S/he will have the opportunity to approve our descriptions at that time, and may also choose to share them with you or others in your community. Thank you for your time and information. You have been extremely helpful.

Homeless Program Managers/Caseworkers

INTRODUCTION

Thank you for taking the time to talk with us today. We're [*INTERVIEWER NAMES*] from [*AHP/URBAN INSTITUTE/WESTAT*] and [*AHP/URBAN INSTITUTE/WESTAT*], respectively. As you're probably already aware, we're working on a HUD-sponsored study of factors affecting homeless people's access to mainstream services and benefits. [*COMMUNITY NAME*] was chosen as a study site, and we've talked with [*ADMINISTRATOR(S)*] to identify specific mechanisms by which that's happening in your community. We're interested in talking to you about [*PROGRAM NAME*], and about any other things you are involved with to help homeless people get mainstream services.

While our final report will include a list of everyone that we interview, we won't cite your comments verbatim or attribute specific statements to you by name. The only potential exception to this rule would occur if you tell us about a program that we end up highlighting as an illustrative program. Should this occur, we would send the final text of the highlight to you for your sign-off before including it in any report.

QUESTIONS

Basics

1. Date of interview
2. Interviewer(s)

Respondent Role

3. Community
4. Name, title, contact info – [*GET CARDS*]
5. Agency (and division, if appropriate)
6. Program name and level – e.g., Chrysalis House, TH; Star of Hope, ES
7. Client types – singles only, adult men only, families only, pregnant teens only, recovering substance abusing families only, etc.
8. Specific role (e.g., director, manager/supervisor, eligibility tech, bene counselor, etc.)
9. What proportion of your time is spent facilitating homeless peoples' access to mainstream benefits and services?

Relevant benefits and services

10. [*SHOW R <u>LIST A</u>*] Which of these mainstream benefits and services do you personally help people get? *[IF R INDICATES FOUR OR FEWER BENEFITS, FOR QUESTIONS 11-17 ASK R ONLY ABOUT THESE. IF R INDICATES MORE THAN FOUR BENEFITS AND SERVICES, ASK R:*]

a. Are any of these benefits and services accessed through the same process? *[IF R INDICATES THAT THE INDICATED BENEFITS AND SERVICES ARE ACCESSED THROUGH FOUR OR FEWER PROCESSES, GROUP THE BENEFITS BY PROCESS AND PROCEED THROUGH ITEMS 11-17 IN REFERENCE TO EACH GROUP. IF R INDICATES THAT THE BENEFITS AND SERVICES ARE ACCESSED THROUGH UNIQUE PROCESSES - OR MORE THAN FOUR PROCESSES - ASK R:*]

b. Which four benefits or services to you help people get most often? *[ASK R ONLY ABOUT THESE*]

Basic information about each benefit or service that R works with/on

Okay, I'd like to start with getting some basic information about eligibility criteria, the application process, and a few other things about each of the mainstream benefits and services you personally help people get.

11. For each mainstream benefit or service mentioned in Q10 that is included in our scope, could you tell me:

    a. To what extent are individuals and families already enrolled in this mainstream benefit/service before coming to your program?

    b. For those not already enrolled, how does the application process work for this benefit? What do clients/you have to do/provide/fill out? Where do you have to go?

    c. What type of assistance do you provide to help people enroll?

    d. How long does the application process take, from the time you start until the application is submitted?

    e. Once the application is in, how long does it take for [mainstream agency] to make a decision? If this involves any additional steps, what are they, or what could they be?

    f. What are the biggest challenges or barriers that any poor person or family would face in establishing eligibility for this benefit/service?

    g. Are there any challenges or barriers that are particularly difficult to overcome because the applicant is **homeless,** as well as being poor?

    h. What might cause a person to lose the benefit/service?

Who else works on access for this benefit?

12. Other than yourself, does anyone else at your program or agency also help people apply for this benefit?

13. Have you, and anyone else who works on access for this benefit, had any special training to help you get through the process faster, or with more success? If yes, please describe?

14. Do you work closely with anyone at the [name the mainstream agency that handles this benefit] to move these applications along faster, or more effectively? If yes, please describe.

Changes in access for/availability of this benefit/service?

A number of our questions relate to mechanisms that your community is using to increase access. When we use the term "mechanisms" we're referring to any approaches your community is using. These include:

- **activities that are intended to *make it easier to apply or to have an application accepted* (smoothing), such as starting mainstream outreach to homeless service locations, creating a unified application for several benefits programs, creating a multi-agency team, co-case management, trainings to increase mutual knowledge among caseworkers in homeless assistance and mainstream agencies, etc,**
- ***making changes in eligibility or the eligibility process*, including actual changes in agency policy, expanded eligibility criteria, presumptive eligibility, relaxing or modifying some documentation rules, and**
- ***expanding or shifting resources* to get more supportive services to homeless people, including new money more money added to existing categories or line items, or new programs for particular homeless people, set-asides, shifts in priorities for who gets a benefit, etc.**

15. Has access to/availability of this benefit/service increased, stayed level, or decreased during the last five years?
    a. *If increase:* What mechanisms, either in the state, the service system, or your agency has helped to increase access/availability? More/new funding? What barriers were removed or neutralized with these mechanisms?
    b. *If level:* What mechanisms, either in the state, the service system, or your agency has helped to maintain the level of access/availability?
    c. *If decrease:* Why has access/availability declined? Funding cuts? Changes in regulations? Additional eligibility barriers?

"Typical" benefit packages

16. What mainstream benefits would you say a "typical" homeless single adult gets?
    a. If the answer would differ depending on whether you're talking about someone in ES vs. someone in TH or PSH, then what would be typical of someone in ES? In TH? In PSH?
17. What mainstream benefits and/or services would you say a "typical" homeless family gets?
    a. If the answer would differ depending on whether you're talking about a family just applying for or in ES vs. someone in TH or PSH, then what

would be typical of someone in ES? In TH? In PSH?

Strategies when a person/family may qualify for more than one benefit/service

18. What screening do you/does your program do to determine the benefits and services a person/family may qualify for?
    a. Does everyone coming to your program/agency get this screening? If not, how decide who gets it?
    b. Who do you attend to first—those who may qualify for many benefits/services, or those who only qualify for one or two?
    c. What happens if a person needs a benefit or service but you don't think s/he will qualify for it?
19. Are there particular benefits or services that you would usually try for first—because they are easier to access or for some other reason? What are these?
20. Are there any types of benefits or services that you know will take longer to get? If yes, how do you prioritize trying to get people these benefits? Start immediately because it *does* take longer? Get the easy ones done first and then start on the hard ones? Something else?

R's Involvement with special mechanisms

21. Other than the usual casework that someone in your position might do, are you involved with any special mechanisms to improve homeless people's access to mainstream services?

[*GIVE EXAMPLES YOU KNOW ARE HAPPENING IN THIS COMMUNITY. ASK FOR OTHERS]*

For each mechanism that R is involved with:

22. [*GET THE NAME OF THE MECHANISM. TRY TO BE CONSISTENT IN NAMING THESE THINGS, SO WE ALL KNOW WE'RE TALKING ABOUT THE SAME THING.*]
23. [*ASK R TO SHOW YOU WHERE THE MECHANISM OR MECHANISMS S/HE WORKS WITH FITS INTO THE OVERALL STRUCTURE OF THE COMMUNITY RESPONSE TO HOMELESSNESS THAT YOU GOT FROM THE OVERVIEW PERSON/PEOPLE. LOCATE IT SPECIFICALLY ON THE GRAPHIC WE HAVE OF THE COMMUNITY ORGANIZING STRUCTURE. ASK R TO CONFIRM THE ACCURACY OF THE GRAPHIC FOR THE PART OF THE SYSTEM THAT S/HE IS FAMILIAR WITH.*]

GRAPHIC DEPICTION OF COMMUNITY ORGANIZING STRUCTURE FOR HOMELESSNESS

[*CAN INCLUDE RELATIONSHIP TO STATE/COUNTY/CITY ENTITIES, IF RELEVANT*]

[*FOR THESE INTERVIEWS, THIS BOX WILL BE FILLED IN WITH THE PICTURE YOU GOT FROM THE OVERVIEW PERSON/PEOPLE YOU INTERVIEWED*]

24. [*FROM R'S PERSPECTIVE*], what is it?
25. What is [*R's*] role in making the mechanism work?
26. What does it do? How does it work?
27. How is it paid for? What funding streams support it?
28. [*HISTORY—DO A BRIEF CHECK TO SEE WHETHER THE R AGREES WITH THE DESCRIPTION OF HISTORY WE GOT FROM THE ADMIN LEVEL; WHAT ELSE S/HE MIGHT WANT TO ADD.*
    a. *FIND OUT SPECIFICALLY WHETHER THE MECHANISM WAS CREATED IN RESPONSE TO HUD'S SHIFT OF RESOURCES OUT OF SERVICES, OR, IF IT PREDATES THAT HUD CHANGE, WHETHER IT WAS MODIFIED/BEEFED UP IN RESPONSE TO SAME.*]
29. Who is involved? Especially which mainstream programs, in which agencies?
30. How is it going?
    a. [*GET NARRATIVE OF HOW IT HAS BEEN RECEIVED, WHETHER THE CASEWORKERS AND MAINSTREAM AGENCY PEOPLE SEEM TO LIKE IT, WHETHER IT HAS HAD SIGNIFICANT CHALLENGES TO OVERCOME AND HOW IT HAS DONE THAT (IF IT HAS), ETC.*]
    b. [*GET EVIDENCE OF SUCCESS (MORE PEOPLE RECEIVING), INCLUDING FROM HMIS AND APRS.*]

[*ONCE YOU HAVE THE INFORMATION FROM QS 21-30, CLASSIFY THE MECHANISM: DOES IT APPEAR TO BE A SMOOTHING, ELIGIBILITY, OR EXPANSION MECHANISM, OR HAVE ELEMENTS OF ONE OR MORE OF THESE MECHANISMS? GIVE EXAMPLES TO JUSTIFY YOUR CLASSIFICATION.*]

- **Smoothing—**anything that makes it easier to apply or to have an application accepted (.e.g., outreach, unified application , multi-agency team, co-case management, trainings, etc.
- **Changes in eligibility**—actual changes in agency policy, expanded eligibility criteria, presumptive eligibility practices, relaxing or modifying some documentation rules, etc.
- **Expanding or shifting resources** to get more supportive services to homeless people, including new money (e.g., new document recordation fee that gets used to pay for services), more money, or new programs for particular homeless people, set-asides, shifts in priorities for who gets a benefit, etc. Also includes new grants or contracts to homeless providers for supportive services, "whatever it takes" funding streams, etc.

31. **Challenges**—What do you see as the biggest challenges to increasing access to mainstream services for homeless people? Please describe how they have

influenced the ways you try to help people get mainstream benefits and services?

a. Type of household—family/single adult

b. Disabilities—do specific types of disabilities or individual barriers make a difference?

c. Sheer availability or amount of a resource, or its limited or reduced availability?

d. For means-tested benefits that provide ongoing income, subsidy, or services, such as GA, TANF, food stamps, Medicaid, SSI, what are the most important factors affecting your strategies?

   i. Probes: eligibility restrictions, level of government, relationships with local government office staff, prior history of cooperation (or lack thereof), ability to influence relevant politicians, rigor of the application process, etc.

e. For services, such as mental health care, primary health care, substance abuse treatment, employment-related assistance, child-related services, what are the most important factors affecting your strategies?

   i. Probes: level of government, relationships with local government office staff, prior history of cooperation (or lack thereof), ability to influence relevant politicians, etc.

f. As far as you are aware, does a person's or family's homelessness, *per se*, pose a challenge to accessing mainstream services, over and above what a poor housed person or family would face?

   i. If yes, please describe.

   ii. As part of this question, does a homeless person's "location" within the system of homeless services make a difference to the ease or difficulty of mainstream service access? E.g., is it easier or harder to connect people staying in ES, vs. people in TH or PSH. If yes, please describe the differences.

32. **Perceptions of success/evidence of success**—Please tell me how you/your program tells itself whether its efforts to improve mainstream access are succeeding?

a. Do you have a formal approach—HMIS or some other data system?

   i. If yes, please describe. –also GET THE DATA SHOWING SUCCESS.

b. I'd also like your impressions about which strategies seem to work best, and your reasons for saying so.

c. Also, could you give me your impressions of factors that make a difference for whether or not your efforts will succeed?

i. Issues with the specific benefit or service—are some easier than others?

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vi. Issues with documentation for immigrants? For other people?

Do you have anything else you would like to add?

Anything that is on the horizon but not yet in practice?

Any threats to existing mechanisms, or mechanisms that have already died due to reduced funding or support?

We will send [*PRIMARY SOURCE NAME*] our descriptions of the programs or activities in your community before we submit our reports to HUD. S/he will have the opportunity to approve our descriptions at that time, and may also choose to share them with you or others in your community. Thank you for your time and information. You have been extremely helpful.

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