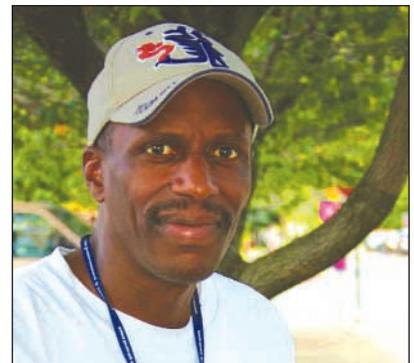
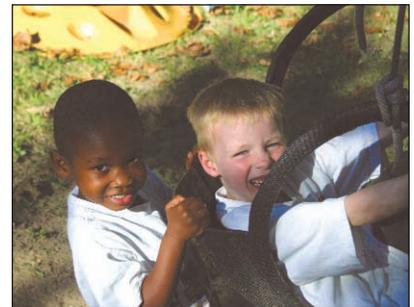


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# A HOME FOR EVERYONE

## A Blueprint To End Homelessness In Washtenaw County



# A Forward

**blue-print** (blu ' print') a photographic print, commonly of a working drawing used during building. The plan is first drawn to scale on special paper or tracing cloth through which light can penetrate...

**T**he plans set here before you belong to you. The people you see before you – without homes, troubled and struggling – also belong to you, to this community. With earnest effort over the years the people of Washtenaw County proved the wisdom of collaboration and the virtue of mutual trust.

The early homelessness Task Forces, the incredible public-private partnership that created the Delonis Center – even this document – all these demonstrate our community's willingness to be accountable.

With our experience in hand, we take this audacious next step: a plan to end

homelessness in Washtenaw County. The cynical among us would have us believe that this will not and can not happen - but would they have guessed that we could come this far? In a recent interview, Philip F. Mangano, Executive Director of the US Inter-agency Council on Homelessness, gave words to the spirit of our agenda:

*"We are not content to manage the crisis, or to maintain the effort, or to accommodate the response. We were called to one goal, one objective, one mission - to abolish homelessness. Now is the time to forward the advocacy, fashion the strategy, and to fulfill that mission."*

A 'Blueprint' is "first drawn to scale on a special paper...through which light can penetrate." We have set these plans on 'special paper' that needs your light. Your support of any aspect of this strategic plan will help bring it to life. This community has reached a tipping point through a mix of hard work, opportunity and political will. Our success will need one more important ingredient: your decision to act.

**Robert E. Guenzel,**  
*Administrator*  
*Washtenaw County*

**John Hieftje,**  
*Mayor*  
*City of Ann Arbor*

**Dick Soble,**  
*Chair of the Board*  
*Washtenaw Housing Alliance*

**Cheryl Farmer,**  
*Mayor*  
*City of Ypsilanti*

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**[CINDY]** *Cindy and her five children moved into their new home on September 13, 2004 - a mobile home in a development outside of Ann Arbor.*

*It has been a long, painful year.*

*The young mother's home and life were shattered when she learned that three of her daughters had become victims of their abusive father - her husband.*

*The State of Michigan's Family Services stepped in and Cindy, now a single mom of five without an income, would need to learn all about a public and not-for-profit system of care in order to keep her family healthy and together.*

*Through support at and from Interfaith Hospitality Network at Alpha House (IHN), Cindy was able to get connected with the Judson Center, Child Protective Services, CASA, and counselors for everyone in the family. The family's new home needed a lot of repairs – roof, floor, walls, plumbing – and people from IHN's volunteer network of area congregations helped refurbish the home – helping to accommodate, and welcome, a family of six.*

# A Home For Everyone

## *A Blueprint to End Homelessness In Washtenaw County*

**O**n the evening of March 18, 2004, Washtenaw County community agencies conducted a 'Point-In-Time' survey that identified 664 people as homeless.

That survey, among others, helped us form a more accurate picture of the people who are homeless in our community. Other numbers - unemployment numbers; people on fixed income numbers; uninsured patient numbers; emergency room visit numbers; people on public assistance numbers; (and numbers of people forced to come off public assistance) - even numbers at the gasoline pump - are forming a picture of the people who will be homeless in our community. The picture is not getting better.

Faced with these facts, this community has come together as never before to understand systems, aligning them with a new priority: putting an end to homelessness in Washtenaw County. With the information we know, and the projections we can make, four goals will drive this commitment:

**PREVENTION** Keep people in their existing housing. Fiscally for the community, and physically and emotionally for those at risk, national data show that it is far less expensive to keep people housed. It is six times more expensive to shelter someone than it is to provide resources and services that keep them in housing.

**HOUSING WITH SERVICES** Create more permanent, affordable housing with services. A safe, affordable home is crucial to people addressing the issues that contribute to becoming homeless. Supportive services with housing provide stability to keep people housed.

**REFORM THE SYSTEM OF CARE** Use community resources more creatively and efficiently - across all sectors. This includes developing standards, integrating funding and creating an evaluation process to guide progress.

**ENGAGE THE COMMUNITY** Success means shared responsibility across the community. Make it clear that people who are homeless, given the respect, the resources and the options we all would need, are this community's best hope for a different future - a future with a home for everyone.

### **WE ARE HOMELESS IN WASHTENAW COUNTY**

**2,756** people will experience homelessness within a year in Washtenaw County

**26%** are families

**41** people will become homeless within any given week in Washtenaw County

**53%** are experiencing homelessness for the first time in the last three years

**46%** of women who are homeless with children reported domestic violence as a primary reason for their homelessness

**51%** of persons needing help from hunger relief agencies are children

**44%** of those interviewed reported moderate to severe addictions

**42%** of those interviewed reported having a mental illness

**34%** are employed, either part or full time

**\$9,500** is the average yearly income—which does not cover the average yearly rent on a two bedroom apartment in Washtenaw County

# A Brief History

**[OTHO]** *Otho Egdor washes dishes and busses tables at Zingermans's Deli in Ann Arbor. He lives in the new Gateway apartments in Ypsilanti.*

*As a kid in Willow Run, Otho had a severe speech impediment and finally dropped out of school in 7th grade when his mother died. He soon started a lifelong addiction to drinking and drugs. He served time in prison and then became homeless for most of 15 years, his physical and mental health deteriorating throughout that time. He credits help from a number of agencies - Public Health, PORT, The Shelter Association and Michigan Ability Partners' WISH program among others, for bringing him back to a point where he can live and work in his community.*

*The picture was taken at a summer outing at his apartment complex. Otho brought deviled eggs.*



Since 1996, this community has made consistent, concerted efforts to understand and to resolve the problems facing homeless people in our community. A Mission Clarity Group and two major task forces comprised of human service providers, housing advocates, governmental representatives, interested neighbors and people who were homeless came together at hundreds of meetings. These people and others gave their time, money and active caring to these issues. Washtenaw County had become a community ready to be accountable for all of its members.

## **MISSION CLARITY GROUP STATEMENT**

**As members of a concerned community, we affirm that homelessness is a shared responsibility and must be addressed collaboratively by all of the institutions, agencies, businesses and individual members in our community.**

Washtenaw Mission  
Clarity Group Report,  
March, 1997

Accountability became commitments and commitments brought about a plan to bring an end to homelessness in Washtenaw County. On January 19, 2000, the Washtenaw County Board of Commissioners passed Resolution #000-0016 engaging the Washtenaw Housing Alliance with a three-phased plan.

**PHASE ONE** Expand emergency shelter services for families to include Alpha House, in March of 2001. The site for the shelter was contributed by Saint Joseph Mercy Health System. The professional staff of Interfaith Hospitality Network (IHN), along with over 2000 volunteers from area religious and civic organizations, work with families to assist them in overcoming whatever barriers they have to successfully finding and maintaining permanent housing.

**PHASE TWO** The construction of a single setting that would consolidate many of the services for homeless individuals, or people at risk of homelessness. Building the Robert J. Delonis Center became a model of public-private partnership. It is owned jointly by Washtenaw County and the Washtenaw Housing Alliance, and is operated by the Shelter Association of Washtenaw County. Under one roof, people who are homeless are now able to access physical and mental health care; food and shelter; support to recover from addictions and employment training and outreach. The Delonis Center opened in November of 2003.

**PHASE THREE** A plan to find, create or acquire affordable housing has become this, the more comprehensive "Blueprint to End Homelessness in Washtenaw County." With its fourfold focus - Prevention, Housing with Services, System Reform and Community Engagement - this plan takes aim at the complexity of homelessness, from changing individual lives to changing community perceptions.

# Prevention

## THE REALITY

Mortgage foreclosures have more than doubled since 2002 in Washtenaw County; evictions within the County increased 10% in one year. Though there are resources available to people at risk of becoming homeless, accessing these resources often requires multiple trips to different agencies. For some resources, tenants cannot receive assistance until served with an eviction notice, adding to costs and risks for both tenants and landlords. Prevention resources have been underfunded, poorly coordinated and poorly communicated across all sectors.

## THE GOAL

*Prevent homelessness through easy, early access to needed resources and services.*

## THE STRATEGIES

- Establish a centralized response system to those at risk of losing housing.
- Centralize and increase dollars for prevention.
- Increase accessibility to legal services support.
- Develop a mortgage foreclosure prevention program.
- Increase supportive services in existing public housing and nonprofit managed housing.

## ACTION NOW

### ■ “Eviction Prevention Program”

On September 1, 2004, the Washtenaw County Board of Commissioners allocated \$100,000 as a challenge grant to form a streamlined solution to avoidable eviction and possible homelessness. The Family Independence Agency is investing in prevention through this fund, as are local property management firms. Developed through the Human Services Collaborative Council’s ‘Barrier Busters’, the program enables:

- People in a financial crisis to make one initial contact to secure assistance;
- Access to services that will address the causes that have led to the housing crisis.
- Establishment of a centralized response system, coordinated with 2-1-1, that links people who are homeless or at risk of becoming homeless to needed services and housing.



**[DIANE]** *Diane Kramer grew up in Chelsea, working all of her adult life. A few years after a divorce, she decided to start her own business, accounting - doing the books for small businesses, non-profits and helping new*

*start-ups get started.*

*The business was doing well at the beginning, but before she was able to afford health insurance for herself, Diane started to get sick. She says she didn't want to go to the doctor until she had health insurance set. When she heard about the Washtenaw*

*Health Plan she applied right away. As soon as she was enrolled, she saw her provider at the Packard Clinic -who informed her, after days in the hospital, that she had cancer.*

*Concerned, her daughter in Colorado tried to get help for her mother. The Housing Bureau for Seniors helped pull together the \$4,000 Diane owed in back rent at the place she's lived for eight years. Her health, and her ability to stay in her home, are still precarious, as she lives month to month on about \$500 and the kind works of a lot of good people, she says, "who I really don't even know."*

# Housing AND Services

## THE REALITY

Washtenaw County has more than 2,500 people on waiting lists for affordable housing. People requesting affordable housing vouchers have an average wait of 28 months. On average, 8 families are added to the waiting list for emergency shelter every week in our community. The average yearly income for a person on disability is \$6,624; the average yearly rent for a two-bedroom apartment in Washtenaw County is \$9,500. Such disparity, without plans to create more affordable housing, puts a significant number of our neighbors at risk of becoming homeless.

In the 2004 community-wide interviews of homeless people, 44% reported moderate to severe addictions and 42% reported having a mental illness. Yet on more than 153 days in 2003, people seeking treatment for drug and alcohol addictions had to be turned away due to funding shortages. 42% were looking for employment and those who were employed earned less than 1/5 of the area's median household income.

Without additional permanently affordable housing with easy access to supportive services, there is little hope for people to change their circumstances. For them, and for the community at large, homelessness is inextricably tied to hopelessness. Today, we have a chance to end both.

## THE GOAL

*Ensure permanent affordable housing along with reliable funding for services that are central to ending homelessness.*

## THE STRATEGIES

- Secure at least **500 units** of permanently affordable supportive housing for chronically homeless persons in our community. This housing can be secured in two ways:
  - Increase the number of permanently affordable apartments developed and managed by non-profit agencies;
  - Secure use of existing, privately owned apartments combined with supportive housing services.
- Ensure a match in sustainable service dollars and adequate funds dedicated to keep properties maintained in a manner that develops tenant and neighborhood pride.
- Increase the number of affordable supportive housing units for young adults.
- Increase the availability of emergency shelter for families.
- Increase services to people who suffer from addictions by increasing numbers of 'detox' beds, access to follow-up treatment services and transitional housing units. Secure access to the full range of treatment services for people with co-occurring disorders.



**[TYRON]** *Tyron Johnson served time in Ohio for gang related drug offenses. He developed diabetes during his four years in custody. Upon release, had two weeks worth of insulin, no money and no place to live except for the family home and neighborhood in gang territory.*

*Wanting to get away from prior friends and behavior, he came to live in Ypsilanti with his brother and roommates. When rent wasn't paid, the group was evicted and Tyron lost his job at Farmer Jacks. No*

*home and no income, Tyron lived in a tent under a bridge in Ann Arbor, trying to keep his insulin cold by asking for ice from local restaurants.*

*In and out of St. Joseph's Hospital for dangerously high sugar levels, Tyron hooked up with PORT, the men's shelter and then the Delonis Center, and the WISH program. After 18 months on a waitlist, Tyron was able to get a Section 8 voucher and is living in an apartment in Ann Arbor. Tyron now works part time for the County through a special program with CSTS.*

*His diabetes is finally under control, and he has not been hospitalized for 11 months.*

## ACTION NOW

■ **Carrot Way Apartments** – Avalon Housing, as a result of collaboration with Food Gatherers, is building Carrot Way Apartments, 30 units of affordable housing on Dhu Varren Road in Ann Arbor. These 1, 2 and 3 bedroom apartments will be permanently affordable to tenants with access to individualized supportive housing services provided by Catholic Social Services.

■ **Maple View** - 10 units of affordable, single bedroom permanent housing, located in Ypsilanti is being launched in 2005 by Michigan Ability Partners.

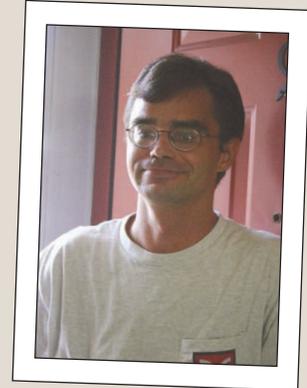
■ **SOLO** - Ozone House and Avalon Housing will collaborate as service provider and property developer to secure 8-10 units of affordable supportive housing for independent youth ages 17-20. Ozone calls the lack of affordable housing with services the biggest gap in the continuum of care for young adults, including teen parents. The apartments help bridge that gap for teens -especially for the growing number who have aged out of foster care, to independent living

■ **Transformation of the Ann Arbor YMCA** - Currently 100 single room occupancy units with no cooking facilities, this housing has rents that far exceed 1/3 of most tenants' incomes. The City of Ann Arbor is developing an RFP for 80-100 efficiency units of permanently affordable, supportive housing. Supportive services will be available to these tenants many of whom have been chronically homeless. It has been recommended that twenty units be reserved for transitional uses by agencies for shorter-term emergency stays.

■ **A Jail Diversion program** for adults with co-occurring disorders is being proposed through the Criminal Justice Collaborative Council to the Washtenaw County Board of Commissioners in October of 2004.

■ **Veterans' Haven of Hope** will offer safe housing for 11 veterans with services provided by the Salvation Army in collaboration with the VA Healthcare Center and claims and benefits support from the County's Veterans Services.

■ **The Washtenaw Housing Alliance** is committed to working with other private sector partners and local funders to help secure service funding for the County's upcoming permanent supportive housing units. Additionally, WHA board members in conjunction with County and City staff, will develop recommendations on the best options for a dedicated revenue stream for supportive housing services in Washtenaw County.



**[STEVEN]** *Steven Briggs has always been a little uncomfortable around people. It was in his late twenties though, when things got harder. Steve presented a therapist with a history of more than 30 jobs in ten years when he was finally diagnosed with a severe anxiety disorder.*

*During that time - for eight years - he lived mainly out of his truck, staying now and then in the homes of relatives who never knew he was homeless. Through the Michigan Rehabilitation Services (MRS) he was able to get State disability, then Social security disability. With a different number of agency services along the way, Steven now lives in an Ann Arbor apartment owned by Avalon Housing. He is in therapy and is working part time for a janitorial service in the evenings for a large company in Saline.*

# Reform the System of Care

## THE REALITY

Essential services for people who are homeless exist in multiple agencies and innumerable programs in dispersed locations. Because of the nature of this structure, seeking help is anything but efficient, and in many ways lacking compassion. At the community level, assessing needs, setting priorities and seeking funding has often been insular and fragmented. Funders have had difficulty making well-informed decisions without access to reliable system-wide data and an assessment of the community's highest priority needs. Also, there has been no set of agreed-upon standards for administration and service delivery among providers or within the community.

## THE GOAL

Provide a system of care that delivers compassionate, effective and efficient support for people who are homeless or precariously housed.

## THE STRATEGIES

- Develop common administrative and service standards and outcome measures across agencies.
- Develop an integrated funding process across all sectors based on community-supported priorities.
- Develop and maintain an integrated, countywide Homeless Management Information System to help the community assess needs, coordinate care and evaluate effectiveness of programs - in real-time.

## ACTION NOW

- The Common Standards & Evaluation Team has been launched by the Washtenaw Housing Alliance in partnership with Health Services of Washtenaw County to develop common standards across providers. Experts from the University of Michigan and Eastern Michigan University Schools of Social Work, Business and Public Policy will support this team.
- The Ford School of Public Policy at the University of Michigan will research the outcomes and cost effectiveness of different housing and services approaches. This information will support providers in making service improvements and funders in making data driven decisions.



**[LINDA]** *Linda Jackson has worked all her life, since she was a teenager, but clinical depression finally caused her to lose her job at Washtenaw Community College, and shortly thereafter, her apartment. She says that all she did or wanted to do was sleep during that dark time, and when anyone asks her anything about 2002 - all she can remember about it is crying.*

*After hospitalization, Linda went straight to the Women's Shelter on Felch Street in Ann Arbor. She had never been homeless before. With help from the PORT staff and staff at the shelter, Linda got help from a number of different therapies to battle the depression. She found a home to share in Ann Arbor through the HomeShare program.*

*Drawn by the idea of helping others "in the same boat," Linda now works full time with Washtenaw County's Community Support & Treatment Services.*

# Engage the Community

## THE REALITY

The people of Washtenaw County have demonstrated their willingness to let go of stereotypes and partisanship to understand and find workable, measurable solutions to serious social affliction. At present, the compelling, emotional stories of our neighbors are not matched with compelling data - real numbers. Without such outcome-oriented data, members of this community will find it hard to perceive their role in helping to prevent people from becoming homeless. Without the ability to measure success from failure, this community will continue to be caught in ad hoc, well-meaning, but ultimately failed policy.

## THE GOAL

An engaged community where people - in their homes, their schools, their places of work and places of worship - understand the moral and practical sense to strategies that will end homelessness in Washtenaw County.

## THE STRATEGIES

- Advocate vigorously on issues related to homelessness at local, state and federal levels.
  - Communicate the measurable effectiveness of our strategies to end homelessness to the entire community.
  - Align community education “campaigns” within a strategic framework.
- A Point-In-Time survey was conducted in March of 2004, giving an unduplicated count as a baseline for future data collection and analysis. Individuals from the University of Michigan’s Ford School of Public Policy have agreed to work with these and other data to help measure progress of our efforts.
  - Community Presentations on the ‘Blueprint to End Homelessness in Washtenaw County’ reached nearly 1000 persons from April through September of 2004. These conversations took place with business and neighborhood groups, service organizations, communities of faith and governmental bodies, among others.
  - “A Home for Everyone: A Blueprint to End Homelessness in Washtenaw County” forum on September 21st, 2004, is a powerful community engagement vehicle, reiterating the goals and ‘next steps’ to ending homelessness.
  - “SERVICES TO END LONG-TERM HOMELESSNESS ACT” (SELHA) introduced in US Congress July 28, 2004, by a bipartisan coalition, calling for funding for health and mental health services, substance abuse treatment, health education, money management, and other services to help end chronic homelessness for individuals and families. States, cities, public or nonprofit entities would be eligible to apply for the grants. A Senate version of SELHA should be introduced before this year’s elections.

## ACTION NOW

**[DEBORAH]** *Deborah would prefer to be called DeBorah, instead of Deborah, but not many people do. She says it’s OK, but she’d really rather that they accent the middle syllable. That’s her name. She’s 15 and living in a family shelter with her mother, her two little sisters and her mother’s boyfriend Tony. They’ve been there for about two months. Tony is working at a local supermarket, and is trying to get a second job so that he can get the family back into an apartment. DeBorah’s mother Ethel is on social security disability and can be easily overwhelmed by life. DeBorah has just started another new high school and she’s been looking forward to her sophomore year. She’s told them her name is DeBorah.*





## What you know about ending homelessness in Washtenaw County

As you are reading this, you know that:

- There are people presently housed who will soon lose their housing and develop more problems, and more needs...
- There are people who, with even a few supportive services, could become stabilized in housing – avoiding the need for more urgent services, and possible homelessness...
- There are people living on the streets, unaware of help, or confused by a system of care that is often fragmented and complex...

But you also know that:

The people who make up this community have demonstrated consistently through the years a capacity for caring enough to get involved, innovate, change systems – in short, the capacity to understand the nature of community. As a member of this community – as a citizen or provider of services – the very fact that you are reading these words is a case in point.

To take your caring to the next level – if you have ideas, resources or time to give to this effort to end homelessness please contact Diane Davidson, Executive Director of the Washtenaw Housing Alliance at [davidsond@ewashtenaw.org](mailto:davidsond@ewashtenaw.org) or call the Alliance at (734) 222-6553.

To see the complete ‘Blueprint’ document, please go to <http://www.ahomeforeveryone.org>

Or, to receive a printed copy of the full 90-plus-page document, please send a note to Washtenaw Housing Alliance, at 110 North Fourth Ave., Ann Arbor, Michigan 48107

We have the goals and the strategies to achieve them.

Now we need us.



**"A Home for Everyone: A Blueprint to End Homelessness in Washtenaw County" October 2004**

Washtenaw County Government / City of Ann Arbor / City of Ypsilanti / Washtenaw Housing Alliance

## BLUEPRINT IMPLEMENTATION GUIDE

	STRATEGY	COMMUNITY CHAMPION	CONVENER	TEAM, RESOURCES	GROUP CHARTER
<b>PREVENTION</b>					
1	Establish a centralized response system WITH needed support services to those at risk of losing housing.	<p>Dale Berry HVA 734-477-6262 <a href="mailto:dberry@hva.org">dberry@hva.org</a></p> <p>Dan Oates AA Police Chief 734-994-2848 <a href="mailto:doates@ci.ann-arbor.mi.us">doates@ci.ann-arbor.mi.us</a></p> <p>Ed Dreslinski 734-994-2286 <a href="mailto:edreslinski@ci.ann-arbor.mi.us">edreslinski@ci.ann-arbor.mi.us</a></p>	<p>Mary Jo Callan Ozone House 734-662-2265 <a href="mailto:mcallan@ozonehouse.org">mcallan@ozonehouse.org</a></p>	<ul style="list-style-type: none"> <li>• HSCC Youth &amp; Family</li> <li>• shelter agencies</li> <li>• Synod</li> <li>• Legal Services,</li> <li>• 211 link</li> <li>• Community Development</li> <li>• FSN</li> </ul>	<p>Building upon research and work completed by the HSCC Youth and Family Action Group, develop a plan for centralizing the response system for people who are homeless or at risk of homelessness. The plan should address:</p> <ul style="list-style-type: none"> <li>• One phone number; relationship to 2-1-1</li> <li>• Case management coordination</li> <li>• Outreach teams</li> <li>• Assessment; triage; follow-up</li> <li>• Evaluation of effectiveness</li> <li>• Funding sources</li> <li>• Timeline</li> </ul>
2	Centralize prevention dollars.	<p>Bob Malek Community President National City Bank 734-995-7775 <a href="mailto:Robert.malek@nationalcity.com">Robert.malek@nationalcity.com</a></p>	<p>HSCC Coordinator Michael Scholl (734) 544-6856</p>	<ul style="list-style-type: none"> <li>• WHA</li> <li>• Barrier Buster Agencies</li> <li>• Community Development</li> </ul>	<p>Outline the process for</p> <ul style="list-style-type: none"> <li>• Accessing Centralized Prevention dollars (who and how)</li> <li>• Assessing need for link to follow up services (who does it? How?)</li> <li>• Evaluating effectiveness (options for assessing impact on dollars and role in effective prevention)</li> <li>• Community reporting on investments, effectiveness and population distribution (who accesses the funds most? For what reasons?)</li> </ul>

## BLUEPRINT IMPLEMENTATION GUIDE

	STRATEGY	COMMUNITY CHAMPION	CONVENER	TEAM, RESOURCES	GROUP CHARTER
<b>HOUSING AND SERVICES</b>					
3	Increase number of units developed and managed by nonprofits	<p>Ashley Zwick Standard Federal Bank 734-995-1771 <a href="mailto:ashley.zwick@abnamro.com">ashley.zwick@abnamro.com</a></p> <p>Bruce Gibb Bruce L. Gibb Associates <a href="mailto:blgibb@umich.edu">blgibb@umich.edu</a></p>	<p>Carole McCabe Avalon Housing 734-663-5858 <a href="mailto:cmccabe@avalonhousing.org">cmccabe@avalonhousing.org</a></p>	<ul style="list-style-type: none"> <li>• Community Development</li> <li>• Nonprofit housing developers</li> <li>• LISC</li> <li>• AA Public Housing</li> </ul>	<ul style="list-style-type: none"> <li>• Outline a plan for how to build community capacity in nonprofit housing development.</li> <li>• Identify needed conditions and skill sets for enhanced capacity for NP development of housing,</li> <li>• Outline pros and cons of location of personnel, funding sources for position(s) and possible funding sources. (short timeline)</li> </ul>
4	Establish use of units of existing, privately owned housing stock combined with supportive housing services. Secure needed vouchers.	<p>Bob Guenzel 734-222-6731 <a href="mailto:guenzelb@ewashtenaw.org">guenzelb@ewashtenaw.org</a></p>	<p>Fran Alexander WHA 734-665-6749 <a href="mailto:fran@alexanderresources.net">fran@alexanderresources.net</a></p>	<ul style="list-style-type: none"> <li>• Washtenaw Area Apartment Association</li> <li>• Ford School of Public Policy</li> <li>• IHN</li> <li>• Catholic Social Services</li> <li>• Synod</li> <li>• Housing Bureau for Seniors</li> <li>• Ann Arbor Housing Commission</li> </ul>	<p>Develop/complete a business plan for a pilot program with identified property management companies:</p> <ul style="list-style-type: none"> <li>• Secure commitments from property management companies</li> <li>• Identify number of units to include in pilot</li> <li>• Identify and secure subsidies, i.e. Section 8 vouchers, etc.</li> <li>• Identify service delivery model</li> <li>• Develop on-going system for evaluation</li> <li>• Annual budget</li> <li>• Timeline</li> </ul>

## BLUEPRINT IMPLEMENTATION GUIDE

	STRATEGY	COMMUNITY CHAMPION	CONVENER	TEAM, RESOURCES	GROUP CHARTER
5	<p><b>Immediate:</b> Secure supportive housing service dollars for new PSH developments 2005-2007</p> <p><b>Near Term:</b> Identify and secure best method for additional sustainable funding for supportive housing services,</p>	<p>Joe Fitzsimmons Community Leader 734- 662-7573 <a href="mailto:FitzsimmonsJJ@cs.com">FitzsimmonsJJ@cs.com</a></p>	<p>Diane Davidson WHA and County Administration 734-222-6553 <a href="mailto:davidsond@ewashtenaw.org">davidsond@ewashtenaw.org</a></p> <p>Bob Guenzel 734-222-6731 <a href="mailto:guenzelb@ewashtenaw.org">guenzelb@ewashtenaw.org</a></p>	<ul style="list-style-type: none"> <li>• Joe Fitzsimmons - WHA</li> <li>• Kathy Reynolds - WCHO</li> <li>• Amy Klinke - Community Development</li> </ul>	<p><b>Immediate:</b></p> <ul style="list-style-type: none"> <li>• Outline a plan for how to fund supportive services to PSH developments coming on line 2005-2007.</li> <li>• Plan should include what types of units qualify, terms connected with receiving funding, evaluation methodology, timeline and annual budget.</li> <li>• Plan should also identify fundraising strategies and initiate a campaign to raise needed funds.</li> </ul> <p><b>Near Term:</b></p> <ul style="list-style-type: none"> <li>• Review dollars entering system to support housing stability and how current investments are divided across the system of care.</li> <li>• Identify what services are included in term 'critical supportive housing services'.</li> <li>• Analyze/review long term funding options including: private endowments, human services or housing millage, bond issuance, state funding.</li> <li>• Develop a funding recommendation that is sustainable and dedicated.</li> </ul>
6	<p>Increase services to people who suffer from addictions:</p> <ul style="list-style-type: none"> <li>• 'Detox' beds.</li> <li>• Follow up treatment resources</li> <li>• Transitional housing.</li> </ul>	<p>Judge Libby Hines <a href="mailto:hinese@ewashtenaw.org">hinese@ewashtenaw.org</a></p> <p>Judge Julie Goodridge <a href="mailto:goodridj@ewashtenaw.org">goodridj@ewashtenaw.org</a></p> <p>Judge Ann Mattson <a href="mailto:mattsona@ewashtenaw.org">mattsona@ewashtenaw.org</a></p>	<p>Kathleen Reynolds WCHO (734) 544-6813 <a href="mailto:reynoldk@ewashtenaw.org">reynoldk@ewashtenaw.org</a></p>	<ul style="list-style-type: none"> <li>• Dawn Farm</li> <li>• SAWC</li> <li>• Home of New Vision</li> <li>• Jail Diversion Effort</li> <li>• Substance Abuse Advisory Council</li> <li>• Hospital and jail partners</li> <li>• Help Source</li> <li>• shelter agencies</li> </ul>	<p>Develop county-wide business plan addressing the three aspects of the strategy. Plan should include: service delivery models, personnel needs/costs, funding options, evaluation methodology, timeline and annual budget.</p>

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	STRATEGY	COMMUNITY CHAMPION	CONVENER	TEAM, RESOURCES	GROUP CHARTER
7	Secure access to the full range of treatment services for people with co-occurring disorders	John Greden 734-763-9629 <a href="mailto:gredenj@med.umich.edu">gredenj@med.umich.edu</a>  David Neal 734-662-8261 <a href="mailto:dneal@umich.edu">dneal@umich.edu</a>	Donna Sabourin WCHO/CSTS 734-544-3017 <a href="mailto:sabourid@ewashtenaw.org">sabourid@ewashtenaw.org</a>	<ul style="list-style-type: none"> <li>• CSTS Co-Occurring Group</li> <li>• Jail Diversion Effort</li> <li>• PORT</li> <li>• Home of New Vision</li> </ul>	Align Mental Health Jail Diversion efforts, CSTS Co-Occurring Group and WHA Blueprint to develop a county-wide service plan. Plan should include: service delivery model, personnel needs/costs, funding options, evaluation methodology, timeline and annual budget.
8	Increase the number of family emergency shelter units.	Judy Rumelhart 734- 663-9007 <a href="mailto:jdrumelhart@aol.com">jdrumelhart@aol.com</a>	SOS & IHN Gary Bell 734-485-6184 <a href="mailto:garyb@soscs.org">garyb@soscs.org</a>  Julie Steiner 734-822-0220 <a href="mailto:jsteiner@alphahouse-ihn.org">jsteiner@alphahouse-ihn.org</a>	<ul style="list-style-type: none"> <li>• Salvation Army</li> <li>• SJMHS</li> </ul>	Develop business plan addressing number and type of units, service delivery model, location options, personnel needs/costs, funding options, evaluation methodology, timeline and annual budget.  Develop plan in a manner that sets stage for necessary fundraising.
9	Increase the number of affordable supportive housing units for young adults.	Rene Greff Owner Arbor Brewing Co. 734-213-1393 <a href="mailto:rene@arborbrewing.com">rene@arborbrewing.com</a>	Mary Jo Callan Ozone House 734-662-2265 <a href="mailto:mcallan@ozonehouse.org">mcallan@ozonehouse.org</a>	<ul style="list-style-type: none"> <li>• Community Development</li> </ul>	Develop business plan addressing site acquisition, number and type of units, service delivery model, personnel needs/costs, funding options, evaluation methodology, timeline and annual budget.  Develop plan in a manner that sets stage for necessary fundraising.
10	Develop integrated strategy for education and employment services for people who are homeless	Larry Whitworth WCC <a href="mailto:whitll@wccnet.edu">whitll@wccnet.edu</a>  Mark Ouimet The Ouimet Group <a href="mailto:mco3502@aol.com">mco3502@aol.com</a>  Laurita Thomas <a href="mailto:Laurita@umich.edu">Laurita@umich.edu</a> 734-647-1913	Trenda Rusher Workforce Development Board/ ETCS/ Michigan Works! 734-544-2955 <a href="mailto:rushert@ewashtenaw.org">rushert@ewashtenaw.org</a>  Ellen Schulmeister SAWC 734-662-2829, ext. 223 <a href="mailto:ellenschule@yahoo.com">ellenschule@yahoo.com</a>	<ul style="list-style-type: none"> <li>• Washtenaw Community College</li> <li>• MAP</li> <li>• SOS</li> <li>• SAWC</li> <li>• FIA</li> <li>• PORT</li> <li>• MSU Extension</li> <li>• Food Gatherers,</li> <li>• Work Skills</li> <li>• MRS</li> <li>• Community Corrections</li> </ul>	Develop an action plan that makes employment and educational services more accessible and more useful for people who are homeless.  Plan should include: <ul style="list-style-type: none"> <li>• High level assessment of current services</li> <li>• Benchmark best practices (flexible funding options?)</li> <li>• Identify major gaps and high priorities</li> <li>• Identify potential costs and funding sources</li> <li>• Outline possible service delivery sites and evaluation models.</li> <li>• Develop near term timeline</li> </ul>

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	STRATEGY	COMMUNITY CHAMPION	CONVENER	TEAM, RESOURCES	GROUP CHARTER
11	<p>Develop innovative strategies to provide employment opportunities:</p> <ol style="list-style-type: none"> <li>1. Culinary training program</li> <li>2. Employment Development initiative for youth aging out of foster care</li> <li>3. Employment services mini-station for offender</li> <li>4. Youth Construction Training Pilot</li> <li>5. Post incarceration training program</li> </ol>	<p>Anne Williams                      ExcellenceQuest  <a href="mailto:excellencequest@aiserv.net">excellencequest@aiserv.net</a></p>	<ol style="list-style-type: none"> <li>1. Eileen Spring                              Food Gatherers                              734-761-2796  <a href="mailto:Eispy006@aol.com">Eispy006@aol.com</a></li> <li>2. Workforce Development Board/ETCS Michigan Works!, FIA                              Trena Rusher                              Susan Hull, FIA                              734-481-2115  <a href="mailto:hulls@michigan.gov">hulls@michigan.gov</a></li> <li>3. Workforce Development Board/ETCS Michigan Works!                              Community Corrections                              Julie Chaffee                              734-973-4716  <a href="mailto:chaffeej@ewashtenaw.org">chaffeej@ewashtenaw.org</a></li> <li>4. Mary Jo Callan                              Ozone House                              734-662-2265  <a href="mailto:mcallan@ozonehouse.org">mcallan@ozonehouse.org</a></li> <li>5. Susan Hornfeld                              MAP  <a href="mailto:michabilitypartners@ameritech.net">michabilitypartners@ameritech.net</a></li> </ol>	<ul style="list-style-type: none"> <li>• Work Skills</li> <li>• MRS</li> <li>• Washtenaw Community College</li> <li>• SAWC</li> </ul>	<p>Identify a business or workplan for how these specific strategies will meet the needs of people who are homeless or at risk of homelessness.</p> <ol style="list-style-type: none"> <li>1. Develop business plan for 2005-06.</li> <li>2. Develop an employment plan for youth aging out of foster care. Plan should include:                             <ul style="list-style-type: none"> <li>▪ Model based on best practices</li> <li>▪ Identify funding sources</li> <li>▪ Service delivery sites</li> <li>▪ Evaluation model</li> <li>▪ Timeline</li> <li>▪ Annual budget</li> </ul> </li> <li>3. Develop an employment plan for homeless or at risk ex- offenders. Plan should include:                             <ul style="list-style-type: none"> <li>▪ Model based on best practices</li> <li>▪ Identify funding sources</li> <li>▪ Service delivery sites</li> <li>▪ Evaluation model</li> <li>▪ Timeline</li> <li>▪ Annual budget</li> </ul> </li> <li>4. Develop a plan for a Youth Construction project. Plan should include:                             <ul style="list-style-type: none"> <li>▪ Identify funding sources</li> <li>▪ Outcomes</li> <li>▪ Timeline</li> <li>▪ Annual budget</li> </ul> </li> <li>5. Develop an employment training plan for homeless or at risk ex- offenders. Plan should include:                             <ul style="list-style-type: none"> <li>▪ Model based on best practices</li> <li>▪ Identify funding sources</li> <li>▪ Service delivery sites</li> <li>▪ Evaluation model</li> <li>▪ Timeline</li> <li>▪ Annual budget</li> </ul> </li> </ol>

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	STRATEGY	COMMUNITY CHAMPION	CONVENER	TEAM, RESOURCES	GROUP CHARTER
<b>SYSTEM REFORM</b>					
12	Develop common service and administrative standards across providers. Develop a shared performance management process for service providers using consumer feedback, standards review and analysis of outcomes.	Marvin Parnes <a href="mailto:mgparnes@umich.edu">mgparnes@umich.edu</a> 734-936-3933	Fran Alexander WHA 734-665-6749 <a href="mailto:fran@alexanderresources.net">fran@alexanderresources.net</a>	<ul style="list-style-type: none"> <li>• Health Services Department: Jeff Capobianco,</li> <li>• HSCC</li> <li>• Funders Forum reps.</li> <li>• Community Development</li> <li>• Ford School of Public Policy</li> <li>• NEW Center</li> </ul>	2004-5 <ul style="list-style-type: none"> <li>▪ Form standards team</li> <li>▪ Research and review literature for best practices; draft standards using a community engagement process</li> </ul> 2005-6 Research and review literature for best practices; outline proposed process; propose a staged approach to implementation; identify possible funding sources.
13	Establish a robust HMIS solution.	Larry Cohn Artizan Partners 734-995-9354 <a href="mailto:larry@artizanpartners.com">larry@artizanpartners.com</a>	Stacy Ebron Community Development 734-622.9014 <a href="mailto:ebrons@ewashtenaw.org">ebrons@ewashtenaw.org</a>	<ul style="list-style-type: none"> <li>• Agencies on 2005 work plan</li> <li>• WHA</li> <li>• WCHO</li> <li>• CSS</li> <li>• Community Development</li> </ul>	Update the 2005 HMIS Work Plan with key partners. Implement a county-wide information management solution that includes data collection from all homeless service agencies, information and data sharing and retrieval, and system integration planning. The plan should include a timeline and budget.
14	Establish an integrated funding structure and process.	Norm Herbert AAACF <a href="mailto:normanh@umich.edu">normanh@umich.edu</a>	Martha Bloom Funders Forum of HSCC (734) 663-0401 ext. 304 <a href="mailto:mbloom@aaacf.org">mbloom@aaacf.org</a>  Frank Cambria 734-222-6748 <a href="mailto:Cambriaf@ewashtenaw.org">Cambriaf@ewashtenaw.org</a>	<ul style="list-style-type: none"> <li>• WHA</li> <li>• Community Development</li> </ul>	Based on research of other community funding structures and interviews with local funders, develop a plan that outlines and clarifies how funding decisions will be made in a more coordinated and aligned manner. Include <ul style="list-style-type: none"> <li>▪ An outline of the proposed funding process</li> <li>▪ The most appropriate funds to include</li> <li>▪ A proposed timeline</li> <li>▪ Measures of effectiveness for the funding process</li> </ul> The make up and fiduciary responsibilities of the funding organization.

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	STRATEGY	COMMUNITY CHAMPION	CONVENER	TEAM, RESOURCES	GROUP CHARTER
15	Integrate Planning Processes	Frank Cambria 734-222-6748 <a href="mailto:CambriaF@washtenaw.org">CambriaF@washtenaw.org</a>	Amy Klinke Community Development 734- 622-9005 <a href="mailto:klinkea@washtenaw.org">klinkea@washtenaw.org</a>	<ul style="list-style-type: none"> <li>Continuum of Care</li> <li>WHA</li> </ul>	Develop an outline that integrates Continuum of Care processes, Blueprint to End Homelessness and any other community plans that address homelessness. The outline should address changes in funding mechanisms, needed organizational changes, staffing implications, and timeline for completion.
16	Advocate vigorously at state, local, and federal levels	Leah Gunn 734-663-7307 <a href="mailto:gunnl@washtenaw.org">gunnl@washtenaw.org</a>  Ruth Ann Jamnick <a href="mailto:rjamnick@house.mi.gov">rjamnick@house.mi.gov</a>	Diane Davidson WHA 734-222-6553 <a href="mailto:davidsond@washtenaw.org">davidsond@washtenaw.org</a>	<ul style="list-style-type: none"> <li>HSCC</li> <li>University teams</li> </ul>	Develop and implement an advocacy plan that includes: identification of issues for 2005, communication methods, technology needs, suggested approaches.
17	Conduct evaluative research	Bob Guenzel 734-222-6731 <a href="mailto:guenzelb@washtenaw.org">guenzelb@washtenaw.org</a>  Professor Elisabeth Gerber University of Michigan <a href="mailto:ergerber@umich.edu">ergerber@umich.edu</a>	Fran Alexander WHA 734-665-6749 <a href="http://fran@alexanderresources.net">fran@alexanderresources.net</a>	<ul style="list-style-type: none"> <li>Ford School of Public Policy</li> <li>Community Development</li> </ul>	Develop an evaluative research model that allows the community to identify what combinations of housing, services, and access work best for which people.

### Community Champion Role:

- Leverage your position and skills to help the team advance their work
- Encourage communication and accountability to whole community
- Serve as a support and resource for the team

### Convener Role:

- Take lead responsibility for guiding team success
- Identify and convene needed resources to advance work
- Keep others stakeholders connected to progress
- Communicate progress to WHA
- Seeks help from Community Champion or WHA as needed

### Acronym Glossary:

AAACF	Ann Arbor Area Community Foundation	HSCC	Human Services Collaborative Council	SAWC	Shelter Association of Washtenaw County
CSS	Catholic Social Services	IHN	Interfaith Hospitality Network	SJMHS	Saint Joseph Mercy Health Systems
CSTS	Community Support & Treatment Services	MAP	Michigan Ability Partners	SOS	SOS Community Services
ETCS	Employment Training and Community Services	NEW	Non Profit Enterprises at Work	WCHO	Washtenaw County Health Organization
FIA	Family Independence Agency	PORT	Project Outreach Team	WDB	Washtenaw County Workforce Development Board Organization
FSN	Family Support Network	RFP	Request for Proposal	WHA	Washtenaw Housing Alliance

## **III-1. Keep People Housed through the Use of Centralized Housing Services and Prevention of Eviction and Foreclosure**

### **Vision**

The following describes our vision for the homelessness prevention services and response in our community:

- Housing resources are centralized, easy to access and expedient, with emergency help available around the clock. Centralized resources include crisis response, eviction prevention and housing referral. Mobile service teams work closely with individuals who have housing challenges and provide necessary support services to keep them housed.
- Proactive, preventive efforts and supports are utilized to prevent property tax and mortgage foreclosures.
- Tenants and homeowners at risk of losing their housing have access to legal representation and support.
- Washtenaw County is a well-informed community (tenants, homeowners, landlords, mortgage holders, banks/lenders, service providers, Housing Commissions, etc.) that works together to keep people housed.

### **Current Reality**

Keeping people housed – in their homes or apartments – is becoming a bigger issue in our County:

- Mortgage foreclosures filed with the Register of Deeds have more than doubled over the last four years, from 111 in 2000 to 268 in 2003.
- 9,051 evictions were filed in Washtenaw County in 2003, up from 8,296 in 2002.
- Between April 1, 2003, and March 31, 2004, the FSN Housing Crisis Team and the Emergency Intake and Assessment program responded to 1321 callers experiencing a housing crisis.
- Legal Services of Southeastern Michigan served 500 individuals in housing crisis (either with notice to quit or with threat of losing their housing subsidy) this past year. More than twice that number contacted Legal Services seeking legal assistance in an eviction-related matter.
- The County Treasurer's office proactively resolved approximately 1500 potential property tax forfeitures in 2003.

Currently many resources are available to people in need of housing assistance but there are gaps and issues in service delivery:

- Access to services is fragmented; consumers must make numerous 'stops' to get their needs met.
- Eligibility is often strictly defined and proof of eligibility overly burdensome.
- Crisis lines have limited hours of operation.
- It is very difficult for tenants to obtain assistance early enough in the eviction process to address their housing crisis (often must have notice to quit or shut off notice before assistance can be provided).
- Financial resources run out early in the calendar year; there are not enough financial resources to help people in need of eviction or foreclosure prevention.
- Follow-up services and ongoing support varies for those who have received financial assistance.
- Landlords and bankers do not know where to refer tenants and homeowners who need assistance.
- Lack of transportation impacts peoples' ability to access services.

### **Washtenaw County Community Input – What do we need?**

This brief summary of what our community needs is based on focus groups with numerous providers including SOS, IHN, MAP, Housing Bureau for Seniors, and Legal Services.

- Easier access to financial assistance and more dollars available.
- Greater access to and utilization of education opportunities – tenant's rights and responsibilities, financial counseling, budgeting, life skills, legal forms, predatory lending, etc.
- Case management services for long-term support to keep people housed.
- More access to legal services and access to mediation services.
- Upfront education and prevention regarding predatory lending.
- Advocacy and information for individuals facing mortgage foreclosure.
- More access to housing subsidies and/or low income housing.
- Housing Commission collaboration with tenants and community re: keeping people housed.
- Follow-up evaluation on impact – do people stay housed with help and what kind of help really has an impact?

## **Recommendations**

### **Centralize resources that include the following components:**

- Intake and Response
- Housing Advocacy and Referral
- Education Resources
- Centralize prevention dollars

### **Provide and expand legal services**

### **Develop mortgage foreclosure prevention program**

[Note: There is some concern in the provider community about centralization of resources and services. Initial efforts to centralize money and/or services must recognize these issues. Monitoring effectiveness over time will also allow adjustments to be made as needed. Issues include:

- Concern that the needs of special populations will be lost and resources will not be available to certain populations as resources get pooled together.
- Fear that individuals with unique situations will fall through the cracks. How can centralized resources remain flexible enough to meet the needs of all consumers?
- Ease of access to centralized resources.

### **Centralize Intake and Response**

- **Centralized Intake:** Provide 24 hour/7 day housing crisis phone service, intake and assessment for families and individuals.
- **Crisis Intervention/Response:** Offer a centralized gateway to multiple services including financial assistance, transportation, information, linkages to other services, including emergency shelters, legal services, etc. While this gateway is centralized, there will be multiple access points to centralized resources, regardless of where a person enters the system. (Note that all referrals would offer direct links to providers or services, not general referrals.)
- **Emergency Shelter Access:** Referral and transportation to meet emergency shelter needs based on confirmed access/availability.
- **Mobile Response and Outreach Teams:** Crisis response and outreach teams will work to engage those who are homeless in services and shelter and respond to housing crises in the community in order to prevent homelessness. Those at risk of homelessness need access to on-going comprehensive case management and/or support services. These service teams will assess needs, advocate with landlords as needed, act as advocates with other service providers, and create plans with their consumers to keep them housed or get them housed.
- **Special Populations:** Ongoing case management and service delivery for homeless youth and domestic violence survivors will remain independent to keep specialization and follow best practices for those populations. The role of the aging population, in terms of best practices, must be examined as well. It will be important to stay linked to these services and special populations that can experience homelessness and look for ways to provide support and share centralized resources.

## Centralize Housing Advocacy and Referral

- ***Develop, create, find and maintain long-term affordable housing and housing assistance options. [Many of these recommendations are covered in another section of this blueprint on Permanent and Affordable Housing.]***
  - Protect existing low-income housing options – track sites where HUD mortgages are close to being paid off and work with landlords, non-profit developers and governmental agencies to maintain these units as affordable and accessible to low-income clients.
  - Find ways to create more long-term housing subsidies. Investigate the use of TANF dollars (as used in other states) for housing subsidies.
  - Create more tenant-based and site-based low income housing options.
  - Work with the Housing Commissions to help reduce evictions and develop collaborative relationships with tenants.
  - Secure additional Section 8 vouchers. Promote acceptance of Section 8 vouchers among landlords, investigate legislation requiring landlords to accept housing subsidies, and monitor discrimination around Section 8 vouchers.
  - Develop low-income housing options for people who are not eligible for public housing (e.g., previously convicted felons, persons with poor credit history, etc.) and lobby local and federal governments to examine exclusions and rigidity of their regulations.
  - Find ways to move beyond one-time eviction prevention payments to time limited housing subsidies until families become financially stable.
  
- ***Establish a centralized housing database and housing resource coordinator(s)***
  - Develop a centralized database that will offer community-wide access to housing options, and optimize the efficiency of case managers in locating housing for their clients. A Housing Resource Coordinator(s) will be responsible for maintaining the database, as well as a database of landlords in Washtenaw County. Additional responsibilities of the coordinator will include: developing relationships with landlords, assisting them with Section 8 voucher compliance and directing them to resources needed for at-risk tenants.

## **Centralize Education Resources: Coordinate and Expand Outreach, Education and Information Support**

- ***Coordinate existing education efforts:*** Numerous education efforts exist in the community. There is a need to assess the breadth of these efforts, identify gaps with existing tenant and homeowner education efforts, and expand knowledge of existing resources, among both service providers and clients.
- ***Banker/lender and landlord education and outreach:*** For this effort to be successful, landlords and lenders will need to be educated about resources in the community available to them and to their tenants, including centralized housing resources, education resources, etc.
- ***Education outreach and/or target population efforts:*** Consider ways to link education to assistance in a supportive way (as done in some best practice models). Also look for ways to bring these education efforts to apartment complexes with high eviction rates and/or public housing sites. Work with the Housing Commissions to develop creative ways to bring information to their tenants.
- ***Educational approach and topics:*** Early education and intervention is crucial – educate people on budget counseling, predatory lending, financial advice and education *before* crisis arises. Critical topics for education include: tenant’s rights and responsibilities, budgeting and financial management, predatory lending and other life skills. There is also a need for people to know where to go for help and when to go for help. In developing these topics, ensure that the different needs and issues facing homeowners and tenants are taken into consideration and that the needs of both groups are addressed.

## **Centralize Prevention Dollars and Get More Dollars**

- A Barrier Buster like approach is planned for Emergency Services dollars whereby they will be centralized and accessible by agencies who specialize in eviction prevention. Additional dollars will be available to supplement the ES dollars from other funders as well. This will result in easy access to dollars, ability to meet an entire request from someone needing assistance, and a larger pool of resources to draw on. It also will highlight the need in the community over time. Rather than having multiple agencies running out of money at different times, tracking the joint fund and when it runs out of money will more clearly highlight the need in our community and ideally allow for a faster response time to collect more funds.
- Maximize use of SER dollars; Collaborate with Family Independence Agency to determine how to better utilize these dollars. What can the community of providers do to support individuals who get SER dollars to ensure a long-term positive housing outcome? Will case management support enable us to access more SER dollars?
- Identify opportunities to centralize other monies available to help clients clear debt and get their finances back in order.

## **Provide and Expand Legal Services**

- ***Continue to provide legal services support and increase accessibility***
  - Every tenant facing eviction should have access to legal advice or representation regardless of income.
  - Provide an attorney at every landlord-tenant day at every district court to provide counsel and advice to tenants.
  - Establish and promote program for lawyers to review loan documents for all refinances, to avoid predatory loans.
  - Promote state and local legislation to prohibit predatory lending.
  - Maintain and expand services currently available to tenants through Michigan Tenant's Counseling Program, particularly organizing and outreach efforts.

## **Develop a mortgage foreclosure prevention program**

- Modeled after the Treasurer's Office and Housing Bureau for Seniors' Property Tax Foreclosure Prevention Program, develop a county-wide Mortgage Foreclosure Prevention program that focuses on families and individuals at risk of homelessness. The program would be proactive in identifying at-risk individuals, work with them to review their options, direct them to legal services as needed, and provide loans, as appropriate.
- Develop prevention and education programs to reduce mortgage foreclosures. Have lawyers available to review low-income people's mortgages and refinances before they are signed. Develop preventive education efforts on predatory lending (consider using the banking community to lead and finance this effort).

## **Links with Other Community Efforts**

There are numerous efforts in the community that are critical to stay in contact with and coordinate efforts with including the 211 phone line, the HSCC Children and Family Work group, and the Barrier Busters process.

## **Effectiveness Research and Model Programs**

There is a collection of extraordinarily promising and cost-effective eviction and foreclosure prevention programs that are in need of more rigorous experimental evaluations. Many communities are providing these types of programs and are being modeled as best practice programs, given there are no evidence-based practices that are researched and replicated. <sup>i</sup>

The National Alliance to End Homelessness identifies the following innovations that are developing in the area of emergency homelessness prevention:

- Enhancing coordination and information sharing among emergency assistance (including rent/mortgage and utility assistance) providers to ensure all existing prevention dollars are maximized.

- Moving beyond one-time eviction prevention payments to providing time limited housing subsidies until families become financially stable.
- Combining emergency assistance with either time limited or ongoing case management to reduce future risk of homelessness.
- Targeting new homelessness prevention/emergency assistance efforts to the neighborhoods that a disproportionate number of people seeking shelter are exiting.
- Integrating homelessness prevention activities at the intake sites for shelters in an effort to identify if resources/services could be deployed to prevent homelessness.

Specific communities that have recently trialed such programs include:

**Hennepin, Minnesota** – Hennepin County Rapid Exit Program: Serves imminently homeless families and single adults by providing legal services, case management, volunteer assistance, landlord/tenant mediation and assistance in securing new housing, and financial assistance (\$331/ average cost per family served).

**Philadelphia, Pennsylvania** – Philadelphia Housing Support Center: coordinates housing and service resources from various city social service departments through one central gateway, serves as a "one-stop shop" for housing resources -- providing both prevention and back-door mechanisms to decrease the actual number of people experiencing homelessness while helping to reduce the length of time others have to remain homeless. Resources and funding come through Family Unification Program Vouchers, TANF dollars, and other mainstream and homeless program funds.

**Washington D.C.** – Community Care Grant Program: This program focuses on families who are at imminent risk of homelessness. Staff help families to access housing and offer transitional, intensive case management services to ensure stabilization of housing. Adult family members must be employed or able to obtain employment and time-limited funds are available to help defray housing costs. The program is a collaboration between the Community Partnership for the Prevention of Homelessness and federally funded Family Support Centers.

**Additional Resources:**

Community Shelter Board, Columbus, Ohio –

Sources: Lessons from Columbus, Ohio, Barbara Poppe, NAEH website,  
<http://www.endhomelessness.org/audio/CSBoutcomes.pdf>

Mobile outreach best practice -

The national best practices proposed for use in this phase of the project include Assertive Community Treatment (Stein & Test, 1980; Dixon, 2000) and Critical Time Interventions. (“Incorporation of the Critical Elements of Integrated Treatment.” Center for Mental Health Services. 1998; Campus for Human Development, Nashville, TN.)

It is less expensive to prevent homelessness than to shelter individuals. In a U.S. Department of Health and Human Services study (1991), they found that the average cost to prevent homelessness was one-sixth the average cost of a stay in a shelter.

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<sup>i</sup> From *Rethinking the Prevention of Homelessness* by Marybeth Shinn and Jim Baumohl, The 1998 National Symposium on Homelessness Research.

## III-2. Increase Stock of Permanent Affordable and Supportive Housing

### Vision

The following describes our vision for the stock of affordable housing available for persons who become homeless or are at risk:

- We have an adequate supply of permanent affordable housing for people with incomes at or below 30% of area median income. Housing costs are set at no more than 30% of the target tenants' household income.
- People in need of additional support have easy access to ongoing Supportive Housing Services – a wide range of supports designed to focus first on helping tenants maintain housing stability. Supportive Housing Services are:
  - Flexible
  - Individualized
  - On-site
  - Voluntary
  - Not time limited

(For a detailed listing of supportive housing services, please see the Supportive Housing Services section of this chapter.)

- These units are able to meet the needs of the wide range of people in need of permanent affordable housing in our community
- Physically accessible for seniors and for the physically challenged
- Efficiencies and 1 bedrooms for single people, as well as 2, 3 and 4 bedroom units for family use
- Accessible to public transit
- Located in safe neighborhoods
- Accessible to employment and education
- Supportive Housing Services are highly responsive to the unique needs of the tenants and assist individuals and families in maintaining safety and stability in housing, health, and employment. Supportive Housing Services encourage productive participation in the community.
- People move rapidly from emergency shelter to appropriate permanent affordable housing. Excellent comprehensive assessment identifies the most appropriate type of housing and related services and is available for each person seeking housing and stability.
- People living in permanent affordable, supportive housing are tenants and have the rights and responsibilities of tenancy. Tenants receive needed supports and education to help them maintain a successful, positive landlord-tenant relationship.
- Permanent affordable housing properties have adequate funding to cover their unique operating costs, including enhanced management, maintenance and

rehabilitation. Properties are maintained in an exemplary fashion to help maintain building values, build tenant and neighborhood pride, and increase community support for low-income housing.

- The environment of the housing encourages healthy, safe life styles and builds a strong sense of community for tenants.
- Property owners and managers are committed to preventing evictions. Effective prevention is achieved through close relationships with tenants, creative accommodations in leases, and easy access to needed services when difficulties arise, for both landlord and the tenant.

## **Current Reality**

The Housing Element of the County's Comprehensive Plan offers the following insights into the nature of housing for 'Extremely Low Income' (ELI) Households in Washtenaw County. (ELI= earning less than 30% of median income)

- The 2000 Census counted 16,936 households with extremely low incomes, comprising 13.7% of total County households. The majority of these households (80%) resided in renter-occupied housing units. 58% of these rental households have a housing cost burden in excess of 50% of their annual income.
- An individual must earn over \$15 per hour or \$30,000 a year to afford a 2-bedroom apartment with the fair market rent of \$815/mo.
- The average income for persons on disability is \$6,624/annually. Significant subsidies are necessary to allow these persons to secure an apartment and have it be permanently affordable.
- Currently, there are over 2,500 people on waiting lists for affordable housing. People requesting affordable housing vouchers have an average wait of 28 months.

## **Effectiveness Research and Model Programs**

Research studies and best practice programs that are designed to help people maintain safety and stability in housing, health, and employment point to the need for supportive services to be combined with permanent, affordable housing. Concrete measures demonstrate the benefits to the individual and the community as noted here:

### **Supportive housing helps people stay housed**

The Coalition for the Homeless operated a pilot rental assistance program in New York City, combined with case management and job development services, from 1989 to 1998. Of the 346 households served, 257 households were monitored through April 1998 and 98 percent had not returned to the shelter system.<sup>ii,iii</sup>

### **Supportive Housing is cost effective**

Researchers (Culhane et al., 2002) found that people placed in service-enriched, supportive housing had marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated. Before placement in supportive housing, homeless people with serious mental illnesses used about \$40,451 per person, per year in services (1999 dollars). Placement in supportive housing was associated with a reduction in services use of \$16,281 per housing unit per year (Culhane et al., 2002). Much of the savings resulted from fewer and shorter stays in state psychiatric hospitals, as well as decreased shelter use. Also, property values in the neighborhoods surrounding the supportive housing have increased or remained steady since the housing was developed.

### **Supportive housing tenants have improved health and lower health care costs**

Results from the Connecticut Supportive Housing Demonstration Program, conducted from 1993 to 1998, show that supportive housing created positive outcomes for tenants while decreasing their use of acute health services and increasing their use of less expensive ongoing and preventive health care (CSH, 2002a).

Emergency room use by tenants in supportive housing programs, in the San Francisco Bay area, dropped by 58 percent in the first 12 months of residency, and inpatient stays declined by 57 percent.<sup>iv</sup>

### **Supportive housing tenants are better able to secure and maintain employment**

A three-year study that followed supportive housing residents with multiple barriers to employment revealed that with appropriate services, even this hard-to-serve population can get and keep jobs. The study proved that over the course of the initiative, tenants obtained 1,800 jobs with an average hourly wage of nearly \$7/hour; Participants' earned income increased by 50% over a control group; Participants' rate of employment increased by 40%.<sup>v</sup> In 2003, 43% of Avalon Housing tenants were employed either full or part time.<sup>vi</sup>

### **Supportive housing tenants need less government support**

Supportive housing tenants' dependence on entitlements dropped significantly—\$1,448 per tenant—over the study period.<sup>vii</sup>

## **Recommendations**

This plan outlines an ambitious strategy for addressing the complex issue of homelessness in Washtenaw County. The essential component of the proposed response is permanent affordable housing coupled with an array of supportive housing services.

The following outlines the current and projected demand for permanently affordable, supportive housing in Washtenaw County as well as additional requirements for this housing:

- Washtenaw County needs at least 500 permanently affordable supportive housing units to meet the needs for individuals, families and youth who have had a history of

significant difficulty maintaining housing. (See Appendix D for national formula applied to determine this number).

- All units must be supported by a match in sustainable service dollars and adequate funds dedicated to keep properties maintained in a manner that develops tenant and neighborhood pride.
- The units must be located on a public transportation line and convenient to employment opportunities.
- In most cases, private sector units will be in mixed income, scattered sites that are geographically dispersed throughout the county.

We propose a **mix of strategies** to attain the needed housing:

#### **Not-for-profit permanently affordable, supportive housing**

Increase the number of rental units owned and operated by private, not-for-profit organizations that can be rented at rates affordable to the households defined above.

- Build broader capacity in the nonprofit sector for development and management of permanently affordable units.
- Our initial strategy suggests providing this housing for people who have had significant difficulty maintaining housing.

#### **For profit, privately owned housing with supportive services available**

- Develop and coordinate a private housing pool through strong partnerships with selected landlords using existing rental units. Tie these units to guaranteed levels of service supports including the availability of a 24-hour crisis intervention. Provide support in establishing creative and accommodating relationships and contracts with proposed tenants.
- Host regular sessions for landlords and property managers for problem solving, informational sessions, and training on relevant issues.
- Increase the number of section 8 vouchers or similar housing subsidies available in Washtenaw County.
- Recruit landlords to supplement section 8 voucher units with community-donated units to multiply the impact of federal dollars with local community private sector support.
- Identify strategies with property owners to ensure that this housing remains affordable and available over time.

#### **Not for profit owned permanently affordable housing with available services**

- Both publicly owned and private nonprofit affordable housing serve low-income people. We recommend enhancing this existing housing by providing additional supportive services on site. While this recommendation will not increase the number of affordable units available in Washtenaw County, it is designed to prevent evictions and to ensure a safe and healthy community for tenants currently living in public housing.
- Develop a reasonable estimate of need/demand for supportive services in Public Housing.

## Success Strategies and Measures:

From a review of programs that have achieved excellent housing stability outcomes, we have culled the following characteristics of successful permanent affordable, supportive housing programs:

- **It is affordable:** Structure housing to be permanently affordable with no more than 30% of a household's income going to housing costs.
- **It is permanent:** There are no time limits attached either to residing in the unit or to eligibility for supportive housing services.
- **Services are flexible:** Supportive services are available onsite, and are customized to meet the needs of the tenants. Services are not time limited.
- **Participation in services and activities is voluntary:** Tenancy is not contingent on service participation. Supportive housing tenants are obligated, like any other tenant, to meet the terms of the residential lease.
- **Property management staff work with service providers and tenants as a team:** Property management staff is trained specifically around the needs of the tenant population and property managers are partners in building a community.
- **Evictions are prevented** through creative lease accommodations and use of knowledgeable and skilled property managers and case managers who can identify early warning signs of problems that could result in housing instability.
- **Become a neighborhood asset** through property maintenance and relationship development in the community.
- **Build community** with and for tenants.

To develop an effective response to homelessness in our community, we recommend that all efforts to provide housing and services incorporate the above elements. This recommendation will require a significant investment in order to ensure that supportive services are available onsite at affordable housing locations.

We also recommend that our community provide supportive services for housing in ways that are consistent with the remarkable outcomes achieved in best practice programs nationally. To that end, we recommend the development of a 'fidelity scale' for delivery of supportive services, based upon the best practice research done by the Corporation for Supportive Housing. To develop a strong, community base of knowledge and to demonstrate a wise use of community resources, measurement of outcomes connected with supportive housing programs is essential. Those measures should include:

- Demographics of people housed
- Eviction rates
- Reasons for tenant change of housing
- Police and emergency contacts
- Employment numbers, among others to be determined with support from researchers and providers

Ongoing feedback should be gathered from the following:

- All tenants
- Users of supportive services
- Neighbors
- Landlord and property management
- 'Adjacent' service providers

Data from this research during the early years of implementing these recommendations will inform the community's strategies in moving forward beyond the first few years of this plan.

## Links to Other Focus Areas

Supportive Housing requires a sustainable revenue stream for service dollars. Affordable housing alone will not work without an equal commitment to providing at risk tenants with needed supports to address the factors that threaten housing stability.

The Corporation for Supportive Housing has developed a set of national averages for supportive housing services, though they note that there is significant variability countrywide as those services are influenced by many local factors.<sup>viii</sup> From this research, the average of \$7000 per unit is used when estimating supportive service costs in this Blueprint.

Our community must continue to document and measure what is needed to deliver consistently high rates of housing stability (fidelity scale, outcome measures, interviews).

## Supportive Housing Services Activities

- **Engagement** Outreach efforts, social and recreational activities, assistance with basic needs, and trust building.
- **Assessment** Housing history, risk assessment, personal goals, and identification of physical/ psychiatric/emotional/material strengths and deficits.
- **Housing Permanency Plans and Goal Development** Develop and monitor housing permanency plans in conjunction with tenants and property managers, and develop and monitor individual goal/service plans with tenants as it relates to enhancement in quality of life.
- **Case Management** Ensure Case Management is in place through referral and advocacy with appropriate agencies, or provide Case Management as needed for individuals and families for whom other options don't exist.
- **Crisis Intervention** Direct staff assistance and advocacy in managing medical, psychiatric, legal, or other types of emergencies. Crisis intervention occurs at the site of the emergency whenever possible.
- **Mental Health Support** Ongoing observation of a consumer's mental health status, communication with involved CSTS or private practice professionals, assistance with care coordination, and referrals to counseling and treatment. Transportation and accompaniment to referrals when indicated.
- **Medical Care** Coordination of health care services when necessary, referral to Washtenaw County indigent health care program for individuals who have no insurance, and patient advocacy. Transportation and accompaniment to appointments when indicated.
- **Substance Abuse Treatment and Recovery Support** Referrals to appropriate de-tox facilities or assessment with the local community substance abuse resource. Facilitation of residential treatment, follow-up, counseling, peer group support

and connection to AA. Assist tenants in participating in substance-free activities. Transportation and accompaniment to appointments when indicated.

- **Conflict Mediation** Facilitate house or building meetings, foster effective communication around issues pertaining to noise, guests, children's behavior, parking, etc. especially for tenants whose perceptions may be compromised by a mental illness or substance abuse problem.
- **Coordination of Entitlements** Assistance with application, appeal process and problem-solving. Referrals to Legal Services as indicated.
- **Employment Support** Facilitate referrals and enrollment in job skills/training programs. Assist with job applications, preparations for interviews.
- **Money Management** Assist with budgeting, making payment arrangements on arrearages, securing emergency funds or loans, and arranging for representative payeeships.
- **Household Support** Assist with grocery shopping, cleaning, laundry, meal preparation etc. as needed to maintain health and hygiene of tenant and housing unit.
- **Education and Childcare** Assist with school and childcare enrollment, links to educational supports such as tutoring or advocacy centers, advanced education applications, including documentation for financial aid, registration, and planning process.
- **Transportation** Assist tenants in negotiating public transportation system as needed for work, school or recreation. Provide transportation to places not accessible by public transportation, difficult to manage with children, or as indicated by an individual's physical or mental status.
- **Socialization/Recreation** Foster development of positive social networks through participation in project sponsored or community sponsored activities.
- **Legal Assistance** Referrals to Legal Services for range of services, including Personal Protection Orders (PPO) and access to entitlement programs. Assist tenant in follow-through, documentation, etc. in support of legal process.
- **24 Hour Support** Availability of staff during night time hours for crisis response, support needs, and redirection from illicit activities or dangerous associations.
- **Security** Staff assistance with enforcement of PPO's, trespass warrants, and routine limit setting by tenants with their guests. Staff presence will deter predatory behaviors by unwanted guests.

## Strategies and Plans in Place

The following plans have goals and strategies that will have an affect on the development of a full supply of affordable housing and the availability of supportive housing services in the community.

- Washtenaw Urban County and HOME Consortium Draft Annual Action Plan 2004-2008 (Under WMA).
  - This plan works on community development and housing revitalization efforts as stated in their plan in collaboration the Community Development Block Grant (CDBG), Home Investment Partnerships (HOME) and American Dream Down Payment Initiative (ADDI) Programs.

[http://www.ewashtenaw.org/government/departments/planning\\_environment/cd/draft\\_annualplan.pdf](http://www.ewashtenaw.org/government/departments/planning_environment/cd/draft_annualplan.pdf)

- Community Support and Treatment Services
  - CSTS provides mental health services as well as housing of those with mental health issues under a contract with the WCHO.  
[http://www.ewashtenaw.org/government/departments/community\\_mental\\_health/index.html](http://www.ewashtenaw.org/government/departments/community_mental_health/index.html)
- Human Services and Collaborative Council (HSCC including the 0-5 and youth and Family Action groups)
  - The HSCC helps to establish economic well being to help supply stable permanent affordable housing. Source: Community Plans Matrix.
- The Blueprint for Aging Population Services
  - Homeless and low-income senior adults are supplied with affordable housing.
- City of Ann Arbor Consolidated Strategy and Plan FY 2004 One-year Action Plan (July 1 2004 thru June 30 2005 funded by HUD)
  - This Plan seeks to reduce the onset, incidence and duration of homelessness as well as increase affordable permanent housing. Source: Community Plans Matrix.

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<sup>ii</sup> Coalition for the Homeless, “Temporary Rent Subsidies for Working Homeless New Yorkers: Program Expansion Can Reduce Shelter Stays and Save Taxpayer Dollars.”

<sup>iii</sup> The New York-New York Initiative, Center for Mental Health Policy and Services Research, University of Pennsylvania. May 2001.

<sup>iv</sup> Source; Proscio, T. Work in Progress 2: An Interim Report on Next Step: Jobs. Corporation for Supportive Housing, June 1998.

<sup>v</sup> Proscio, T. Work in Progress 2: An Interim Report on Next Step: Jobs. Corporation for Supportive Housing, June 1998.

<sup>vii</sup> Proscio, T. Work in Progress 2: An Interim Report on Next Step: Jobs. Corporation for Supportive Housing, June 1998.

<sup>viii</sup> Strategic Framework for Ending Long-term Homelessness”, CSH paper (May 2002) available at [http://documents.csh.org/docs/StrategicFramework-5\\_2\\_02.doc](http://documents.csh.org/docs/StrategicFramework-5_2_02.doc)

### **III-3. Secure Reliable Funding Sources for Supportive Services**

#### **Vision**

Reliable funding is critical for effective planning and delivery of services to help people achieve and maintain housing stability. The following are elements of our vision for funding:

- Reliable funding for services that are core to ending homelessness is available.
- Access to and appropriate use of existing mainstream services is maximized, allowing resources to go to direct services and minimizing the need for service providers to help consumers navigate larger systems of care.
- Natural community resources (religious congregations, organized skilled volunteers, caring neighbors) are used very effectively to help address issues related to homelessness.
- The amount of time spent by service providers in securing resources for core services is appropriate. Service providers are focusing their energies on providing services, tracking outcomes and refining service philosophy and delivery based on feedback from consumers, the community and other agencies in the continuum of care.
- The community is aware of how resources dedicated to ending homelessness are spent and what outcomes are being achieved.
- The community knows what they have done and what they can do to help end homelessness through contributions of time and dollars.

#### **Current Reality**

Washtenaw County is a committed and generous community. The Delonis Center is an excellent example of a county based, creative public-private partnership and that generous spirit.

Our community is also faced with challenges that are national challenges. Federal and state resources are steadily diminishing and those resources may have very targeted uses and time limitations for services, in direct contradiction to the best practice research documented throughout this plan. Increasingly, commitments to critical human services must be met locally and through a creative mix of government and private dollars.

Additionally, even local dollars are often not coordinated effectively and service providers and funders bear an excessive administrative burden connected to multiple applications and multiple auditing processes. This is time spent that does not translate into better services and better outcomes for the community. Some sources of funding

have guidelines that paradoxically withdraw funding for services that have been shown to be effective, assuming that the ability to deliver the desired outcomes can be sustained in other manners. These inconsistencies leave the community vulnerable to a constantly changing array of services that are developed in an ad hoc, non-strategic manner.

Lastly, private donors and tax payers do not have ready access to information on how monies are being used and what outcomes have been achieved, eroding their confidence in giving and in possibilities for genuine community impact.

## **Effectiveness Research and Model Programs**

Research conducted by The Urban Institute and Walter R. McDonald and Associates in 2003 analyzed strategies used by seven leading communities across the United States to determine what has worked in addressing issues of chronic homelessness. Along with an assessment of structures and service approaches, this study summarized the funding strategies used by each community. The following is an excerpt of their findings:

- The experience of these seven communities indicates very strongly that reducing chronic street homelessness requires a significant investment of mainstream public agencies, bringing both their commitment and energy, and *local* dollars. The goal cannot be met if the homeless assistance network providers are the only players, and Federal funding streams the only resources.
- The communities and service networks enjoying the greatest success in reducing chronic street homelessness all capture resources from many different funding streams.
- The local agencies that control these funding streams have made the decision to devote not only Federal resources they control, but also their own state and local resources, to achieving the goal.
- In addition, some communities have created special funding streams that help support permanent housing programs and supportive services. These include:<sup>ix</sup>
  - Housing tax levy (Seattle)
  - Tax increment financing generated by a redevelopment agency and reinvested in permanent supportive housing (San Diego)
  - Community redevelopment bonds (Philadelphia)
  - Special state funding streams (California's Integrated Services for Homeless People with Mental Illness, and its Supportive Housing Initiative Act)
  - Investments by Business Improvement Districts and other associations of downtown businesses and corporations (Birmingham, Columbus, Philadelphia, San Diego)

## Recommendations

To be effective in addressing issues of homelessness in our community, we recommend the following:

- Our community must secure a locally supported and controlled funding stream for supportive service dollars.
- Conduct a vigorous community education campaign to communicate the need, the resources currently available, outcomes achieved and outcomes desired. Build on the Community Engagement and Education sessions from summer 2004. Focus on community, provider and consumer accountability. Build a sense of community potential by sharing successes of our community and other communities.

## Strategies and Plans in Place

The following plans have goals and strategies that will have an affect on the development of reliable funding sources for supportive services in the community.

- HUD Continuum of Care
  - HUD CoC gathers and distributes funds for housing and homelessness.
- Family Support Network
  - FSN gathers funding from its nine affiliated organizations to help end homelessness.
- Human Service Community Collaborative (HSCC)
  - HSCC engages in integrated funding initiatives with its sub-action groups as well as with other organizations (called the State Blended Funding Initiative).
- Business Leaders Round Table
- Washtenaw Community Health Organization (WCHO)
  - The WCHO has overall responsibility for the management of funds for behavioral health and primary care services for the indigent.
- Washtenaw County United Way
  - The mission of the WUW is to generate and allocate resources to help individuals and families build better lives and stronger communities. Source: Funder's Forum Community Goals Matrix.
- The Ann Arbor Area Community Foundation (AAACF)
  - This foundation is dedicated to building endowment to enrich the quality of life in Washtenaw County. Source: Community Plans Matrix.

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<sup>ix</sup> Strategies for Reducing Chronic Street Homelessness, prepared for: U.S. Department of Housing and Urban Development by: Burt, Hedderson, Zweig, et al, January 2004.

## **III-4. Ensure Needed Housing and Treatment for People with Drug and Alcohol Addictions and Co-Occurring Disorders**

### **Vision**

We propose that the following vision reflects a community that is committed to ending homelessness for people who have drug or alcohol addictions or co-occurring disorders:

- Outreach occurs consistently and non-judgmentally to these individuals, helping to reduce the loneliness, stigma and isolation associated with homelessness and addiction.
- Service providers share a common and effective approach to assessment and referrals for people who are homeless and indigent.
- People who are homeless and have drug or alcohol addictions or co-occurring disorders have access to permanent affordable supportive housing with services (“Housing First”).
- Individuals who are ambivalent about entering into addiction treatment or even housing have access to a shelter facility that provides immediate ‘harm reduction’ services and increases the likelihood of recovery through a low demand approach.
- The individual receives support from one helping person from the time of first contact through sustained recovery. The helping person meets the individual ‘where he or she is’ while simultaneously helping them see pathways for recovery. Long-term, supportive relationships that are central to recovery are commonplace.
- Individuals have immediate access to detox treatment with follow up treatment and dry, clean transitional housing available. Medical detox is available as needed.
- There is appropriate treatment available by request. This treatment is flexible and based upon the assessed needs of the individual seeking support.

### **Current Reality**

Of people who are chronically homeless nationally, estimates suggest that at least 40 percent have drug or alcohol addictions, 25 percent have some form of physical disability or disabling health condition, and 20 percent have serious mental illnesses.<sup>x</sup>

In Washtenaw County, alcohol/drug abuse was mentioned most often (44%) as the primary reason for becoming homeless by those interviewed in the 2004 Point in Time. Chronic substance abuse was the most frequently identified characteristic of both men and women in 371 interviews with people who were homeless in the county in March, 2004.

Current assessment of services for people with addictions or co-occurring disorders indicates the following:

**Resources dedicated to homelessness prevention and effective treatment for people with drug and alcohol addictions and co-occurring disorders are inadequate given the current need.**

- There has been a steady reduction in dedicated resources for people who are homeless and who have addiction abuse or co-occurring disorders.
- Currently, there are two major providers of service to people who are indigent and have drug and alcohol addictions or co-occurring disorders: Dawn Farm and Home of New Vision.
- Demand for detox and extended treatment services from people who are homeless or indigent outpaces the availability of those services.
- Washtenaw County does not have enough permanent affordable housing and needed services to support people who have addictions or co-occurring disorders.

**The community allocates significant resources to reactive responses to the needs of people who are homeless and have drug and alcohol addictions and co-occurring disorders. These efforts do not support recovery from addiction, mental illness or homelessness.**

- Hospitals, ambulance services, police and courts all devote significant resources to addressing issues related to drug and alcohol addictions or co-occurring disorders for people who are homeless or at risk of homelessness.
- People who are homeless or indigent and are seeking referrals to treatment actually reach treatment only 40% of the time (Access data).
- Current trends are towards an increased use of short-term, less intensive treatment options. This is particularly problematic for chronically homeless people, as it is 'under-responsive' to the presenting issues. When people with addictions fail in treatment, they tend to return to the "highly precarious circumstances that precipitated their homelessness". Individuals are reluctant to follow through on treatment that does not meet their needs and this increases their vulnerability to homelessness. They are difficult to reengage in services once they have had negative experiences with an unresponsive treatment system. <sup>xi</sup>

**Gaps in critical programs and services threaten the usefulness of otherwise effective services in this system of care.**

- There is no residential or ¾ house co-occurring treatment facilities in the County.
- There are no medical detox beds available in the County.
- Shelter services for people who are homeless and are currently suffering from drug and alcohol addictions are very limited and do not include the full range of services to help them recover from homelessness and addictions.
- Access to substance free, affordable housing is extremely low. This leads to less than optimal placements, many of which are not conducive to stabilizing a person in recovery.

## Effectiveness Research and Model Programs

*The model programs that influence the recommendations below include:*

- Housing First models – Franklin County, OH<sup>xii</sup>
- Engagement Center – Columbus, OH
- Healing Place – Louisville, KY
- Glide Memorial Church – San Francisco, CA
- Hill House: ¾ house for single men with co-occurring disorders
- Lamp Post Community– Los Angeles

Based on research compiled in Substance Abuse Mental Health Services Administration's (SAMHSA) Blueprint for Change<sup>xiii</sup>, the following set of approaches has been identified as effective:

### **Provide housing along with low demand treatment**

The housing first approach provides housing stability first, so that residents are better able to address their other needs.<sup>xiv</sup> The goal is to quickly get people into stable housing and then link them with services. Providing housing increases retention in addiction treatments for people who are homeless, individuals do less well when high-intensity services are required as a condition of housing.<sup>xv</sup> Ultimately, people with drug and alcohol addictions need safe housing with the appropriate level of support to help them maintain both housing stability and treatment gains.

### **Outreach is critical**

A study of individuals enrolled in the SAMHSA Access to Community Care and Effective Services and Supports program who were contacted through street outreach revealed that even individuals with the most severe disorders, who are the most reluctant to accept treatment, will enroll in services and show improved outcomes when served by an outreach team.<sup>xvi</sup>

A study of the effectiveness of outreach with homeless people who have drug and alcohol addictions found that nearly half of persons contacted through outreach became enrolled in services.<sup>xvii</sup> More important, those contacted through outreach had significantly higher levels of substance use than walk-in clients, and were more likely to be engaged in HIV risk behaviors. This indicates that outreach can be successful in reaching individuals most in need of services.

Consistent, caring, personal relationships, and the introduction of services at the client's pace are critical elements in outreach efforts designed to engage people who are homeless into treatment.<sup>xviii, xix, xx, xxi, xxii</sup>

### **Integrate services for people with co-occurring disorders**

An integrated approach for people who have co-occurring disorders is superior to a parallel or a sequential approach to treatment. Integrated treatment reduces alcohol and drug use, homelessness, and the severity of mental health symptoms. Individuals had retention rates as high as 74 percent in its programs that offered integrated treatment. Individuals did best when their treatment was combined with other services such as housing, legal services, and income support.<sup>xxiii, xxiv, xxv</sup>

### **Include self-help programs**

Participation in self-help programs decreases inpatient treatment and substance use and increases self-esteem for people with mental illnesses and drug and alcohol addictions. Individuals with mental illnesses in self-help groups report greater self-esteem, fewer hospitalizations, and better community adjustment.<sup>xxvi</sup> People with co-occurring mental illnesses and addictions who are homeless experience a greater decrease in substance use when they have a high level of self-help group participation.<sup>xxvii</sup>

### **Include the recovering community as support and as staff**

Consumers and recovering persons can make a unique and valuable contribution as program and agency staff. In particular, consumers and recovering persons have experiences and characteristics that enhance their ability to provide services to individuals who are homeless.<sup>xxviii,xxix,xxx</sup>

### **Develop unique services for women**

Gender-specific programs have been shown to improve retention and outcomes for women in addiction treatment.<sup>xxxi</sup> For example, a Los Angeles study that examined women treated in publicly funded residential drug treatment programs found that participants in women-only programs had more problems at program outset, but they spent more time in treatment and were twice as likely to complete treatment compared to women in mixed-gender programs.<sup>xxxii</sup>

Because physical and sexual abuse are so common among women who are homeless and those who have mental illnesses and substance use disorders, programs designed for women must include an active program of trauma recovery.<sup>xxxiii</sup>

## **Recommendations**

To help end homelessness for people who have drug or alcohol addictions or co-occurring disorders, we recommend that all programs and services demonstrate awareness of the following:

- Alcohol and drug addictions are chronic illnesses. Efforts to treat addiction using an acute care model will increase the risk for failed treatment and heighten the chronicity of the illness.
- Resistance to treatment is part of the addiction illness. Providers must have skills in responding with openness and support to re-engage the person struggling with addictions. Providers must communicate their belief that it is possible to recover from this illness, even in the face of resistance and failed efforts.
- Special populations have unique dynamics and needs. Programs and services must respond to people in a culturally sensitive manner to be effective (e.g. age, gender, ethnicity, religion, sexual orientation).
- Use of the recovering community and related self-help programs will support sustained recovery.

The following represent specific recommendations to help end homelessness for people with drug and alcohol addictions and co-occurring disorders:

## Programs and Services

- **Increase the number of detox beds** to ensure detox treatment 'on request'. For Washtenaw County to have adequate access to detox treatment, we recommend at least 22 beds, an increase of nine to existing availability.
- The increase in detox beds must be paired with **access to needed treatment services**, and an **increase in dry and clean Transitional Housing beds** for those people recovering who will benefit from a congregate living community of support until recovery is more firmly established as a way of life.
- Increase access to a **full range of services for people with co-occurring disorders**.
- **Provide an adequate supply of housing and supportive services** for the ambivalent, 'pre-contemplative' individual, including
  - Access to treatment as desired
  - Medical services
  - Psychiatric support
  - Immediate detox access
- **Identify options for shelter** for people for whom housing cannot be secured or for those who are not willing to move to housing. A heavy investment in infrastructure is not recommended, but something is needed to ensure safe shelter and harm reduction while housing stock is increased.

Both the housing and supportive services and the shelter approach are 'low demand' services approach. These are not an alternative to higher levels of needed treatment. These are harm reduction efforts for the pre-contemplative individual. The success of these housing and supportive services depends heavily on the immediate access to detox treatment for the people who are ready to move into treatment. (See recommendations for detox beds.)

- **Assess need for increased outreach services (PORT)** as increased detox, services and transitional housing or permanent supportive housing become available.
- **Ensure consistency in diagnosis** and treatment recommendations of people who are indigent or homeless:

There is a very wide range of individuals with addictions. Assessment of addictions and mental health issues must be done in ways that use the expertise and knowledge of the fields of addiction and mental health treatment. Service providers must be able to assess treatment needs in a common fashion, based upon demonstrated best practices for sustained recovery if they are to provide genuine service to the individual, and to the community.

Providers must work effectively across boundaries to ensure consistency in this area and to join together to advocate for appropriate dollars.

We recommend that the following data be collected to ensure consistency and to track system effectiveness.

- Referral success
- Number of referrals that vary from requested treatment: %ages that offer less intensive , %ages that offer more intensive
- Number of consumers whose needs could not be met within a given year due to financial constraints (both Access and not for profit numbers)
- Recovery outcomes, especially relative to level of care

Hospital emergency rooms, in their work addressing the physical health challenges of homeless people with addictions or co-occurring disorders, have unique opportunities to support recovery and healthier lives. Knowledge of the nature of addiction and connections with other community service providers are essential to allow for the delivery of dignified and effective health care.

- Establish a common and **effective forum for dialogue and planning** between addiction specialists, physical, and mental illness service providers and leaders. The objective is to ensure that ongoing assessment of the community’s needs is done in a manner that uses the diverse wisdom and experience of these fields and to reduce segmentation in service delivery.
- **Establish effective discharge planning from jails and hospitals**  
Providing short-term intensive support services immediately after discharge from hospitals, jails, or residential treatment has proven effective in preventing recurrent homelessness during the transition to other community providers for people who have been homeless and suffering from drug and alcohol addictions or co-occurring disorders.<sup>xxxiv ;xxxv ;xxxvi;xxxvii</sup>

A team made up of addiction treatment professionals, homeless service providers and jail and police staff and hospital staff, must develop an agreed upon process and standards for jail and hospital discharge planning.

A jail and hospital discharge plan for a person with co-occurring and drug and alcohol addictions should include:

- An assessment of the person’s clinical and social needs and public safety risks
- Planning for treatment and services required to address the person’s needs
- Identification of required community and correctional programs responsible for post-release services
- Coordination of the transition plan to ensure implementation and avoid gaps in care with community based services<sup>xxxviii;xxxix;xl;xli;xlii</sup>

- **Conduct a community education and advocacy campaign**  
This education must reach the general public, police and emergency personnel, and the urban business community. This will help reduce the loneliness, stigma and isolation of persons with addictions and to ensure that the community is secure. Advocacy is critical as commitments to treatment dollars are shrinking for this group and needs are increasing.

- **Develop a strategy to access/advocate for Medicaid dollars**  
Homeless people who have addictions are less likely than those with serious mental illnesses or co-occurring disorders to be receiving Federal disability benefits. This is in large part because individuals with addictions, no matter how severe, are not considered disabled under Social Security Administration guidelines for the purpose of receiving SSI, unless they have other disabling health conditions not attributable to their substance use.<sup>xliii</sup>

## Measures of Success

Addictions and co-occurring:

- Numbers of people who are homeless and have addictions or co-occurring disorders and the community's ability to serve
- Decreased recidivism following treatment
- Number of people treated and length of time staying clean or sober
- Permanent housing stability
- Increased employment numbers (include percent with jobs, at what rate of pay/skill)
- Decrease in police contacts and incarcerations
- Decrease in need for healthcare services

## Strategies and Plans in Place

The following groups/committees have goals and strategies that will have an affect on the development of services for people with drug and alcohol addictions in the community.

- Community Health Committee (Part of HIP)
  - CHC arranged the Health Improvement Plan which assesses the health of county residents (as well as homeless), identifies health goals, and encourages health improvement strategies.  
[http://www.ewashtenaw.org/government/departments/public\\_health/ph\\_hipfaq.html/#what](http://www.ewashtenaw.org/government/departments/public_health/ph_hipfaq.html/#what)
- Washtenaw Community Health Organization
  - The WCHO provides an integrated mental health, substance abuse and physical health care delivery system for Medicaid and indigent consumers who receive services that is responsive to the needs and values of citizens of Washtenaw County. The WCHO has a comprehensive Five Year Plan.  
<http://www.ewashtenaw.org/government/departments/wcho/index.html>
- Family Support Network
  - FSN assists those who are mentally ill and homeless to move towards residential stability, increased income, and self-sufficiency.

- Building Restorative Communities
  - BRC provides integration of juvenile justice system, substance abuse and mental health services to provide appropriate support and care for youth with mental health and/or substance abuse problems.  
[http://mibrc.org/counties/washtenaw/SCfeb5\\_files/frame.htm](http://mibrc.org/counties/washtenaw/SCfeb5_files/frame.htm)
- National Alliance for the Mentally Ill (NAMI)
  - NAMI is dedicated to the eradication of mental illnesses and to the improvement of the quality of life of all whose lives are affected by these diseases.  
[http://www.nami.org/Content/NavigationMenu/Inform\\_Yourself/About\\_NAMI/About\\_NAMI.htm](http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_NAMI/About_NAMI.htm)
- Health Improvement Plan/Community Health Committee.
  - HIP is a community health assessment and planning effort aimed at improving the health of county residents. The HIP is committed to reducing use of controlled and highly addictive substances.  
Source: Community Plans Matrix
- The Blueprint for Aging Population Services
  - This blueprint looks to improve the accessibility of mental health and substance abuse programs to all seniors.
- City of Ann Arbor Consolidated Strategy and Plan FY 2004 One-year Action Plan
  - This plan tries to improve and increase accessibility of mental health and abuse programs. Source: Community Plans Matrix

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<sup>x</sup> Culhane, 2001

<sup>xi</sup> Orwin et al., 1999

<sup>xii</sup> <http://urban.csuohio.edu/housingforum/housing.pdf>

<sup>xiii</sup> SAMHSA, Blueprint for Change, Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Disorders, 2003.

<sup>xiv</sup> <http://urban.csuohio.edu/housingforum/housing.pdf>

<sup>xv</sup> Orwin et al., 1999, p. 45

<sup>xvi</sup> Lam and Rosenheck, 1999

<sup>xvii</sup> Tommasello et al., 1999

<sup>xviii</sup> CMHS, 2001c

<sup>xix</sup> Lam and Rosenheck, 1999

<sup>xx</sup> Tsemberis and Eifenbein, 1999

<sup>xxi</sup> Morse et al., 1996

<sup>xxii</sup> Bybee et al., 1995

<sup>xxiii</sup> CMHS and CSAT, 2000a

<sup>xxiv</sup> Drake et al., 1998

<sup>xxv</sup> Drake et al., 1997

<sup>xxvi</sup> HHS, 1999

<sup>xxvii</sup> Gonzalez and Rosenheck, 2002

<sup>xxviii</sup> Glasser, 1999

<sup>xxix</sup> Van Tosh, 1993

<sup>xxx</sup> Dixon et al., 1994

<sup>xxxi</sup> Zenger, 2002

<sup>xxxii</sup> Grella, 1999

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- xxxiii Harris, 1996
  - xxxiv (Rosenheck and Dennis, 2001
  - xxxv Lezak and Edgar, 1998
  - xxxvi Avery et al., 1997
  - xxxvii Susser et al., 1997
  - xxxviii Rosenheck and Dennis, 2001
  - xxxix Shinn and Baumohl, 1999
  - xl Lezak and Edgar, 1998
  - xli Avery et al., 1997
  - xlii Susser et al., 1997
  - xliii Baumohl and Huebner, 1991

## III-5. Provide Adequate Services for Families and Children Who are Homeless

### Vision

The vision we hold for families and children who are homeless or precariously housed is the same as the one we hold for our own families:

- The ability to live in a safe and secure neighborhood, with access to good schools, healthcare, and the opportunity to work and to participate in the community in a meaningful way.
- We also envision that all families have a strong network of support for times when life presents challenges that are difficult to resolve alone.

### Current Reality

Of the 664 persons counted as homeless on the night of March 18, 2004, 12% (54) had children with them. Overall, 26% of the persons who were homeless are families with children. These numbers do not include the people who are 'doubling up' with family and friends, often a strained and precarious situation.

During in-depth interviews with 55 families we found the following:

- Families who are homeless are made up largely of single women with children (82%, 45 women)
- 56% are experiencing homelessness for the first time, compared to 40% of those who are single and homeless
- 56% are African-American, compared to 43% of single individuals who are homeless
- 62% are between the ages of 22 and 40
- 40% report domestic violence contributing to their homelessness
- 71% have been turned down for housing, compared to 45% of single individuals

These single parents are primarily mothers who often have grown up in poverty and typically lack the education and skills needed to secure employment beyond entry level, low paying service jobs.

They are sometimes joined in homelessness by two parent households that cannot maintain their homes. For these families, both parents often have low paying, low skill jobs without health care. An illness means the loss of a job. The loss of a job means choices must be made between childcare, clothing, food and shelter. Mainstream services such as TANF, food stamps, Medicare or SSI take months to receive and even then do not lift the family out of the burgeoning debt that has accrued in the months without work.

The major cause of homelessness in families is poverty and a lack of affordable housing. Homelessness for families is on an alarming increase nationally since 1997. This is attributed to decreases in public assistance dollars for families (TANF), steadily

increasing costs of housing, and a loss of secure, reasonably well-paying jobs with benefits for people with low to moderate skills, both locally and nationally.

Strains occur for families as the nature of poverty and homelessness often exhaust a troubled family's social supports, if they ever had them. Extended family and caring neighbors are often called upon to share homes and resources in support of the homeless family, but often these remedies are temporary and can deplete relationships and resources.

What happens when stable, safe and adequate housing is not available for children and families? The consequences are unacceptable and costly for the families and for the community. Consider these:

- Compared with housed children, homeless children suffer worse health, more developmental delays, more anxiety, depression, and behavioral problems, and lower academic achievement. (Shinn and Weitzmann 1996)
- Nearly 61% of children who are homeless have not received their proper immunizations; 40% suffer from asthma and their rate of middle ear infections is 50% higher than children with homes. (Redlener and Johnson 1999)
- Children without a home are twice as likely to experience hunger.
- Children in poverty are twice as likely to repeat a grade and are more than three times as likely to be expelled or drop out of school.

Parents also suffer the ill effects of homelessness and poverty.

- Mothers who are homeless suffer higher rates of depressive disorders and one-third of homeless mothers had made at least one suicide attempt (Bassuk et al., 1996).
- In families that were homeless or who were housed in poor conditions, over one-third had a chronic health condition.
- Homelessness also frequently breaks up families. Separations may be caused by placement of children into foster care when their parents become homeless. Parents may leave their children with relatives and friends in order to save them from homelessness or to help them attend their regular school.

**Current Family Services:**

We currently have 4 agencies in Washtenaw County providing sheltering and housing support for families who are homeless or at risk: SOS, Interfaith Hospitality Network, Salvation Army and SafeHouse.

The table below outlines the shelter and transitional services available for families in our community:

	<b>Number of families housed in shelter 2003</b>	<b>Average length of stay</b>	<b>Numbers linked to permanent housing</b>
<b>IHN</b>	35	75 days	15

<b>SafeHouse</b>	164	25 days	65
<b>Salvation Army</b>	36	63 days	
<b>SOS</b>	26	123 days	16

From the point in time count of March 2004, we can estimate that 8-10 new families face homelessness every week in Washtenaw County. Additionally, there were 26 families living in transitional housing through SOS in 2003.

### Effectiveness Research and Model Programs

We know that even very troubled, challenged families who are homeless can make the transition to permanent, stable housing and employment when housing is affordable and family-specific services are made available.

We also know that children with early supports have a better chance of breaking the cycle of poverty, welfare or crime. Consider the following:

- In the High/Scope Perry Preschool Study and the Erickson 1999 study, it is shown that dollars invested in early childhood development yield extraordinary individual and community returns. With support for growth in cognition, language, motor skills, and social-emotional functioning, a child is more likely to succeed in school and later participate meaningfully in society. However, without support during critical early years, a child is more likely to drop out of school, receive welfare benefits and be involved in criminal behaviors.
- Beyond Shelter, a Los Angeles based family housing program has helped 2,500 homeless families secure housing since 1988. Of those families, approximately 2,200 are stabilized in permanent housing. The affordable housing is coupled with services for the families. These services are tailored to each family and include assistance with homemaking, nutrition, parenting education, money management, child care, job training, job placement, and job retention.

In a 7 month study of 185 families involved with Beyond Shelter in 2001, over 80 % of the adults were employed and others were enrolled in job training programs. Only 2.3 % of those who received the services with reported substance abuse problems had relapsed and .4 % of domestic violence survivors had returned to a dangerous relationship.

Source: Martha Farrell Erickson & Karen Kurz-Riemer, *Infants, Toddlers and Families: A Framework for Support and Intervention* (New York: The Guilford Press, 1999), 19. Lawrence J. Schweinhart, *Significant Benefits: The High/Scope Perry Preschool Study Through Age 27* (Ypsilanti, Michigan: High/Scope Press, 1993), xv, 55.)

- Low-income parents who receive subsidies to cover childcare are able to earn more money. In a 2004 study by University of Michigan, MIT and High/Scope Education Foundation, researchers found that on average, women who received government

subsidies for childcare earned twice as much as women who did not have child care subsidies. (Sandra Danzinger, University of Michigan, Ann Arbor News source, April 2004)

## Recommendations

Based on this assessment of our community and review of national best practices, we put forth the following recommendations:

- Ensure adequate supply of 2-4 bedroom units in permanent supportive housing chapter to match demographics of families. Ideally these units would be in mixed income, scattered sites. Ensure that child friendly environments (other children, play areas) are available in these units. Ensure that the larger units of permanent supportive housing are in family friendly neighborhoods: safe, near transit, child care and schools.
- Develop agreements with private landlords to adjust the manner in which they screen tenants for housing. Current successful tenants recommend that landlords screen only for serious legal violations that could affect their success as tenants and to focus credit checks on the tenants' history of responsibility to landlords. Attention to recent financial behavior and the use of payeeships to protect the landlord and tenant should be highlighted.
- Develop an adequate supply of family emergency units. Based on current utilization rates in comparison with our annualized estimate of families who are homeless, we can estimate a need of 10-20 units. Shelter units must provide intense, short-term assessment and emergency support for families without homes.
- Ensure that providers of supportive housing services are familiar with community resources for families: parenting education, money management, childcare, nutrition, job training, job placement, and job retention. Ensure those needed community resources for families remain intact.
- Ensure enhanced childcare supports (e.g., subsidies for working poor, therapeutic childcare) are available to help address trauma of poverty and homelessness. Off hours childcare must be available as many low-income families work evenings, nights and weekends. After school programming is also key, if we want to reduce the risks for homelessness in the coming generation.
- Secure affordable counseling services for families and youth who are homeless or at risk, with a focus on trauma, depression and affective disorders.
- Develop strong, active partnerships with public sector employment programs and private sector employers to link at risk adults with needed skills, work supports such as childcare and transportation and jobs. Help families break the cycle of poverty.
- Engage volunteer communities to expand the network of supports for families in permanent housing.
- Advocate for changes to public assistance programs in order to reduce the numbers of families and children living in poverty.

## Strategies and Plans in Place

The following groups/committees have goals and strategies that will have an affect on the development of services for families and children who are homeless in the community.

- Building Restorative Communities grant
  - BRC is looking at implementing principles of “Balanced and Restorative Justice” (BARJ) to the juvenile delinquent population.
- Washtenaw Health Plan
  - The WHP helps people without insurance (families and youth included) access the health care services they need.  
[http://www.ewashtenaw.org/government/departments/public\\_health/ph\\_whp.html](http://www.ewashtenaw.org/government/departments/public_health/ph_whp.html)
- Human Services Community Collaborative (HSCC including the 0-5 and youth and Family Action groups)
  - The HSCC serves the needs of children families and adults in Washtenaw County to achieve its vision to create a community of dignity and respect where all people can live to their maximum potential.  
<http://www.ewashtenaw.org/government/departments/hsc/SC/June03/030604hscplan.pdf>
- Gender Violence Coalition
  - (in collaboration with HSCC)
- Project Great Start
  - The PGS is developing a plan for mobilizing the resources of Washtenaw County in support of children education (In collaboration with the HSCC, Washtenaw Intermediate School District and the United Way).  
<http://www.ewashtenaw.org/government/departments/hsc/0-5/0305050-5greatstart.pdf>
- Family Support Network
  - FSN is a collaborative effort on the part of nine organizations to provide integrated services to homeless families, children, and youth in Washtenaw County. <http://comnet.org/sos/fsn.html>
- Education Project for Homeless Youth
  - The EPY is dedicated to helping children and youth, in homeless situations, enroll, regularly attend and succeed in school. <http://www.new.org/cgi-bin/directory/viewitem?256>
- Health Improvement Plan/Community Health Committee.
  - The primary mission of the HIP is to prioritize critical health needs of Washtenaw County, which includes child and domestic abuse situations.

- Washtenaw Urban County and HOME Consortium Draft Annual Action Plan 2004-2005 (Under WMA)
  - The plan hopes to supply adequate affordable childcare and youth programming. Source: Community Plans Matrix
  
- City of Ann Arbor Consolidated Strategy and Plan FY 2004 One-year Action Plan (July 1 2004 through June 30 2005 funded by HUD)
  - This Plan seeks to reduce the onset, incidence and duration of homelessness as well as providing youth and family services. Source: Community Plans Matrix

## III-6. Ensure Readiness and Access to Education and Employment

### Vision

Adequate education and development of skills for long term employment are critical components in the plan to end homelessness. Our vision for the community includes the following:

- All community members, from children through adults, have access to meaningful and effective educational opportunities.
- A broad range of employment opportunities and training for employment exist within our community meeting the needs of people who are struggling to secure or maintain housing for themselves and their families.
- People of all abilities have opportunities, and are encouraged, to engage in meaningful work that matches their ability to contribute and offer a service to the community.

### Current Reality

*Almost one in five homeless persons is employed (U.S. Conference of Mayors, 1998).*

People who were homeless have indicated that insufficient income and lack of employment were among the most important factors preventing them from exiting homelessness (Shaheen and Williams, 2003). Further, even if these individuals do manage to find a job, it is rare that an entry-level job will provide enough income to pay for adequate living arrangements. The National Low Income Housing Coalition has concluded *“there is no community in the nation in which a person working at minimum wage can afford (using the federal standard of affordability) to rent a one-bedroom unit.”*

#### Community Information:

- In Washtenaw County, there are currently over 37,000 people (roughly 11.1% of the population) living below the poverty line.
- Local fair market rent for a 2-bedroom apartment is \$815, making it difficult for many individuals and families. An individual must earn \$16.98 per hour in order to be paying no more than more than 30% of one’s income for housing, based on these estimates.
- Many local agencies and programs seek to address the unemployment, underemployment and educational gaps that currently exist. Agencies such as: Washtenaw Community College Adult Transitions Program, Michigan Works!/ETCS, HelpSource, Michigan Rehabilitation Services, and Michigan Ability Partners, and programs such as FreshStart, HERO, and SOS Employability program, among others, all attempt to address the need for educational and employment-related services.

- While many resources exist and many agencies are committed to improving the opportunities for people in our county who live in poverty or are homeless, there is no integrated strategy (cross-agencies) for addressing the special needs of this population.

**Provider Forum Input:**

Providers in the community who attended a Forum on the Draft Blueprint to End Homelessness in Washtenaw County identified the following issues related to employment and education issues for people who are homeless:

- **Access to agencies and programs** – There is a limited knowledge (both within and outside of the human service sector) about what type of services are actually available and how to access such services. Our community lacks strong, effective coordination between employment, education, and homelessness services.
- **Funding issues** – Service providers indicate that there is limited funding and that the performance standards associated with funding make it difficult to serve certain populations, including people who are homeless.
- **Access to training and employment opportunities** – There is limited funding and therefore limited services available to help people with low skill levels and education find and keep jobs, a lack of vocational and/or trade training for ‘at-risk’ populations, and a very competitive job market for service industry jobs, the most common source of employment for people with low to moderate levels of education and job training. Criminal histories add to the challenges for some people who are homeless.
- **Existing efforts underway** – There are some efforts underway in the community to address the employment issues of people who are homeless (e.g., SOS employment coordinator, Michigan Works! staffing at the Delonis Center). Looking at these efforts, in terms of what’s working and what produces the best outcomes, can help inform additional initiatives in the community.

(National data matches the issues raised by local providers:

In 1998, the U.S Department of Labor’s Job Training for the Homeless Demonstration Program [JTHDP] found that the most severe barriers (to employment) experienced by people who are homeless include such issues as: *lack of education or competitive work skills, lack of transportation, lack of day care, and disabling conditions.*)

## Effectiveness Research and Model Programs

Nationally, there have been several attempts to address the lack of educational and employment related opportunities available to individuals struggling with homelessness and/or poverty. Some examples of the most successful programs include:

**Bakersfield Homeless Center, Bakersfield, CA** – This agency offers support for all stages of job placement, including a P.O. Box and an open phone line answered at a private residence. Strategies include such activities as accepting volunteers in the shelter’s dormitory, kitchen and cafeteria with progression to enrollment in a number of 10 week classes on basic job skills, life skills, appropriate attire, manner and interview

skills. At the same time, a case manager completes a needs assessment in order to ensure a “good fit” between individual skills and job opportunities. Strategic partnerships with private sector employers are developed and used for long-term employment. The following programs have also all been recognized as examples of superb education and employment-related services:

- Bailey House, New York, NY
- STRIVE, New York, NY
- IMPACT Employment Services, Boston, MA
- The Maryland SSI Outreach Project, Baltimore, MD
- Lawson House YMCA, Chicago, IL
- Massachusetts Career Development Institute, Springfield, MA
- Corporation for Supportive Housing: Next Step Jobs

These successful agencies offer programs that address such issues as: basic education; GED and/or ESL preparation; individualized job readiness, training, development and counseling; industry-specific skills training (computers, culinary arts, etc.), as well as follow-up services. Perhaps the most important aspect of all of these programs is the fact that they all provide the following:

- Stages/Steps of employment process
- Multiple opportunities for employment, with a wider definition of “work”
- Individualized assistance with barriers to employment
- Assistance with supportive (transportation, childcare, job ‘coaches’, etc.) and transitional (from volunteer experience to community partnerships between the public and private sector to increase available job opportunities) employment options
- Follow-up services that assist individuals in keeping employment once they’ve found it

## Recommendations

Based upon the current reality, national best practices and our community’s vision, the following recommendations are put forth to address local issues related to education and employment for people who are homeless or precariously housed.

### **Develop an integrated strategy for education and employment services for people who are homeless.**

Convene a cross-agency, cross-sector team to examine the issues of employment and education of people who are homeless. In developing a strategy, the group will:

- Map current services and gaps in services for people who are homeless and in need of employment/education services.
- Outline supportive services needed for employment and education success (e.g, childcare, transportation, mentoring.)
- Discuss funding sources, flexibility of funding sources, and innovative uses of existing resources.
- Review national practices and local practices (What’s working well here, what can we learn from others.)

- Review existing initiatives, assess impact and outcomes of them.
- Determine appropriate measures of success for current and future initiatives.
- In addition, the group can look at an important process issue.
- How to strengthen collaboration between homelessness providers and providers of education and employment services?

The outcome of these dialogues will be an integrated strategy that will set a vision, identify opportunities and define clear objectives and recommendations for ensuring that people who are homeless have access to training and employment opportunities.

### **Develop innovative initiatives to prevent homelessness and provide employment opportunities.**

There are numerous efforts underway and/or planned for people who are homeless and for at-risk individuals. These efforts include:

- Culinary training program at the Delonis Center (Food Gatherers)
- Employment Development initiative for youth aging out of foster care (Michigan Works!)
- Employment services mini-station at Community Corrections (Michigan Works and Community Corrections)
- Post incarceration training program (RFP: 2004-2005)

### **Use existing private sector relationships to increase employment opportunities for people who are homeless.**

Using existing relationships and the Work Force Board, sensitize the private sector about homelessness and create opportunities for employment for people who are homeless. Be creative in this collaboration and find ways to make it mutually beneficial.

### **Increased supportive services such as childcare.**

### **Establish a more flexible definition of work.**

Many people who are homeless have disabilities that may preclude maintaining a traditional job in the private sector. There are still many work opportunities to help people gain some measure of self sufficiency and increase the real experience of contribution to the community.

## **Chapter Resources and References**

### **A – Potential resources for follow up work on these recommendations:**

- **Trenda Rusher:** ETCS Executive Director, Washtenaw County
- **Paula Bartha:** Washtenaw Community College Job Education Specialist Adult Transitions Department
- **Faye Askew-King:** SOS Community Services Program Director
- **Kate Warner:** Washtenaw Affordable Non-profit Housing Corporation Co-executive Director
- **Steve Girardin:** Department of Labor and Economic Growth Michigan Rehabilitation Services Site Manager
- **Susan Hornfeld:** Michigan Ability Partners Executive Director
- **Lynn Fountain:** ETCS/Michigan Works!
- **Dean J. Roopas:** All Types business services Manager

- **Rod Jones:** Work Skills
- **Jim Niager:** Center for Independent Living
- **Wendy Berr:** Veterans Administration
- **Marti Rodwell:** H.E.R.O.

## B - References

Fleischer, W. and Sherwood, K. *The Next Wave: Employing People with Multiple Barriers to Work: Policy Lessons from the Next Step Job Initiative*. Corporation for Supportive Housing. Retrieved from [www.csh.org](http://www.csh.org) on June 6, 2004.

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National Low Income Housing Coalition Website <http://www.nlihc.org>

Shaheen, G., Williams, F., and Dennis D., eds. *Work as a Priority: A Resource for Employing People who Have a Serious Mental Illness and who are Homeless*. DHHS Pub. No. SMA 03-3834. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003.

U.S. Census Bureau: State and County QuickFacts –Washtenaw County. Retrieved from <http://quickfacts.census.gov/qfd/states/26/26161.html> on June 6, 2004.

## III-7. Assessment and Accountability

### Vision

Our vision for assessment and accountability for services for the community:

- We have a data system that has reliable information both to measure needs and to confirm outcomes achieved by programs and services.
- Through accessible data and useful analysis and dialogue, we understand the nature and extent of homelessness in our community.
- Through a robust data collection system we know who is at risk of homelessness and what services they need to achieve their housing goals.
- We understand gaps in existing services and are able to analyze the data in order to make adjustments to fill those gaps.
- Data collection meets the needs of both the individual agency/program, and the community as a whole, specifically through the availability of aggregate data.
- Analysis of aggregate data and the ability to communicate using a shared system helps agencies to improve delivery of housing and services to persons who are homeless.

### Current Reality

The current situation in Washtenaw County:

- Our community's web based HMIS system is hosted, underwritten and technically supported by Washtenaw County, and an upgrade to ServicePoint 3.5 will be implemented in Fall 2004.
- Six (6) homeless assistance providers are currently using ServicePoint. (SOS Community Services, Salvation Army, Interfaith Hospitality Network, Delonis Center, Michigan Abilities Partners, Project Outreach Team).
- In fourth quarter 2004, Avalon Housing, POWER Inc., Catholic Social Services (Father Pat Jackson House and Housing Support Services Team) will enter data into the HMIS system. In 2005, Ozone House, Dawn Farm, Home of New Vision, SafeHouse and additional Family Support Network agencies will be engaged by the HMIS Steering Committee to participate in HMIS.
- Some agencies have their own internal data management systems and many use one or more MIS mandated by external funding sources or regulatory bodies. Thus, investment in system integration is valued, as it will reduce duplicate data entry.
- Michigan is building a statewide HMIS system using ServicePoint with separate modules for agencies serving domestic violence victims and for Community Mental Health agencies.
- Issues regarding privacy and security have been a significant concern for agencies, especially agencies serving specific subpopulations such as survivors of domestic abuse and youth.

- Recent clarification of HIPAA requirements indicate that very few homeless service providers are “covered entities” under HIPAA. For programs or agencies that are covered entities, they must act in accordance with HIPAA regulations. Agencies that are not “covered entities” must comply with HUD’s privacy and security standards, which in several instances exceed the HIPAA privacy rule. HUD technical assistance will be made available to agencies that have difficulty meeting these requirements.
- Systematic collection and analysis of data is not established as a common business practice in many agencies. Many agencies do not have resources dedicated to this work and will need training and technical assistance to ensure that the maximum value can be gained from this data. Both trend data and program evaluation data can be obtained from a well-used internal HMIS reporting function.

## Effectiveness Research and Model Programs

To effectively address the needs of people who are homeless, communities must be able to count the number of homeless individuals to gain a better understanding of the challenges they face. The National Alliance to End Homelessness has identified several communities that utilize best practices in developing a comprehensive Homeless Management Information System:

- ***Spokane, WA*** – Spokane’s HMIS was designed to achieve an accurate count of homeless individuals living in the city in order to better understand their needs and to improve communication among providers of homeless services.<sup>xiv</sup>
- ***Wisconsin*** – In Wisconsin, the partners acknowledged their need for empirical data about families and individuals who were homeless, including, to the greatest extent possible, an unduplicated count and tracking of client outcomes to measure program efficacy. The local agencies needed quantifiable data in order to better target funds and document the need for additional funds.<sup>xiv</sup>
- ***Massachusetts Housing and Shelter Alliance*** – When seeking to prevent homelessness, it is important to know and quantify where people who are homeless come from. Such data would indicate where prevention efforts could be most productive. One entry point to homelessness can be public systems of care or custody. The Massachusetts Housing and Shelter Alliance (MHSA), collects nightly census data from adult shelters in the state. It also has a subpopulation Census: the collection of shelter based data on new guests entering from certain specific state systems of care, treatment and custody. This data indicates which public systems of care are discharging people into shelter.<sup>xlvi</sup>
- ***The City of Philadelphia HMIS System*** – The Philadelphia system covers City-funded programs. The data that is currently collected about clients who are homeless is used to allocate resources, to conduct performance based contracting (and thus to look at client outcomes), and to look at trends in numbers and demographic characteristics. The system integrates data on clients who are homeless with data on other human service programs via what will be a social

services data warehouse. This is in part to implement Mayor Street's vision for a collaborative case management system.<sup>xlvii</sup>

Our research has shown the following to be elements of a successful HMIS program:<sup>xlviii</sup>

### **Participation**

- For data to be useful for community planning, every agency providing homelessness services must participate.
- This can be encouraged and mandated via funders (i.e., funders can offer bonus points for participation in HMIS).

### **Confidentiality/HIPAA**

- The software has various access levels. Therefore people at different access levels to the system may see different parts of a client's record. In addition, both the client and the agency have the power to withhold some or all information from being shared. For example, domestic violence agencies can close all information to all other agencies. Some clients may want to have certain services or referrals closed - the client is really driving what is shared and what is not shared.
- For agencies who must comply with HIPAA, any health information that is shared about people has to be done so with the consent of the client (at a minimum) and the client must be informed that the information will be shared and for what purpose.

### **Cost**

- A combination of federal and local sources can be used to fund HMIS. Federal sources include HUD Emergency Shelter Grant administrative dollars, HOPWA dollars, and supportive housing grants (SHP).

### **Standardization**

- Homeless service providers will use standardized forms - intake, assessment, discharge, and follow-up - when working with each homeless client or household. When a person who is homeless seeks services at any of the participating organizations, he/she must complete an intake form or a contact log form. Those who participate in more intensive services, such as case management or sheltering, may complete additional detailed assessments during this period. All forms are then entered into the centralized system.

### **Outcomes**

- Individually within agencies, good HMIS reports can help assess changes in trends, identify unmet needs and evaluate outcomes.
- Agencies can generate outcomes analysis for funders using HMIS.
- HMIS will be used to respond to a wide variety of public policy needs, as well as planning, reporting, and evaluation at both the provider and the government levels. Homeless Service Providers who receive HUD funding can use HMIS data to complete HUD's Annual Progress Report forms. In addition, all agencies can use HMIS data for their agency/program for annual reporting for other grants received, as well as to provide support for various community development plans.
- HMIS will be used to identify community needs and to evaluate overall outcomes of efforts on key strategies within the Blueprint.

## Data Integration

- With an integration approach, users can enter information in one system and the data can be accessed in other systems. In general, that integration is invisible to the user. The unique requirements of 2-1-1, ServicePoint, ENCOMPASS and other reporting tools can create significant challenges in developing seamless, high quality systems integration.

## Recommendations

### Develop and maintain a countywide HMIS system that includes:

- Continuous and accurate information on people being served by homeless service programs
- Readily available and easily accessible outcomes and evaluation information on an individual (client) basis and an aggregate basis (program and community/continuum progress addressing homelessness)
- HUD and/or HIPAA compliance
- Data integrity monitoring
- Information sharing according to the Social Work Code of Ethics
- Single point of data entry

### Meet the projected timeline for additional agency involvement as outlined in the HMIS development plan for 2004-2005

- **Critical 'customer requirements' for HMIS** have been identified by agencies and from County planning throughout 2004. HMIS personnel need additional input from the members of the Funders Forum to help identify what data reporting is most useful for them in their tasks of community wide needs assessment and program specific evaluation and funding. This should occur in the first half of 2005.
- **Use the Washtenaw System Integration Team to make clear progress on the significant tasks of system integration for our community.** Priorities for integration should be identified and resources secured. Requirements gathering to support integration between several key systems utilized in Washtenaw County (ENCOMPASS, ServicePoint, 2-1-1, CTK) is in progress.

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<sup>xliv</sup> <http://www.huduser.org/periodicals/fieldworks/1202/fworks3.html>

<sup>xlv</sup> <http://www.hud.gov/offices/cpd/homeless/hmis/implementation/models/wi-hmis.cfm>

<sup>xlvi</sup> <http://www.naeh.org/best/MHSAHMIS.htm>

<sup>xlvii</sup> <http://www.naeh.org/best/PhillyHMIS.htm>

<sup>xlviii</sup> <http://hudcomp.hud.gov/compass?scope=HMIS&choice=AOTW&chunk-size=25&search-category=ROOT&ui=sr&page=1&taxonomy=HUDSearch&Go.x=10&Go.y=8>

## III-8. Establish Shared Standards and Integrated Funding. Demonstrate Progress to the Community

### Vision

At the core of system reform is alignment of standards of care and an integrated system of funding and reporting to the whole community. We envision the following outcomes:

- Our community is confident that resources devoted to ending homelessness have positive outcomes and that the services offered to people who are homeless are delivered with integrity, dignity and consistent quality.
- Our community has administrative and program standards, practices, and outcome measures that define and support a highly effective, seamless continuum of housing and services for people who are homeless and precariously housed.
- Community funding structures are integrated and use an annual, aligned, single application process with requests for services based upon a set of community-supported priorities.
- Service providers are committed to and skilled in the measurement of outcomes achieved for the community as well as regular assessment of the experience of the person served. There is a demonstrated commitment to critical standards and outcomes by both providers and funders.
- A well-informed, representative funding body with a solid understanding of issues facing those in need makes well-informed decisions based on providers' achievement of desired outcomes and demonstrated commitment to these agreed-upon standards and practices.

### Current Reality

**Community Priorities and Impact:** Strategic, community wide planning and action is not readily supported and the community has not had a shared set of community priorities for addressing homelessness. Funders cannot make well informed decisions without access to an assessment of the community's highest priority needs.

**Funding:** Currently most non-government run agencies have non-stable, variable funding sources. In addition, the funding is fragmented and the process is time consuming to pursue, inefficient, and detracts from providing service.

**Outcome Focus:** There is not a consistent agreement across agencies and among funders on outcomes. There is no common language and understanding about outcome measurement. There are some efforts with the County to emphasize evidence-based practices and outcome measures.

- The County Substance Abuse Prevention Program is using an outcome-based model for evaluating RFPs on substance abuse prevention, and relies also on evidence-based practices where available.

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III-8. Establish Shared Standards and Integrated Funding

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- Data on effectiveness and outcomes is inconsistent and community members cannot readily see the impact of their tax dollars and charitable gifts.

**Standards and Best Practices:** There are no agreed-upon best practices or standards for service delivery among providers or within the community.

## Effectiveness Research and Model Programs

### Effectiveness Research:

The following research findings were developed by a 2004 HUD sponsored study that benchmarked seven leading communities in their work to end chronic homelessness. This is a summary of their findings relative to organizational structure and community leadership:<sup>xlix</sup>

- The organizational structures all had strong links to elected officials and mainstream governmental and private sector resources.
- All groups developed a level of authority and resources, but in very different ways.
- The organizational membership also crossed over city, county, and private sector boundaries.

### Model Program:

- Community Shelter Board, Columbus, OH (CSB): As part of their consolidation of funding sources in Columbus, CSB has developed an outcome driven funding approach. As part of their application/proposal process, agencies are presented with a clear set of standards (both administrative and service) and outcomes. Agencies must first demonstrate their ability to meet the administrative standards and demonstrate how they intend to meet and measure the outcomes. Outcomes follow the Housing First philosophy and require agencies to focus on getting people into stable housing.

### Local Efforts:

- WCHO is working with a community of providers and researchers to identify and integrate evidenced based practices in mental health and substance abuse care by public and private agencies.

## Recommendations

We recommend the following:

- **Create an integrated funding process across sectors/groups**
- **Establish shared quality standards and outcome measures**
- **Develop an ongoing quality service group.**

Each of these is described in detail below.

### **Integrated Funding Process**

To create a structure that supports strategic, community wide planning to end homelessness and to build capacity for providing high quality service and tracking outcomes, **we recommend that our community develop an integrated funding process across sectors.**

Through this process and structure, funders would jointly develop requests for services that are based upon a community-supported set of priorities. For housing and services to address homelessness in our community this Blueprint would be that set of priorities. Funding would be awarded based on proposals that provide significant and meaningful support for the most essential housing and support services, both new and existing (as identified in the Blueprint)

Funding awards also provide resources necessary to conduct thorough, ongoing evaluation of programs and services.

This funding group should include people who:

- Are committed to ending homelessness and are educated and informed regarding housing and services
- Are funders, consumers and community leaders
- Have strong links to elected officials and mainstream governmental and private sector resources
- Cross jurisdictional boundaries
- Can act decisively and objectively

The Funding Review Process should:

- Identify what dollars are to be included in process (early ideas: CDBG, HOME, Cities, AAACF, United Way, parts of WCHO, CSBG, C of C)
- Create common timing, application and communication process

### ***Additional Principles/Ideas for Funding Group***

We recommend that:

- A quality service group support this funding group most likely as a sub committee of the whole body. See below for details.
- An existing structure or group be modified to serve these purposes, if possible. Sunset structures that conflict with this model of accountability.
- This funding group work as transparently as possible, helping service providers understand the thinking and approach recommended. We also recommend that this group seek feedback formally as to their effectiveness in advancing community priorities.

### **Shared Standards and Outcome Measures**

These steps are recommended to support effective high quality services and improved capabilities for tracking and communicating outcomes.

### **Develop shared administrative and program standards, evidence-based and best practices, and outcome measures**

Charter a representative group of measurement experts, providers and funders to develop agreed-upon outcomes, standards and a process for reviewing funding

requests. See Chapter Resources, Section A, at the end of this chapter for a list of resources to consider serving on this team.

- **Outcomes Measures:**
  - Consistent with Housing First principles (e.g., move to stable housing)
  - Specific to special populations as needed (e.g., domestic violence, chronic homeless, youth)
  - Realistic and bold; Doable with a stretch
  - Based largely on the CSB model with tailoring of specific outcomes to our community and our resources
- **Standards:**
  - Include both administrative and program standards
  - CSB can serve as template/model/strawman
- **Practices<sup>1</sup>:** Practices will be based on the following definitions of evidence-based practices and others as described below:
  - *Evidence-Based Practices* (EBPs) – Clinical or administrative interventions or practices for which there is consistent scientific evidence showing that they improve client outcomes<sup>ii</sup>. The term evidence-based practices sometimes encompasses all the terms that follow about best, promising, and emerging practices.
  - *Best Practices* – Best practices are the best clinical or administrative practice or approach at the moment, given the situation, the consumer’s or family’s needs and desires, the evidence about what works for this situation/need/desire, and the resources available. Sometimes, the term “best practices” is used synonymously with the term “evidence-based practices.”
  - *Promising Practices* – Promising practices are clinical or administrative practices for which there is considerable evidence or expert consensus and which show promise in improving client outcomes, but which are not yet proven by the highest or strongest scientific evidence.
  - *Emerging Practices* – Emerging practices are new innovations in clinical or administrative practice that address critical needs of a particular program, population or system, but do not yet have scientific evidence or broad expert consensus support.
- **Suggested process**
  - Gather Information
    - Review research in appendix and other sources
    - Collaborate with efforts in WCHO (Jeff Capobianco)
    - Conduct interviews, groups with providers
  - Draft Standards, Practices and Outcomes
    - Conduct Community Forum for review, input and further refinement of standards, practices and measures
    - Finalization of draft
    - Ongoing education and research (see below)
    - Regular meetings with providers, funders to evaluate process, measures, etc. (see below)
- **Critical Success Factors**
  - Engagement and commitment from the broad provider community
  - Team makeup: representatives must be capable of balancing and bridging the theoretical and operational viewpoints

- Ongoing involvement and communication regarding how well the process and measures are working
- Resources dedicated to keeping up-to-date with research/evidence-based practices

### **Develop an Ongoing Quality Service Group**

- Team Make-up: To ensure both objectivity and broad representation, team makeup should include the following:
  - Expertise in a variety of service provision and programming
  - Expertise in outcome measurement
  - Consumers
- Group responsibilities include:
  - Assisting the funding group with clarifying outcome measures needed in RFPs
  - Participating in and overseeing the Agency Review Process
  - Communication of results to agencies and to funders
  - Ongoing coordination, education and communication with provider community
  - Overseeing ongoing research related to evidence-based practices

## **Strategies and Plans in Place**

The following groups/committees have goals and strategies that will have an affect on the development of integrated funding, shared standards and outcomes in the community.

- HSCC Funders Forum
  - The HSCC strives to provide leadership, coordinate policy, leverage resources, build assets, and foster partnerships that will promote healthy growth, learning and development for everyone in our community.  
<http://www.ewashtenaw.org/government/departments/hsccl/missionandvision.html>
- Washtenaw Urban County and HOME Consortium Draft Annual Action Plan 2004-2008 (Under WMA)
  - This plan works on community development and housing revitalization efforts as stated in their plan in collaboration the Community Development Block Grant (CDBG), Home Investment Partnerships (HOME) and American Dream Down Payment Initiative (ADDI) Programs.  
[http://www.ewashtenaw.org/government/departments/planning\\_environment/cd/draft\\_annualplan.pdf](http://www.ewashtenaw.org/government/departments/planning_environment/cd/draft_annualplan.pdf)
- City of Ann Arbor Consolidated Strategy and Plan FY 2004 One-year Action Plan (July 1 2004 thru June 30 2005 funded by HUD)
  - This Plan seeks to reduce the onset, incidence and duration of homelessness as well as increase affordable permanent housing. Source: Community Plans Matrix

## Chapter Resources and References

### A – Potential Resources for the Development Team

*Jeff Capobianco* – WCHO employee working on researching and implementing evidence-based practices

*Cris Sullivan* – Michigan State University Community Psychology Professor; Experience working on outcomes for domestic violence and women's issues (phone: 517-358-8867, email: [sulliv22@msu.edu](mailto:sulliv22@msu.edu))

*David Moxley* - Wayne State University Social Work Professor; Works with social service organizations in the creation, development, and evaluation of agency-based knowledge and intervention technology. Also has extensive background in mental health and homelessness (email: [ad2084@wayne.edu](mailto:ad2084@wayne.edu))

*Carol Mowbray* – University of Michigan Social Work Professor; Specializes in research on mental health and homelessness services

*Beth Barr* – SafeHouse staff member and/or *Tanya Hilgendorf* – Ozone House staff member – both of these individuals served on the committee that drafted these initial plans

*Sue Ann Savas* – UM lecturer who works with child welfare agencies across the country to develop evaluation and quality improvement programs (email: [ssavas@umich.edu](mailto:ssavas@umich.edu))

*Larry Cohn* - Specializes in creating management information systems for nonprofit social service organizations. (email: [Larry@artisanpartners.com](mailto:Larry@artisanpartners.com))

### B – Community Shelter Board Administrative and Program Standards

#### Main Categories

- Organizational Structure and Management
- Compliance with Federal, State and Local Laws
- Personnel
- Fiscal Administration
- Program Operations
- Data Collection and HMIS
- Evaluation
- Consumer Involvement
- Community Relations and Good Neighbor Agreements
- Facility Standards
- Safety Standards
- Security Plan

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<sup>xlix</sup> *Strategies for Reducing Chronic Street Homelessness*, prepared for: U.S. Department of Housing and Urban Development by: Burt, Hedderson, Zweig, et al, January 2004.

<sup>i</sup> *Turning Knowledge into Practice*, ACMHA, 2003.

<sup>ii</sup> Drake, et al., 2001.

## III-9-i. Adjacent Services: Health Care

### Current Reality

- Poor health is a cause of homelessness; homelessness causes poor health; and homelessness complicates efforts to treat health problems.
- The majority of all homeless people are uninsured compared to 11 percent of the Washtenaw County general population (36,954 individuals).
- People without health care insurance are less likely to receive needed preventive and treatment services (Adults with health insurance are twice as likely to receive a routine checkup as adults without health insurance).
- People living in poverty and the homeless consistently rate lower on measures of health status and higher on disease prevalence scales.
- People who are homeless have higher rates of serious mental illness than the general population (45% vs. 4%), higher rates of substance abuse (50% vs. 7.3%) and nearly 27% have some sort of physical or developmental disability.
- People who are homeless have higher chronic disease rates than the general population (asthma rates 4 times greater, 3 times the rate of unintentional injury and excess diabetes).
- Healthcare costs are a significant cause of bankruptcy (which often leads to homelessness) for individuals who are un- or under-insured.
- Mainstream health care services and safety net services do not serve homeless people well due to resource constraints, lack of experience in dealing with this population and insufficient linkages to the full range of health and supportive services required to stabilize homeless people.

### Effectiveness Research and Model Programs

#### Adaptation of Clinical Practice for Homeless Patients

Clinicians who routinely care for homeless people recognize the need to take their patients' living situation and co-occurring disorders into consideration when developing a plan of care. Standard clinical practice guidelines fail to address the special challenges faced by homeless patients that may limit their ability to adhere to a plan of care. To fill this gap, the HCH Clinicians' Network has made the adaptation of clinical practice guidelines for homeless patients one of its top priorities.

<http://www.nhchc.org/network.htm#Adapting%20Your%20Practice>

#### Health Care for the Homeless

The HCH program emphasizes a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and client advocacy. Emphasis is placed on coordinating efforts with other community health providers and social service agencies.

HCH recognizes the complex needs of homeless people and strives to provide a coordinated, comprehensive approach to the care they provide their homeless clients, and in such a way that is welcoming to them as patients. Specifically, HCH programs:

- Provide primary care and substance abuse services at locations accessible to homeless people.
- Provide around-the-clock access to emergency health services.
- Refer homeless persons for necessary hospital services.
- Refer homeless persons for needed mental health services unless these services are provided directly.
- Provide outreach services to inform homeless individuals of the availability of services.
- Aid homeless individuals in establishing eligibility for housing assistance and services under entitlement programs.  
<http://bphc.hrsa.gov/homeless/Default.htm>

Best practices in Washtenaw County include:

- Packard Community Clinic, an agency serving the poor for over 25 years. Recent partnerships with WCHO have added on site services for mental health support as well.
- On site health care services at the Delonis Center are provided by health care staff of the Delonis Center, PORT and University of Michigan.
- The Corner Health Center, established in 1981, provides crucial primary medical services such as prenatal care, general medical and pediatric care, contraception, and crisis intervention, to Washtenaw County uninsured youth (ages 12-21) and their children.
- Care coordination and consultation is provided by a team made up of staff from the Delonis Center, PORT and CSTS.

## Recommendations

- Establish a targeted system of health care delivery for homeless people that includes outreach capacity, on-site integrated mental health and substance abuse services, with walk-in capacity and no co-payments.
- Establish a process at shelters in the county to medically evaluate people who are homeless upon intake and if health services are needed, give them immediate access to health care.
- Collaborate with health care services for the homeless to facilitate access of homeless persons to other health and dental care.
- With Public Health develop prevention and early intervention programs for key health problems for people who are homeless.
- Increase access for people who are homeless to Washtenaw County Human Services Collaborative Council sponsored and endorsed community initiatives.
- Collaborate with mainstream services and safety net services to facilitate access for homeless persons when appropriate including the following:

## Health Care Programs in Place

- ***Washtenaw Health Plan***  
WHP is a local collaborative program that provides access to health care to county residents who are uninsured and not eligible for other public programs. The Plan currently covers 4000 individuals.
- ***The Washtenaw County Prescription Program***  
The WCPP provides access for all County residents to a discount on prescription drugs.
- ***The Washtenaw Community Health Organization***  
The WCHO is a local organization created by the University of Michigan and Washtenaw County to provide integrated physical/mental health and/or substance abuse services for Medicaid and indigent customers.

## III-9-ii. Adjacent Services: Food

### Current Reality

The U.S. produces more food than any other nation in the world. Yet, each year nearly 35 million Americans are threatened by hunger including 13 million children. According to America's Second Harvest, "Hunger in America 2001: the Faces and Facts", more than 200,000 people access food bank services in Southeastern Michigan every year including:

- Children. 51% up from 41% in 1997
- Working Adults. 39 % of client households receiving food have one or more adults working-up from 32% in 1997
- Poor. 75% of client households receiving food have incomes below the Federal Poverty Level
- Precariously Housed. 47% of recipients had to choose between paying for food and paying for utilities or rent

In order to distinguish the realities of domestic hunger from the crisis of famine experienced in other countries, national anti hunger advocates use the term "food insecurity" which is defined as the "limited or uncertain availability of nutritionally adequate foods, including involuntarily cutting back on meals, food portions or not knowing the source of the next meal." The concept of "food security" translates into access to enough food for an active healthy life and includes:

- the ready availability of nutritionally adequate and safe foods
- an assured ability to acquire foods in socially acceptable ways

The work of private NGO's such as Food Gatherers has been to garner local food resources which would otherwise be wasted and convert this food into consumer friendly resources. This food distribution system relies almost exclusively on local donations of surplus food and on the distribution mechanisms of a wide variety of community free meals, and emergency pantries operating out of multi-service non-profits, grassroots agencies and faith based efforts. This food distribution system must distribute food quickly (often within 48hours) at low or no cost.

Global trends in food production and the economic viability of local grocers and farmers impact the availability of healthy food. Consumers, particularly those in low income communities, have less access to healthy and affordable food. In Washtenaw County, between 1950 and 2003, the number of grocery stores per capita decreased by 48%, the number of fast food restaurants has increased by 6,100 %.(HIP Report) 2000). During the last three decades, there has been a steady rate of farmland loss in Washtenaw County between 5-10% every five years. Small and medium scale farmers are projected to virtually vanish within 15 years unless more viable markets emerge (Hamm, 2003). The success of food rescue programs like Food Gatherers is dependent upon a robust local food economy owned and managed by people engaged in their community.

Publicly funded food programs such as School Lunches, Food Stamps and WIC are administered by a variety of government departments including the Dept. of Education,

Family Independence Agency and the Department of Community Health. Some serve only children, seniors, or low income families. (For a detailed description of these programs see the Food Bank Council of Michigan “Opening the door for Health in Michigan” at [www.fbcmich.org](http://www.fbcmich.org))

During the last several years, the efforts of local private non-governmental agencies in efforts to reduce hunger have vastly expanded while participation in government assistance programs has declined. In 1988, Food Gatherers rescued and distributed approximately 3,000 pounds of food. These days Food Gatherers annually distributes 2.1 million pounds to more than 150 nonprofit programs. Programs providing emergency food assistance report increases in demand of 20- 40%. At the same time, the USDA (2000) reports that as much as 2/3 of eligible recipients are not accessing food stamps, the first line of defense against hunger for millions of families throughout the nation. Less than 30% of residents living at or below the poverty line participate in Washtenaw County’s food stamp program. Barriers include an unwieldy application process, inadequate benefit levels (\$1.31 per meal) and a restrictive asset limit (if a family has more than \$2,000 in savings or assets they are disqualified).

Community Food Security is defined by anti-hunger advocates to be “a condition in which all community residents obtain a safe, culturally acceptable, nutritionally adequate diet through a sustainable food system that maximizes community self reliance and social justice.” Better coordination between government and private efforts to alleviate hunger as well as the creation of sustainable food resources on the community-wide level are necessary ingredients to achieving greater food security in Washtenaw County.

## **Local Model Programs**

MSU Extension Services Family Nutrition Program: Provides free nutrition, food preparation and budgeting skills, and food safety training to both providers of hunger relief assistance and consumers.

Growing Hope: Dedicated to improving peoples lives and communities through gardening. Targets communities most at risk of hunger and helps create community gardens fostering self reliance and better nutrition.

Chain of Plenty/YMCA Program : Housed in Food Gatherers’ Community Kitchen located in the Delonis Center, the Chain provides life skills and job training in the food service industry to special needs students at the same time the students prepare lunch for people in need.

The Food Stamp Hotline: In response to Michigan’s low rate of participation in the food stamp program, The Center for Civil Justice conducts free food stamp screening over the phone. Since 2000, they have helped increase the rate of participation by 14%.

## Other Programs

The Garden Project/San Francisco. A former vacant lot now houses a beautiful garden where ex-offenders come to work to regain job skills. Sales of the garden's produce to area restaurants support the program which also spins off graduates into good jobs with the city's landscaping department.

The Hartford Food System/Connecticut. Works to create an equitable and sustainable food system that undresses the underlying causes of food insecurity and poor nutrition facing low income and elderly residents. This organization engages farmers, policy makers, non-profits and the commercial food sector and develops innovative programs directed at four major food system components: production, distributions, education and training and public policy.

## Recommendations

- Increase public awareness of the problem of hunger and advocate for policies that respond to root causes such as poverty.
- Advocate for policies that expand eligibility and promote participation in the Food Stamp Program.
- Reduce the complexity and stigma of applying for and using food stamps.
- Ensure that state and local governments exhaust all federal nutrition assistance programs available to them.
- Educate low income people about their eligibility for nutrition assistance, and work with providers to break down barriers to access these programs.
- Ensure that individuals and families have access to affordable and nutritious food through the expansion of food rescue activities and garden programs for youth, senior and residential communities.
- Provide nutrition, budgeting, and food safety education to populations at risk.
- Support efforts which strengthen local food production such as farmers markets.
- Engage recipients of food assistance in activities which promote self sufficiency, peer education and advocacy such as Growing Hope.
- Coordinate public and private efforts to better target those at greatest risk of food insecurity (i.e., although the poverty level of families with children is 7% in Washtenaw County as a whole, it is 26% in Ypsilanti and 51% in the city's predominantly African-American Southside. (Census 2000))
- Coordinate better public and private data collection.

## Chapter Resources and References

National Anti-Hunger Organizations "A Blueprint to End Hunger" June 3, 2004

## III-9-iii. Adjacent Services: Transportation

### Current Reality

Transportation is a major unmet need that exists for people who are homeless in Washtenaw County.

Issues identified regarding transportation include:

- Inconsistent routes and service
- Transportation not available during non-traditional hours
- Difficulty simply getting to one's job, much less necessary appointments or child care

### PROBLEMS

- Transit service in Washtenaw County is limited and fragmented.
  - The AATA provides fixed-route service only in the Ann Arbor and Ypsilanti area. Service outside of Ann Arbor is limited in the evenings and weekends and does not operate late at night.
  - While much of the non-urban portion of the county has some demand-responsive service, availability is limited to weekdays only.
  - Large areas of the County have no demand-responsive service.
  - Although the AATA is working on a plan to strengthen the bus system within the next six years (called "AATA Destination 2010") as of now, adequate funds are not being allocated to improve the bus system.
- Special programs to support public transit use are not targeted toward people who are homeless.
  - A program called "Get Downtown" developed by AATA in conjunction with the Ann Arbor Downtown Development Authority (DDA) and the Ann Arbor Chamber of Commerce provides bus passes to employees of participating downtown Ann Arbor employers, paid for by the employer and the (DDA).
  - The non-profit SOS Community Services purchases monthly bus passes for Washtenaw County's homeless families and several other social service organizations also purchase tokens or passes for their clients. (AATA offers a program where low-income persons are eligible to pay ½ fare on AATA buses or purchase passes for ½ price. Social service agencies can apply on an individual basis for/with their clients but cannot purchase these in bulk for general use with their clients. Some agencies report it is difficult to access these rates for their clients.)
- There are many resources for transport available in Washtenaw County, however, as with most services, there is a gap in communicating this info to those that are in most need.

## MORE BACKGROUND INFORMATION

- Primary reason for the lack of consistent transportation services in Washtenaw County is differences in local funding. Funding is provided by cities and townships. Differences in service within the County are a result of the different funding levels provided by cities and townships.
- Both AATA fixed-route (The Ride) and demand-responsive (A-Ride) service are provided throughout the urbanized area.
- About 200,000 people (more than 60% of the county's population) live within ½ mile of an existing AATA route.
- There is a service called Ride Source, operated by AATA, which works to coordinate available transportation including work transportation and acts as a clearinghouse for information on available transportation.
- Milan Public Transit, Chelsea Area Transportation System (CATS), and Northfield's Human Services (People's Express) provide demand-responsive service in the non-urban portion of the County, and connect to AATA service.
- Northfield's Human Services has received a HUD grant in each of the past two years to provide a limited number of trips for low-income people for \$1.

### **Effectiveness Research and Model Programs**

#### *Santa Clara Homeless Transit Pass Program*

This program, administered by case managers at shelters and other homeless service programs, provides discount public transit tickets to homeless people, thus helping them to access services, employment and housing opportunities while also increasing the number of public transit riders. In order to continue, Santa Clara's plan seeks to expand the transit available between service programs and to encourage efforts to locate all new service programs near transit lines.

<http://www.endhomelessness.org/localplans/santaclara.pdf>

#### *Columbus Homeless Bus System*

Service agencies are given transit passes by the local authority and these are given to the homeless. Passes cost the agency \$1 and allow the homeless person to travel the entire system for one day.

[http://www.csb.org/What\\_s\\_New/Ending%20Chronic%20Homelessness%20Cover.htm](http://www.csb.org/What_s_New/Ending%20Chronic%20Homelessness%20Cover.htm)

#### *The Ann Arbor Transportation Authority*

The work between CATS and AATA for service between Ann Arbor, Chelsea and Dexter is an example of collaboration across jurisdictions that could be very helpful if subsidies for transit were available to people in very low-income brackets. The AATA and a number of other organizations are beginning to work on a countywide funding source for transit that would permit a consistent network of transit service. Such a network could provide more comprehensive demand-responsive service.

## Recommendations

- Partner with AATA to evaluate the low-income rate passes and the ease of accessing these rates for people who are homeless or precariously housed. Expand transportation options for people to access shelter and case manager appointments. Include a transfer system in this effort so that people using discount passes do not have to pay an additional fee when engaging in bus transfers. *Action underway via the HSCC.*
- Engage townships to support public transportation in the outlying County to enable their citizens to access social services more easily and to overcome barriers to obtaining employment.
- Create and maintain current database of transportation services for people who are homeless, accessible electronically and on paper to homeless service providers and homeless.
- Ensure that county social services agencies organize their services so that they are clustered at transportation points within the county.
- Expand the Ride Source that coordinates transportation during non-traditional hours.

## Chapter Resources and References

- SEMCOG Public Transportation Plan:  
<http://www.semco.org/Products/pdfs/2025rtp.pdf>
- Human Services Collaborative Council Plan 2004  
<http://www.ewashtenaw.org//government/departments/hsc/SC/May04/hscplan4-30.pdf>
- AATA Strategic Plan  
<http://theride.org/StrategicPlan.html>

## IV-1. Special Populations: Youth

### Relevant data on demographics and projections

#### National Data

- 1.7 million teenagers and young adults are believed to be on the streets nationwide. (National Network for Youth, 2002)
- “On the streets” is not a literal term, however. Many kids find temporary places to stay, motels, cars, parks, friends, acquaintances.
- Whether on the streets or in temporary unsafe settings, youth are in danger of abuse, sexual assault, and exploitation and of using illegal and dangerous means to support themselves (i.e. drug dealing, prostitution, survival sex, shop lifting) abusing drugs and alcohol, and dropping out of school. (Dept. of Health and Human Services, 2004)
- 1 in 7-10 of high school population experience housing instability in one year.
- In national studies, up to 50% of youth on the streets identify as LGBTQ.

#### State and Local Data

- 15,000 homeless youth in Michigan. (Michigan Network for Youth and Families, 2001)
- Approximately 650 runaway reports were made to authorities in Washtenaw County in 2003.
- Runaway stats do not include “throwaways”, youth of any age who are thrown out of the home with nowhere to go who are not reported to authorities...and youth 17 and older who leave home or are thrown out, without alternative housing plans. (A recent study showed that only about 20% of youth who leave home are reported to authorities)
- Majority of population are believed to be between 15 and 17 years of age. Some as young as nine years old.
- Runaway and homeless youth are often victims of child abuse and neglect. In Washtenaw County there were 2,500 investigations of abuse/neglect, 418 confirmed victims of abuse/neglect in 2002. (Kids Count, 2003)
- Abused adolescents are least protected in the state child protection system.
- Kids in out of home care experience high rates of homelessness (30-50%): Currently in Washtenaw County there are 372 youth in foster care, 32 for delinquency in 2002. (2003, Kids Count)
- Teen parents also experience high rates of homelessness. Teen pregnancy rate in Washtenaw County: 200 live births to youth 15-19 in 2002.

#### Why they leave or become homeless

- Abuse/neglect/abandonment: “Children who leave home prematurely often do so as a result of intense family conflict or even physical, sexual, or psychological abuse. Children may leave to protect themselves or because they are no longer wanted in the home.” (*Runaway/Throwaway Children: National Estimates and Characteristics, NYSMART Bulletin, 2002*)
- Locally, over 60% report history of abuse or neglect.

- Being thrown out after becoming pregnant – locally 40% of homeless youth seeking services are pregnant or parenting. 27% Statewide (MNYF, 2004)
- Being thrown out because of sexual orientation.
- Exiting foster care or institutional care without needed skills/support (A national study showed that 25% of foster care youth experienced homelessness.) Locally 29% of homeless youth who seek services were formerly in foster care. Statewide the figure is 26% (MNYF, 2004). Also a Casey Foundation study found that 21% of foster care alumni experienced homelessness within 1 year of discharge, with the average number of homelessness episodes being 3.8.
- Death or imprisonment of parent/guardian.
- Intense family conflict related to domestic violence between parents, parental mental illness/substance abuse, remarriage, youth with disabilities. (More manageable when a child is young, households with serious parenting, relationship and/or functioning problems tend to be more strained when a child becomes an adolescent)

### **Key services that prevent homelessness and/or ensure housing stability for this population in our community**

- 24 hour licensed youth emergency shelter and crisis intervention (this means 24 hour access, as well) for youth and families
- Comprehensive Psychosocial Assessments and Service Planning
- Counseling for youth and families
- Case Management (including access to needed mental health and other treatment services)
- Life Skills Development (hard and soft skills)
- Outreach, including school and street outreach
- Transitional Housing
- Permanent Housing with Supports
- Eviction Prevention and Independent Living Assistance
- Leadership Development
- Educational and Employment Supports Note: Services for teen parents are quite similar, but service plan/intervention must take into consideration the special developmental needs and vulnerability of both the youth and her child(ren), and help the youth avoid future pregnancies.

### **Best practices/national research regarding the prevention of homelessness or ensuring of housing stability for this population**

- Comprehensive services: in addition to shelter and housing, responding effectively to runaway and homeless youth requires a “strong social service and mental health component that can attend to the child maltreatment, family conflict, substance abuse, and traumatic stress that precipitate and complicate these [homelessness] episodes.” (*Runaway/Thrownaway Children: National Estimates and Characteristics, NYSMART Bulletin, 2002*)
- Strategies to end youth homelessness: from the National Alliance to End Homelessness (NAEH)

- **Increase Funding for Runaway and Homeless Youth Services.** Each year, federally funded runaway and homeless youth programs provide street outreach, emergency shelter, and transitional living services to an estimated 600,000 youth. In recent years, the federal government has increased resources to provide transitional housing and independent living services to runaway and homeless youth, yet these programs are still woefully under-funded.
- **Better Preparation and Aftercare for Youth in Out of Home Placements.** Young people exiting public custodial care are at heightened risk for future homelessness and housing instability. Many in prolonged state care, including those in contact with the foster care and juvenile justice systems, are neither sufficiently prepared to live independently, nor provided adequate aftercare services that will ensure a stable residential placement following discharge.

### **NAEH Identified Best Practices:**

- [Connecticut Department of Children and Families Housing Continuum](#)  
Youth work their way through a continuum of housing options, moving from highly structured, supervised living arrangements to a transitional phase where support is provided while structure and restriction is decreased. Connecticut contracts approximately 60 Independent Living Providers and is able to expand housing options within the continuum as demand increases. (NAEH: Best Practices. [Connecticut Department of Children and Families Housing Continuum](#))
- [Illinois Department of Family and Children](#): This program was built on research that demonstrates that housing is essential to stabilizing clients and providing services to meet their needs. The Department for Children and Families involved advocates, current and former foster youth, providers, and state agency officials in the development of the program. DCFS chose several housing advocacy agencies that they had existing relationships with and placed 16 Housing Advocates throughout the state to help youth locate affordable housing and access social services for stabilization. (NAEH: Best Practices. Illinois Department of Children and Families Youth Housing Assistance Program)
- [Lighthouse](#) developed a semi-supervised scattered-site apartment model based on the philosophy that young people learn best by "doing" and that youth should have opportunities to live on their own and develop self-sufficiency skills prior to discharge from care. The agency has served over 1000 youth in its model and averages around 80 youth a day living in their own apartments. (NAEH: Best Practices. Lighthouse Youth Services Housing Continuum, Cincinnati, OH.)
- In 1994, the State of New Mexico established [Adolescent Transition Groups \(ATGs\)](#) to support the most vulnerable youth transitioning from out-of-home care into adulthood. Adolescent Transition Groups are comprised of representatives from state and local child welfare, juvenile justice, education, and mental health agencies, as well as youth advocates, attorneys, and other community stakeholders. ATGs exemplify a systems management approach that utilizes the experiences of individuals to identify systemic barriers for youth in transition. The primary goals of ATGs are to help youth access services that they are eligible for as adults, to identify and address barriers to services and service gaps, and to raise awareness and promote dialogue between child and adult systems of care. (NEAH: Best Practices.

## Adolescent Transition Groups State of New Mexico)

- Project SAFE - resources for parents of teens was initiated in 1999 to prevent teen homelessness in Snohomish County Washington. Project SAFE offers three services to parents/caretakers of teens: phone consultation, groups and workshops, and a resource library. Parent/caretakers who are concerned about their teen can call and speak with a therapist who provides consultation and links to various resources in the community. They then receive a follow-up phone call, can opt to participate in support and educational workshops, and have access to project SAFE newsletters, "tip sheets" and other resource library materials. (NEAH: Best Practices. Project SAFE Everett Washington)
- Youth Development: National Academy of Science recognized Youth Development as being an effective model in creating positive youth behavior outcomes and preventing problem behaviors (2002 Report). Youth development is defined as the process of promoting the social, emotional, physical, and cognitive development of young people through meeting their needs for safety, love, belonging, respect, identity, mastery, and meaning. Youth development requires a comprehensive approach within a safe and supportive environment that works to build on the strengths, skills, talents and abilities of young people. This approach to working with youth has been endorsed by US Dept. of Health and Human Services and the National Network for Youth specifically for runaway and homeless youth services, as well as by Casey Family Programs, William T. Grant Foundation, W.K. Kellogg Foundation, David and Lucile Packard Foundation, Council of State Governments, National League of Cities, U.S. Conference of Mayors, and many others. Ozone House currently uses a Youth Development model.
- Services for Foster Care Youth: Appropriate support for youth leaving foster care and other institutional care: A 2003 Casey Family Programs Nationwide study of foster care alumni identified the need for a critical array of service supports for children while in care and while making the transition from foster care. The study identified life skills preparation; caring relationships with adults, employment experiences, educational completion, and a sense of belonging as predictive of successful adulthood.

### Unique characteristics of providing effective services for this population

- **Youth Centered**: Youth need consistently accessible, flexible, and comprehensive services that address a variety of needs in Youth-Centered manner. Services and the environment in which they are provided must be tailored to them. Disenfranchised youth, distrustful of professionals in particular and adults in general, will not seek services from traditional or bureaucratic social service settings where they believe they will be judged or patronized. They require a place of their own where staff, and the agency culture in general, are highly tuned to their needs and interests.
- **Outreach**: Outreach must be on-going, multi-faceted, and use innovative approaches to engage and connect with youth.

- **Engagement:** Engagement and trust-building skills are critically important for program staff working with disenfranchised youth, as well as a good sense of humor.
- **Family Focused:** Staff must be able to work with the whole family through counseling and other means of support to help youth return home and/or develop more positive family relationships.
- **Making Connections:** Program staff must be able to develop a warm, caring, and trust enhancing relationship with a youth that help establish the safe and supportive environment necessary to assist youth to develop a more positive worldview, improve their interpersonal skills, and reduce social isolation and stress.
- **Cultural Competency:** The staff must be culturally competent in areas related to sexual orientation, race, and socioeconomic background.
- **Therapeutic Skills:** Expertise and therapeutic skills related to trauma, grief and loss, mental illness, substance abuse, domestic violence, family functioning and conflict resolution are also critical.

## Recommendations

### Significant Recommendations in Blueprint for this Population:

- Supportive Housing. Ozone is beginning to provide this service, but it is the biggest gap in the continuum of services and housing for young adults, including teen parents. The nature, duration, and intensity of the services conjoined with this housing differs from SPH for chronically homeless adults. For youth without serious disabilities it focuses on providing opportunities needed for successful transition to independence: educational, employment, health care, housing, and chances to establish productive personal relationships and networks.

### Critical, additional recommendations for the prevention of homelessness or ensuring housing stability for this population:

- More prevention services for families. Because of the close connection to abuse and neglect more intensive, long term family support services are needed for all high risk families (especially teen parents). For high risk families with young children these services help improve attachment and parenting skills which lead to reduction of abuse and neglect. For families with adolescents these services can help improve parenting skills and reduce conflict to avoid youth running away or being thrown out.
- Improved protection and responsiveness from child welfare system. Better identification and services for young people, and their families, in abusive and neglectful situations are needed to help youth avoid homelessness. Dramatically expanded mental health services, skill development, and adequate after-care support for foster care and other youth living in out of home placements will help youth be better equipped to live independently after they age out of the system.

## IV-2. Special Population: Survivors of Domestic Violence

### Relevant data on demographics and projections

- Nearly twenty-five percent of surveyed women and 7.5 percent of surveyed men said they were raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date at some time in their lifetime. (Title: Extent, Nature, and Consequences of Intimate Partner Violence. Research Report by Patricia Tjaden and Nancy Thoennes, National Institute of Justice and the Centers for Disease Control and Prevention, July 2000, <http://ncjrs.org/txtfiles1/nij/181867.txt>).
- In 1999 Michigan newspapers reported forty-one (41) homicides in Michigan as a result of domestic violence.
- From June 1, 2003, to Dec 31, 2003, The Domestic Violence Project/SAFE House served 2,661 survivors of domestic violence, ninety-six (96) of whom were staying in SAFE House's shelter and therefore homeless. Many more were doubled up with friends or family members.
- In a study of 777 homeless parents (the majority of whom were mothers) in ten U.S. cities, 22% said they had left their last place of residence because of domestic violence (Homes for the Homeless, 1998, [www.nationalhomeless.org/domestic.html](http://www.nationalhomeless.org/domestic.html), Published by the National Coalition for the Homeless, April 1999)
- A 1995 survey of homeless adults in Michigan found that physical abuse/being afraid of someone was most frequently cited as the main cause of homelessness (Douglass, 1995). ([www.nationalhomeless.org/domestic.html](http://www.nationalhomeless.org/domestic.html), Published by the National Coalition for the Homeless, April 1999)
- Of cities surveyed by the U.S. Conference of Mayors in 2000, 56 percent identified domestic violence as a primary cause of homelessness. (Chicago Coalition For The Homeless, Homelessness-Causes and Facts, [www.chicagohomeless.org/IndexNew.asp](http://www.chicagohomeless.org/IndexNew.asp))

### Key services that prevent homelessness and/or ensure housing stability for this population in our community

Many survivors of domestic violence become homeless because of a variety of reasons. Research indicates that survivors are homeless because their home or even home community is no longer safe for them or their loved ones. As a result, survivors seek shelter to ameliorate the effects of the violence and to seek supportive services toward ending the violence in their lives. Those services include:

- Non-Residential support services such as counseling, help securing education and employment and assistance with eviction prevention.
- Safety planning.
- Assistance with Personal Protection Orders (which can sometimes allow the survivor to stay in previous housing and force the assailant to leave).
- Other types of legal advocacy that includes court accompaniment, informing of court processes, etc.
- Crisis intervention in person and over the phone twenty-four hours per day, seven days a week.
- Intensive case assistance through a specialized program called "Families First."
- Community education about the impacts of domestic violence.

## **Best practices/national research regarding the prevention of homelessness or ensuring of housing stability for this population**

- Policies that prevent landlords from evicting survivors from public housing due to the assailant's behavior (e.g., he assaults her, she is evicted because he committed a crime on the property).
- Education for employers so they can understand domestic violence and not punish survivors for the assailant's behavior or for the survivor's response to it (e.g., he calls her constantly while she's at work, she comes late because he hid the car keys, she needs to leave early because he went to the school to try to abduct the kids and the school called her).
- Quality, caring, long term relationships with advocates.
- Specific financial assistance to address the problems that have stemmed as a result of economic abuse.
- Education for professionals in various fields about the impacts of domestic violence. As examples, education for law enforcement about the severity of the crime, education for mental health professionals who may identify domestic violence through therapy, etc.
- Community education about the impacts of domestic violence, the role of male privilege as well as information regarding the oppression of women.
- Advocacy for prevention activities.

## **Unique characteristics of providing effective services for this population**

- The survivor's safety must be a service providers' first concern. Demonstrated lethality assessment and safety planning skills are essential.
- A thorough understanding of the dynamics of domestic violence and of the behavior of batterers is necessary so that the service provider does not either 1) collude with the batterer, 2) jeopardize the survivor's safety, 3) alienate the battered person from professional assistance or 4) expect responses that a battered person cannot provide. This understanding is developed through daily, ongoing contact with hundreds of survivors talking explicitly about domestic violence, not through even extensive training.
- A thorough understanding of related issues such as sexual assault, child sexual and physical abuse, animal abuse, and stalking is necessary.
- Solid empathy, active listening and empowerment counseling skills are critical. Survivors need a space where they will receive non-judgmental, supportive flexible services. Whenever possible, an advocate who is also a survivor of domestic violence should be available.

## **Recommendations in the existing plan that are especially critical for this population**

- Increase stock of permanently affordable, supportive housing.
- Secure reliable funding sources for supportive services.
- Expand options for education and employment.

**Critical additional recommendations for the prevention of homelessness or ensuring housing stability for this population**

- Educate the community at large about the impact and severity of domestic violence.
- Send a clear message that domestic violence is not tolerated in this community.

## IV-3. Special Populations: Older Adults

### Relevant data on demographics and projections

Between 1990 and 2000:

- Washtenaw County's age 60-plus population grew more than three times as fast as did Michigan's comparable segment.
- The age 85-plus population in Washtenaw County recorded a growth rate that was 80 percent higher than for the 60-plus population as a whole, indicating a trend toward a higher average age of older adults in the County.
- The minority population age 60-plus grew 50 percent during this period, comprising 13 percent of the 60-plus population.

Projected Growth in the Older Adult Population:

- Between 2000 and 2030, the 60-plus population in the County is projected to grow nearly three-fold, from about 26,000 to nearly 73,000. In comparison, the Counties overall population growth is expected to increase only 39 percent.
- An exceptionally high rate of growth, 53 percent, in the older adult population of Washtenaw County is expected to be sustained between 2010 and 2020, with an estimated 28 percent growth rate for the same population by the end of the current decade.

Housing Statistics:

- According to a Congressional report on affordable housing in 2002, nationally there are six times as many older adults with unmet housing needs as are currently served by rent-assisted housing.
- Presently, Washtenaw County older adults are served by a total of 18 subsidized senior housing complexes, with a combined total of 2,089 units.
- Presently, Washtenaw County has only three Adult Foster Care homes, with a total of 14 beds, that are Medicare approved.
- There are no low-cost/subsidized Assisted Living facilities in Washtenaw County, while these types of facilities comprise the fastest growing housing options for those older adults with financial resources.
- Specific geographic areas within Washtenaw County (e.g. Ypsilanti) suffer relatively severe housing problems due to lower incomes and reduced housing options.
- Waiting lists for low-cost housing options relate to the overall availability:
  - Supply of one bedroom units appear adequate with a standard 1-3 month waiting period.
  - Supply of two bedroom units are inadequate with a 2 year waiting period.
  - Supply of specifically modified housing for those with a disability is severely inadequate with a 4-6 year waiting period.
- Recent trends in public policy regarding special populations have had a negative impact on the supply of affordable housing for older adults.

### **Key services that prevent homelessness and/or ensure housing stability for this population in our community**

- Housing Bureau for Seniors - Housing Counseling, Foreclosure/Eviction Prevention, and HomeShare.
- Neighborhood Senior Services - Home Maintenance and Repair, Elder Abuse Prevention, Case Management, Information and Assistance, Prescription Assistance and Accessibility Modifications.
- Catholic Social Services, Older Adult Services – Tax Assistance, Medicare/Medicaid Assistance Program, Lifeline, and Caregiver Support.
- Area Agency on Aging 1B – In-Home Services Assistance, Case Management, Information and Assistance, and Home and Community Based Living Assistance, Housing Vouchers.

### **Best practices/national research regarding the prevention of homelessness or ensuring of housing stability for this population**

- The NCB Development Corporation (<http://www.ncbdc.org>), in partnership with the Robert Wood Johnson Foundation, is working to create assisted living facilities to low- to moderate-income older adults. One success is the Rock Cove Assisted Living, a 30-unit facility located in Oregon. It was created in response to an unmet need for decent housing and services for elderly of all income levels who were unable to live alone, but who did not need continuous skilled nursing care. Working in a collaborative effort with Columbia Cascade Housing Corporation (CCHC), they overcame challenges posed by the site and hostile community members, and obtained the financing needed to make the facility affordable to low-income elderly. A growing number of elderly who have lived and worked in the area all their lives can stay and live in dignity at an affordable rate. Parents of residents can live close to their children.
- The Eden Alternative (<http://www.edenalt.com>) is an increasingly popular best practice, transforming nursing homes from *institutional* environments in which patients are *treated to a living* environment in which care is *exchanged*, with residents and staff both giving and receiving. Over 300 nursing facilities have implemented the Eden Alternative throughout the country.

### **Unique characteristics of providing effective services for this population**

- Affordable Support Services (e.g. transportation, home health care, etc.) are critical to the ability for older adults to remain in affordable housing.
- Congregate, low-cost housing options often mix older adults with a higher percentage of mentally impaired and substance abusing residents.
- Older adults have underestimated the cost of housing and related services for their later years resulting in insufficient preparation, planning and resources to live safely and comfortably.
- Older adults are often without any local family/personal supports to assist when housing issues arise.

## **Additional recommendations for the prevention of homelessness or ensuring housing stability for this population**

- The State of Michigan must provide greater availability of funding to support older adults remaining in independent living while receiving the services needed for health concerns. There is a wide spectrum of community-based services, designed to help older adults remain independent in the community and avoid premature institutionalization, available to varying degrees in communities throughout Washtenaw County. These services include personal care, chore, and homemaker services, home delivered meals, transportation, respite, home injury control and resource advocacy including legal and financial counseling. It is important that older adults who wish to remain independent in the community place have access to these essential services, especially when limited by financial factors.
- The Blueprint for Aging Services Partnership Report (September 2003) examined housing issues among older residents in Washtenaw County and developed a series of recommended actions related to financing and increasing the availability of affordable housing.

## IV-4. Special Populations: Veterans

### Relevant data on demographics and projections

- Almost 1900 encounters with homeless veterans seen by the VA Ann Arbor Healthcare System's (VAAHS) Health Care for Homeless Veterans (HCHV) Program occurred in 2003.
- In FY 2003, nationally the VA provided services to approximately 100,000 homeless veterans, the majority through the auspices of its specialized homeless programs.
- The Urban Institute reported an 11% drop in the homeless male veteran population from 1987 to 1996 in the US.
- In FY 2003, the VA's total costs associated with the treatment of all homeless veterans in the US using VA health care services was \$1.19 billion.
- Key characteristics of homeless veterans:
  - Many suffer from serious medical and mental illnesses, including addiction disorders.
  - Damaged relationships with friends and family.
  - Unemployed, unemployable, disabled, and/or lack of sufficient income.

### Key services that prevent homelessness and/or ensure housing stability for this population in our community

The HCHV Program has a full-time outreach social worker for Washtenaw County who provides the following primary services:

- Outreach to identify veterans among the homeless persons encountered in shelters, soup kitchens, and other community locations.
- Determination of eligibility and enrollment in the VAAHS and/or provision of information to appropriate community referrals.
- Clinical assessments to determine the needs of each veteran seen by the social worker with priority given to those most vulnerable.
- Referral to medical and psychiatric inpatient and/or outpatient treatment, and to social and entitlement services.
- Assignment to a primary care provider to address healthcare needs.
- Referrals to High Intensity Outpatient Treatment (HIOT) Program and/or Work Therapy Program (WTP) to provide successful rehabilitation including temporary housing and entry-level employment.
- Rehabilitation in community-based contracted residential treatment facilities arranged and monitored by the HCHV social worker.
- Referrals to transitional housing with supportive services through the Grant and Per Diem Program (Home Zone, Salvation Army Staples Family Center).

The Washtenaw County Veteran Services Office through Federal Benefits Advocacy, the Michigan Veterans Trust Fund, and the Washtenaw County Soldiers Relief Commission provides the following:

- Verification of veteran status and establishment of eligibility for entitlements.
- Temporary financial relief to prevent loss of housing and/or utilities.
- Financial assistance to establish housing.
- Thorough development of compensation and pension claims to ensure expedited decisions and to secure awards which offer financial security.
- Referrals to access medical treatment at the VAAHHS.
- Provision of direct service delivery at the Delonis Center and other transitional housing settings to coordinate linkages to long-term services and stable housing supports.
- Serves as the Point-of-Contact regarding delinquent mortgage foreclosures and property tax sales for federal (VA Home Loans) and state (County Treasurer) agencies.
- Referrals to job placement/employment opportunities with Veterans Employment Representative to include resume preparation and interview techniques (ETCS).

### **Best practices/national research regarding the prevention of homelessness or ensuring of housing stability for this population**

- Critical Time Intervention Management. The CTI is a case management model developed by Drs. Ezra Susser and Alan Felix of Columbia University. It was developed for hospitalized seriously mentally ill homeless veterans who have sought help on their own, who have a high rate of recidivism, a low quality of life and who use a disproportionate number of bed days of care.
- Therapeutic employment, Placement and Support. Research has demonstrated the therapeutic effectiveness of supported employment (which provides individualized support to clients in finding and keeping mainstream community jobs.) The Individual Placement and Support (IPS) model of supported employment, developed by Robert E. Blake, M.D, Ph.D., and Deborah Becker, M.Ed., is being adapted and implemented at ten VA medical centers.
- Evaluation of Residential Treatment Modalities. This is a follow-up study on the cost effectiveness of, and the role of aftercare in, three approaches to residential treatment of veterans. As of the end of December, 2003, 1,242 homeless veterans or 92 percent of the total sample were enrolled in the study and 1,005 have been discharged from residential care and are being followed.

### **Unique characteristics of providing effective services for this population**

- Due to the high incidence of mental health and substance abuse issues among veterans who are homeless, the VA recommends a continuum of care that ranges from aggressive outreach to permanent housing coupled with on-going clinical case management.
- Homeless veterans have skills and competencies developed and enhanced during military service that could still be of value and useful (e.g., discipline, can take direction, understand authority).

### **Recommendations in the existing plan that are especially critical for this population**

- Focus on Prevention of Loss of Housing.
- Housing First/Supportive Housing.
- Meet the needs for housing and treatment for people with drug and alcohol addiction and co-occurring disorders.
- Expand options for education and employment.

### **Additional recommendations for the prevention of homelessness or ensuring housing stability for this population**

- Permanent housing with supportive services.
- Job training and placement with mentoring.
- Transitional housing for adult single males with substance dependence.
- Explore collaborative efforts to secure more grants through the Department of Veterans Affairs (DVA) Homeless Providers Grant and Per Diem Program and to pursue other DVA homeless programs (HUD-VASH, VA Supported Housing Program, VBA Acquired Property Sales for Homeless Providers, and VA Excess Property for Homeless Veterans).

## IV-5. Special Populations: Lesbian, Gay, Bi-sexual and Transgender (LGBT)

### Data on demographics and projections

- A 2002 study has suggested that 35% of homeless youth are lesbian, gay, bisexual or transgender (Mottet & Ohle, 2003).
- According to Paul Gibson of the U.S. Department of Health and Human Services, 26% of lesbian and gay youth are forced to leave home because of their sexual orientation (Indiana Youth Group, “Statistics on GLBT Homelessness” [www.indianayouthgroup.org/homelessness.doc](http://www.indianayouthgroup.org/homelessness.doc)).
- In 1998 Pohan and Bailey found that 26% of GLBT youth who ‘come out’ to their families are thrown out of their homes because of conflicts with moral and religious values.
- Other studies show that 1 in 5 transgender people are in need or at risk of needing homeless shelter assistance.
- It is known that transgender people are requesting shelter in large numbers. For example, 4.3% of the people who request services from Atlanta’s largest male-only shelter are transgender women who are not allowed in women’s shelters.
- Similarly, Nashville’s largest homeless shelter for youth, Oasis, estimates that approximately 1% of their requests for emergency assistance come from transgender youth.
- Transgender people are disproportionately represented in the homeless population because of the frequent discrimination they face at home, in school, and on the job.

Note: These studies provide only a rough estimate and likely do not reveal the full scope of the problem. No one has a clear idea of the true number of transgender individuals in need of services, because no one is accurately counting.

### Contributing factors to homelessness in the LGBT population?

- Poverty due to chronic under-employment and discrimination.
- As a youth, being thrown out because of their bisexual/transgender nature. This causes many GLBT young people to become homeless, increasing their likelihood of engaging in prostitution and heightening risk for alcohol and drug abuse, violence, suicide, and HIV and other STD’s.
- Lack of economic/housing support from family—a safety net that many people can utilize during hard times— and of education and training because of harassment or discrimination, which results in an inability to acquire jobs.
- Inability to access standard healthcare due to multiple barriers, including discrimination.
- Inability to pay for transgender-related healthcare such as hormones, counseling, and gender reassignment procedures (Transgender-related healthcare is not typically covered by insurance providers in the US).
- Substance abuse and addiction.
- Discrimination by housing providers, landlords, social service agencies.

- Criminal record of all types of survival street crimes (drug trade, theft, sex work) to which a person turns when unable to earn a living through legal means.
- HIV infection or other sexually transmitted [diseases] acquired from survival sex work or other means.
- Victimization from crime while living on the street or from hate crimes.

### **Key services that prevent homelessness and/or ensure housing stability for this population in our community**

- Anti-discrimination and anti-harassment laws and policies protecting sexual orientation at shelter/municipal/state/federal levels.
- Family education and support.
- Diversity training on bisexual and transgender issues.
- Access to affordable therapeutic and medical services.
- Support services for people undergoing gender transition.
- Sensible, flexible policies that permit transgender people to obtain identification documents in their new name and gender, as needed.
- Hate-crime laws and policies at state/federal levels.
- Diversity training on sexual-orientation concerns in K-12 schools, institutions of higher learning, religious institutions, shelter and other social-service agencies, governmental agencies.

### **Unique characteristics of providing effective services for this population**

- Cultural competencies are needed throughout agencies and programs serving people who are homeless, specifically knowledge of bisexual and transgender issues and concerns. This is essential due to the higher percentages of LGBT persons at risk of homelessness.
- People should be treated according to their self-identified gender and not necessarily according to their legal identification or the subjective determination of service providers. This requires sensitivity and clear conversations between the consumer and the agency.
- Programs need safe bathrooms, showers, and locker rooms.

### **Additional recommendations for the prevention of homelessness or ensuring housing stability for this population**

- For our community to be serious and committed to working to prevent the homelessness of, and ensure housing stability for lesbian, gay, bisexual and transgender individuals, we must take a high-profile stance in favor of anti-discrimination laws and policies along with the social acceptance of GLBT people.
- Ensure that the consumer's evaluation of agencies are used to inform agencies of their level of competency in meeting the needs of LGBT consumers with dignity, respect and fairness.

## Chapter Resources and References

- National Coalition for the Homeless 1012 Fourteenth Street, NW, #600, Washington, DC 20005-3471 Phone: 202-737-6444 | Fax: 202-737-6445 Email: [info@nationalhomeless.org](mailto:info@nationalhomeless.org)
- National Gay and Lesbian Task Force 1325 Massachusetts Ave. NW Suite 600. Washington, DC 20005 202-393-5177 | FAX 202-393-2241. TTY 202-393-2284. Email: [nglhf@nglhf.org](mailto:ngltf@nglhf.org)
- Beyond Barriers – Homelessness: A Practical Framework for Pursuing Equality for Lesbians, Bisexuals and Gay Men: [www.beyondbarriers.org.uk](http://www.beyondbarriers.org.uk) (The information provided by this document may be generalized to bisexual/lesbian/ gay-male homelessness in the United States).
- James Toy, MSW, 734-764-5191, [james.toy@umich.edu](mailto:james.toy@umich.edu) Member, Public Policy Committee, Washtenaw Rainbow Action Project (WRAP), 325 Braun Court, POB 7951, Ann Arbor, MI 48107
- Michelle J. Kinnucan, WRAP, PO Box 7951, Ann Arbor, MI 48107; 734.995.9867 (voice) 734.995.9915 (fax); [mjkinnuc@juno.com](mailto:mjkinnuc@juno.com)
- All quoted material is from Mottet, L., & Ohle, J. (2003). *Transitioning Our Shelters: A Guide to Making Homeless Shelters Safe for Transgender People*. New York: The National Coalition for the Homeless and the National Gay and Lesbian Task Force Policy Institute. All footnotes in the original document are omitted here. This document is available online at:  
<http://www.thetaskforce.org/downloads/TransHomeless.pdf> or  
<http://www.nationalhomeless.org/civilrights/transshelters.pdf>

## **IV-6. Special Populations: People with Developmental Disabilities**

**Relevant data on demographics and projections**

**Hold for Section IV-6 –  
Special Populations:  
People with Developmental Disabilities**

**Hold for Section IV-6 –  
Special Populations:  
People with Developmental Disabilities**

**Hold for Section IV-6 –  
Special Populations:  
People with Developmental Disabilities**

**Hold for Section IV-6 –  
Special Populations:  
People with Developmental Disabilities**

## V. Measures of Success

Draft: September, 2004

Goal	Indicator	Data Sources
Prevent Homelessness	<p>Reduce the number of evictions filed</p> <p>Increase amount of services and permanent supportive housing for youth aging out of foster care</p> <p>Reduce the number of people entering shelter who report recent release from prison or hospitals</p> <p>Increase the number of units receiving supportive services</p>	<p>Court data on evictions</p> <p>Lead Entity data collection</p> <p>Intake data from shelters</p> <p>Lead Entity data collection/tracking</p>
Reduce Homelessness	<p>Reduce the number of homeless on any given day</p> <p>Increase the number of permanent supportive housing units</p> <p>Increase the number of units made affordable</p> <p>Increase number of clients moved from shelter to housing within three months</p>	<p>Point-In-Time Count</p> <p>Lead Entity data collection/tracking</p> <p>Lead Entity data collection/tracking</p> <p>Data from Shelter</p>
Reduce Mainstream Costs	Reduce the number of arrests of chronically homeless individuals for vagrancy or public intoxication	Jail roster and information from Community Corrections

	Reduce the number of hospitalizations of chronically homeless persons	Emergency room data
Reform the System	<p>Increase the number of provider organizations participating in community evaluations</p> <p>Develop customer input on service standards and increase performance against these measures</p> <p>Reduce the number of RFP formats/versions</p>	<p>Lead Entity data collection</p> <p>Lead Entity oversight/Provider Data Collection</p> <p>Funder Forum data</p>

## **Appendix A.**

### **Homelessness in Washtenaw County – Data Overview**

In March 2004, two community agencies conducted major surveys with people who were homeless.

- On March 18, 2004, the Washtenaw County Continuum of Care group conducted a Point-In-Time count of individuals and families that were homeless. For questions or more information on this survey, please contact Washtenaw County Community Development department (Stacy Ebron, HMIS Coordinator, [Ebrons@ewashtenaw.org](mailto:Ebrons@ewashtenaw.org), 734.222.3805)
- In the first three weeks of March 2004, the Washtenaw Housing Alliance, in conjunction with member organizations and other service providers, conducted 334 in-depth interviews with individuals and families who were homeless. For questions or more information on this survey, please contact the Washtenaw Housing Alliance (Diane Davidson, [Davidsond@ewashtenaw.org](mailto:Davidsond@ewashtenaw.org), 734.222.6553)

The following is a summary overview of the information gathered in these two surveys, presented separately.

## Continuum of Care Point-In-Time Count

### The Count of People Who Were Homeless in Our County

- ◆ 664 persons were counted on the night of March 18, 2004
- ◆ This included 527 adults, 110 children, and 27 unaccompanied youth
- ◆ Of those counted, 455 agreed to participate in a brief survey

### Annualized Projections on the Magnitude of Homelessness in Our County

Using methodology and research from Martha Burt at The Urban Institute, the following annualized estimates have been made based on the above data from the Point-In-Time Count:

- ✓ **2,756** people will experience homelessness/ become homeless within a year in Washtenaw County
- ✓ An estimated **41** people will become homeless within a given week in Washtenaw County

### Overview Quick Facts

- ◆ 61% were male
- ◆ Average age = 40 years old
- ◆ 12% (54) of adults who were surveyed had children with them; Overall, 26% of the persons counted were families with children
- ◆ 33% slept in emergency shelters
- ◆ 53% of those responding reported it was their first time experiencing homelessness in the last three years; 20% (86 of those interviewed) have been homeless four or more times in the last three years
- ◆ 33% were employed, either part or full time
- ◆ Chronic substance abuse and mental illness were common challenges of those individuals who were homeless; 44% of those interviewed reported substance abuse and 42% reported mental illness

Basic Information			
◆ Male	61%	◆ Age 34 or under	31%
◆ Female	39%	◆ Age 35-44	28%
◆ African American	42%	◆ Age 45-54	30%
◆ Caucasian	47%	◆ Age 55 and older	11%

## Experience with Homelessness

### Length of Current Homeless Experience

- ✓ 28% were homeless for three months or less
- ✓ 65% were homeless for a year or less
- ✓ 23% were homeless for two or more years

## Reasons for Homelessness

- ✓ Unemployment – 40%
- ✓ Unable to pay mortgage or rent – 39%
- ✓ Alcohol/drug abuse – 39%
- ✓ Physical/mental disabilities – 35%
- ✓ Argument with family/friends – 25%

## Persons with Co-Occurring Disorder

A group of 100 survey respondents were identified who indicated they experienced both mental illness and chronic substance abuse (loosely defining co-occurring disorder). In looking at the responses to survey questions for this group, the following differences stood out.

Of people with both mental illness and chronic substance abuse:

- ✓ 32% had been homeless for two or more years (compared to 23% overall)
- ✓ 47% reported they were unable to work (compared to 30% overall)
- ✓ 85% reported alcohol/drug abuse as a primary reason for becoming homeless, and 66% reported physical/mental disabilities as a primary reason (compared to 43% and 35% of all the respondents)

## Washtenaw Housing Alliance Survey Findings

This data is from in-depth interviews conducted in the first three weeks of March 2004 with individuals and families who were homeless. The survey was conducted by the Washtenaw Housing Alliance, in conjunction with member organizations and other service providers.

While the demographic profile for this survey is presented below (Basic Information), the methodology used in the Point-In-Time survey (and the intention to count all the homeless on a given night) provides a more representative demographic snapshot of individuals and families who are homeless in our County. The purpose of the WHA survey was to collect more detailed information on the experience and challenges of individuals and families who are homeless in our community as a supplement to the Point-In-Time survey.

Basic Information			
◆ Male	47%	◆ Age 30 and under	41%
◆ Female	53%	◆ Age 31-40	19%
◆ African American	44%	◆ Age 41-50	27%
◆ Caucasian	42%	◆ Age 50 and older	11%

### History of Homelessness

- ✓ 42% were homeless for the first time
- ✓ 13% lived in a homeless shelter as a child
- ✓ 71% became homeless in Washtenaw County

### Employment

The WHA survey data closely matched the Point-in-Time survey data with 34% (or 115 people) reporting they were employed:

- ✓ 52% of those employed worked full time
- ✓ 56% of those employed earned \$200 or less a week
- ✓ Another 143 were seeking employment

## **Education**

- ✓ 36% had less than a High School education
- ✓ 28% had a High School diploma or GED
- ✓ 24% had some college education
- ✓ 11% attended a technical school or graduated from college

## **Health Care**

- ✓ 71% were able to see a doctor when they were sick and homeless, while 15% were not able to see a doctor (12% - no need)
- ✓ 32% had Medicaid; 13% used the Washtenaw Health Plan
- ✓ 23% saw a dentist while homeless, with 22% reporting they had no need to see a dentist

## **Main Form of Transportation**

- ✓ Sixty-three percent of individuals (210) used Public Transportation as their main form of transportation
- ✓ 10% walk or bike
- ✓ 21% used their own or a family or friend's vehicle

## Detailed Findings from the WHA survey

### The Face of Homelessness Overall

- ✓ Most common services received: case management (62%), emergency shelter (44%), food (49%), food stamps (32%), medical/dental care (32%), mental health care (26%), and substance abuse treatment (25%). When asked directly about mental health care and substance abuse treatment, the numbers go up. Forty-two percent (42%) responded that they were receiving mental/emotional, behavioral treatment, and 38% said they were in an alcohol or drug abuse treatment program.
- ✓ Reasons for homelessness:
  - Unemployment (38%)
  - Unable to pay rent/mortgage (40%)
  - Argument with family/friends (35%)
  - Alcohol/drug abuse (33%)
  - Family/domestic violence (18%)
  - Physical or mental disabilities (17%)
  - Left hospital, jail/prison, or foster care (16%)
- ✓ Barriers of stable housing:
  - Budgeting/planning my expenses (45%)
  - Keeping a job (44%)
  - Family problems (36%)
  - Staying clean or sober (30%)
  - Getting to work (26%)
- ✓ Transportation is the most common barrier to getting/keeping a job (37%)

### Families who were homeless

- ✓ Characteristics of families who were homeless (based on a sample size of 55 from the WHA in-depth survey)
  - Families who were homeless were made up largely of women with children (93%, 51 women)
  - Fifty-six percent (56%) were experiencing homelessness for the first time (compared to 40% of those who were single and homeless)
  - Fifty-six percent (56%) were African-American (compared to 43% of singles individuals who were homeless)
  - 62% were between the ages of 22 and 40
  - 40% reported domestic violence as a reason for homelessness
  - 71% had been turned down for housing (compared to 45% of single individuals)

- ✓ Employment and Transportation
  - 60% had a job compared to 34% of single individuals who were homeless
  - Transportation (45%), lack of needed skills (33%), caring for children (31%), and education (27%) were barriers of getting/keeping a job for these families
  - 38% used their own car as primary form of transportation and 38% (compared to 68% of single individuals) relied on public transportation as their primary form of transportation
  
- ✓ Use of Services
  - Families who were homeless were more likely than single individuals to use the following services: case management (73% vs. 61%), transitional housing (36% vs. 15%), and food stamps (58% vs. 28%). Single individuals were more likely to use emergency shelter (48% vs. 33%), mental health care (30% vs. 13%), and food (54% vs. 25%).
  - Mental health and substance abuse (when asked specifically about these sets of services): Families were less likely to receive mental/emotional treatment (18% vs. 47%) and substance abuse treatment (16% vs. 43%) than single individuals who were homeless. However, 49% of families (heads of households) felt or had been told they need mental/emotional treatment.

*\* Data on families was collected from an adult in the family and data reported here refers to that adult when looking at job status, mental health care, etc.*

## **Differences between men and women who were homeless**

There were differences between men and women who were homeless.

- ✓ Barriers to stable housing:
  - Men: Keeping a job (49%), Budgeting/planning my expenses (39%), and Staying clean and sober (36%)
  - Women: Budgeting/planning my expenses (49%), Family problems (43%) and Keeping a job (40%)
  
- ✓ Work Status
  - Women who were homeless were more likely to have jobs than men who were homeless (44% vs. 23%)
  - Men were more likely to report disability or illness (combined 46%) as reasons for being unable to work than women (18%)
  
- ✓ Women were more likely to report having been turned down for housing than men (60% vs. 38%)

## People who are Homeless for the First Time

There were differences between people who were homeless for the first time and persons who had been homeless multiple times.

- ✓ Women were more likely to be homeless for the first time than men (63% vs. 45%)
- ✓ 42% of individuals who were experiencing homelessness for the first time are employed (compared to 29% of individuals who had experienced homelessness multiple times)
- ✓ Persons who had been homeless multiple times appear to have more physical challenges:
  - 22% reported physical/mental disabilities (vs. 13%) and 12% reported physical illness (vs. 7%) as a reason for homelessness
  - 26% (compared to 13%) reported disability as a reason they are unable to work
- ✓ Individuals who were experiencing homelessness for the first time had more education; 45% had attended or graduated from college or technical school compared to 30% of those who had experienced homelessness multiple times

## Appendix B. Washtenaw County Blueprint to End Homelessness Process Overview

Task	Who	When
Reviewed potential framework and outline for a 10 year Plan	Washtenaw Housing Alliance (WHA) Operations Committee (OC)	October 2003
Conducted one-on-one interviews with other service providers	OC members	November 2003
Consulted with other communities regarding community planning strategies	WHA with Indianapolis, Atlanta, and Columbus	November 2003-February 2004
Shared results and framework with broad provider community via email and website communication	Washtenaw Housing Alliance (WHA)	December 2003
Established early set of community priorities	WHA drafted and reviewed with provider community via small group meetings and email	February 2004
Conducted community survey of homeless and point- in-time count	WHA, Community Development	March 2004
Formed work groups to conduct research, engage larger audience and recommend actions for each priority area	Work groups made up of WHA members, and other community providers	March and April 2004
Held Provider Forum to share entire draft blueprint, gather input and establish priorities	Entire provider community (150 persons)	May 2004
Conducted community engagement and education sessions with various local associations and groups	WHA Board members and OC members; 1000 people were reached in 40 presentations	Summer 2004

Blueprint was reviewed by National leaders in homelessness and planning. Adjustments made and plan clarified using their feedback	WHA with Interagency Council on Homelessness and Urban Institute	August-September 2004
Made final revisions to Blueprint based on provider forum and input from other stakeholders; Established final priorities for Phase I of implementation	Work teams	June – July 2004
Established work teams, including conveners, champions and general members representing a cross-section of stakeholders in the community	WHA in conjunction with broad community of interest (providers, private sector partners, etc.)	August 2004
Conducted Community Forum to launch the Blueprint within the entire community	350 people attended: people who were experiencing homelessness or were formerly homeless; business leaders; service providers; local government and political leaders; interested citizens	September 21 2004
Launched work teams	WHA with key work team members (champions, conveners)	November 2004
Ongoing planning, implementation and communication	Work teams, WHA	Ongoing

## Appendix C. Process for Estimating Annualized Count

### Formula and Process for Estimating The Number of Persons Experiencing Homelessness Based on 2004 Point-In-Time Count Data

To determine an estimate of the number of persons who have experienced homelessness in Washtenaw County, Community Development staff used a formula provided by Martha R. Burt of the Urban Institute. The following is a summary of the formula and the steps used to calculate the annual projection of persons experiencing homelessness.

It is important to understand that the projection is only as good as your coverage levels and participation levels. If only 50% of your providers participate or your Point-In-Time Count (PITC) does not include Street Outreach, your numbers will obviously be impacted. If methods are not used to determine if those counted by one service provider have not also been counted by another service provider, then duplication error can also greatly influence your overall projection. This formula is only meant to be used as an estimate of the number of persons who may experience homelessness in a given year and does not correct for any other limitations associated with Point-In-Time Count survey methods. Finally, although included in our count for reporting persons, persons living in Permanent Supportive Housing (PSH) are not included in this annual projection.

#### POINT-IN-TIME COUNT DATA REQUIREMENTS

1. Number of Persons who experienced homelessness for 7 days or less (A)
2. Number of Persons who experienced homelessness for 7 days or less for the first time in the year (B). Note: This allows us to determine the number of persons who are newly homeless so that people who are repeatedly homeless in a year are not over-counted.
3. Total Number of Homeless Persons Counted in the Point-In-Time (C)

**Formula:**  $B \times 51 \text{ (weeks)} + C \text{ (Represents 52}^{\text{nd}} \text{ week of the year)} = \text{Annual Projection}$

#### Annual Projection Process

**Step 1:** Determine the number of people from the Point-In-Time Count (sheltered and unsheltered, excluding persons living in PSH) who have experienced homelessness for a week or less (this number includes adult heads of households and those persons accompanying them, single adults, unaccompanied youth, and children).

**Step 2:** Of those counted in Step 1 (the number of these people who have experienced homeless for a week or less) determine the number who have not been homeless at any other point in the year. This number is a projection of the number of persons who will become newly homeless each week.

**Note:** Because we did not have survey data to determine if the person(s) had been homeless at any other point in the year, we estimated this number based on the 1996 National Survey of Homeless Assistance Providers and Clients which found that 17% of those surveyed had been homeless at some other point in the year. Therefore we decreased the number found in Step 1, by 17%.

- Step 3:** Multiply the number of newly homeless persons expected each week (found in Step 2) by 51 weeks.
- Step 4:** Add the numbers from Step 1 and Step 3. This yields the annual projection of people experiencing homelessness in a year (52 weeks) based on the Point-In-Time Count.
- Step 5:** Discuss the annualized number with Homeless Service Providers to determine if the weekly and annual projections are consistent with their own projections. This “reality check” is important since the projection is based on a single Point-In-Time and as such seasonal or event-related reasons may explain why the numbers are unusually high or low and/or may or may not reflect numbers seen at other times in the year.

### **Washtenaw County Estimation Process/Formula**

- Step 1:** Add total number of persons (sheltered and unsheltered, excluding those in PSH)

555 Adults + 110 Children = 665 People experiencing homelessness on the date of the PITC

- Step 2:** 49 people reported that they had been experiencing homelessness for 7 days or less. Based on national research 17% of these people may have been homeless at other points during the year, so this number was adjusted to 41, or 83% of 49.
- Step 3:** If 41 people are newly homeless each week, and there are 51 other weeks (excluding the PITC week) in the year, then the number of persons experiencing homelessness in 51 weeks is:  $41 \text{ (people)} * 51 \text{ (weeks)} = 2091$  people who are homeless in 51 weeks.
- Step 4:**  $665 \text{ people (on PITC)} + 2091 \text{ people (51 weeks)} =$  estimated 2756 people experiencing homelessness in one year.
- Step 5:** Do not skip your reality check. It is critical to talk with providers to determine if there are reasons shelter counts and/or street numbers may be unusually high or low. You also need to take into account your coverage rate and area. Did all providers participate, is a group under or overrepresented, how extensive was your street outreach, etc.

## Resources

For more information on the estimation process, please contact:

The Urban Institute ([www.urbaninstitute.org](http://www.urbaninstitute.org))

Corporation for Supportive Housing (<http://csh.org>)

See the 2005 Publication, *Estimating the Need: Projecting from Point-in-Time to Annual Estimates of the Number of Homeless People in a Community and Using this Information to Plan for Permanent Supportive Housing* written by Martha R. Burt and Carol Wilkins

For more information on the Washtenaw County Continuum of Care Point-in-Time Count process:

Please contact the Washtenaw County Office of Community Development at (734) 622-9025 or

([http://www.ewashtenaw.org/government/departments/community\\_development](http://www.ewashtenaw.org/government/departments/community_development))

## **Appendix D.**

# **Process for Estimating Permanent Supportive Housing Need in Washtenaw County**

This appendix walks through the calculation/formula process for estimating community need for permanent supportive housing.

- Step 1:** Calculated the Units Needed Using PIT data per the CSH formula. Came up with estimate of 854. Calculated a 20% reduction as a reality fact for 683. (See next 2 pages for calculations and calculation process.)
- Step 2:** Looked at Indianapolis and Columbus populations and estimated housing needs as another data point. Found that using Indy's percentage, Washtenaw County would target 645 units, and using Columbus's we would be targeting 484.
- Step 3:** Discussed the process and numbers with Carole and Michael at Avalon Housing. (Discussed the formerly agreed-upon community estimates of 300 and range of 300-500 as part of this discussion.) Agreed on a range of 500 - 650 units, with language for the community overview to read 'at least 500 units'.
- Step 4:**
- A) Tested the range with various stakeholders: Mark Roby, Deb Pippins (she ran it by the entire PORT team), Ellen Schulmeister, Diane Davidson and Donna Sabourin. Got buy-in from everyone.
  - B) Tested our thinking and process with John Peterson at CSH. He supported our process and estimate.
- Step 5:** Went to print with "AT LEAST 500 units" language. Documented process for ALL!

## PSH Unit Estimates For Washtenaw County

Date: September 15, 2004

### Step 1:

$$\text{Episodic} + \text{Chronic} - \text{Overlap} = \text{SamplePSHneed}$$
$$86 + 95 - 39 = 142$$

Episodic = homeless four or more times in last 3 years

Chronic = homeless for 2 or more years

Overlap = number of population who are both chronic and episodic

### Step 2:

$$\text{SamplePSHneed} / \text{Total PIT count (interviewed)} = \% \text{ of sample needing PSH}$$
$$142/455 = .31$$

### Step 3:

$$\% \text{ of sample needing PSH} \times \text{annual projected homelessness in year}$$
$$.31 \times 2756 = 854$$

So, the formula estimate is **854**. Backing down the number by 20% (based on turnover, won't accept housing, community readiness) the number is **683**.

## Estimation process for Generating Estimate of PSH need (from CSH)

PIT data needed:

- How many people are chronic? (A)
  - homeless longer than X years (the high possibility)
- How many are episodic (B)
  - homeless X times or more (the high possibility)
- How many are in both categories? (C)

Initial Formula:  $(A)\text{chronic} + (B)\text{episodic} - \text{overlap}(C) = D$

- Add chronic (length of time homeless) and episodic (frequency) categories together and then subtract anyone who is in both categories.

Creating the PSH unit estimate

- Take that number (D) and determine what percent this group is of the total number surveyed.
- Apply that percent to our annualized number and you have the number of total PSH housing units needed to address chronic homelessness.
- Then: Of D, what percent are families? What percent are individuals?  
(We may want to deliberately increase the family percentage because of how much more they 'hide' in other people's homes or send kids off.)
- Apply that percent to the total housing production number for a reasonable split of demand for families or individual units.
- Most communities then apply what they call a 'Reality Factor': not 100% of that number is what is needed because:
  - turnover
  - won't accept housing or doesn't qualify
  - community acceptance/readiness.

Jacksonville, for instance, took their final housing production generated by this formula and reduced it by 20%.