

USICH BRIEFING PAPER

PREFACE:

Five federal workgroups were convened to initiate development of the federal plan. At their first meeting, each workgroup was presented with an overview of the literature. These were prepared and presented by Carol Wilkins and Janice Elliott, under contract with USICH.

Community Approaches to Homelessness

Scope of the problem: homelessness in the United States

Data from the 2008 Annual Assessment Report to Congress (AHAR) and data provided by HUD for forthcoming 2009 AHAR report¹ indicate the following:

1. **On a single night in January 2009, 643,067 people were homeless.** Of these:
 - **Nearly 63% were “sheltered”**, meaning they were in emergency shelters or transitional housing programs. The other 37% were unsheltered, meaning that they were living in places not meant for human habitation, including sleeping on the streets, in cars, parks, or abandoned buildings. (Note: Neither category includes people living doubled-up or in substandard housing.)
 - 63% (404,957) were individuals (53% sheltered, 46% unsheltered)
 - 37% (238,110) were persons in families (four out of five were sheltered, the rest unsheltered)
 - **Subpopulations**
 - 110,917 were chronically homeless adults (disabled and homeless continuously one year or more, or 4 or more episodes in the past 3 years)
 - this represented 27% of homeless individuals and 17% of all people experiencing homelessness at the single point in time
 - 59% of chronically homeless individuals were unsheltered, a decrease of 7% from 2008
 - Veterans represented about 17% of the sheltered adult population

¹ U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2010). 2009 Annual Homeless Assessment Report (AHAR), forthcoming; and U.S. Department of Housing and Urban Development, Office of Community Planning and Development. (2009, July). *The 2008 Annual Homeless Assessment Report to Congress (AHAR)*. Washington, DC.

- Unaccompanied youth represented 2.3% of all homeless individuals.
 - Persons living with HIV/AIDS accounted for 5% of sheltered individuals
 - Recent victims of domestic violence comprised almost 12% of all sheltered persons
 - Persons with severe mental illness represented about 26% of all homeless adults
 - Persons with chronic substance abuse issues accounted for 36% of all homeless adults.
2. **Over the course of the year (2009), 1,558,000 people used emergency shelters or transitional housing programs.** This represents approximately 0.5% of the 2009 US Population (or 3.4% of the population living below the federal poverty level). This figure includes persons who were unsheltered at various times during the year that accessed shelter at least one night, but it does not include persons who were unsheltered over the course of the year and never accessed shelter. There is no accurate annual count for persons who never access shelter.
- About two-fifths of people entering an emergency shelter or transitional housing program during 2009 came from another homeless situation (sheltered or unsheltered), two-fifths came from a housed situation (in their own or someone else's home), and the remaining one fifth were split between institutional settings or other situations such as hotels or motels.
 - Most people had relatively short lengths of stay in emergency shelters: three-fifths stayed less than a month, and a third stayed a week or less.
 - **Demographics of the sheltered homeless population over the course of the year**
 - **66% were individuals adults (1,034,659)**
 - 70% of people homeless as individual adults (without accompanying children) were men
 - 2.2% (22,722) were unaccompanied youth and several-children households
 - 38% had a disability, compared to 18% of the US population
 - 12% were veterans
 - The most common age group: 31-50 years old (49%)
 - 14.5% of individuals were in institutional settings before becoming homeless
 - **34% were persons in families (535,447)**
 - 60% (323,325) of these were children. More than half (53%) of the children were under age 6.
 - 13% of adults in families had a disability
 - More than half of adults in families were 18-30 years old (55%)
 - Considered as *households* rather than separate people, there were 170,129 sheltered families, and increase of 7% over 2008.
 - Typical homeless family was a mother and 1-2 children
 - Families represented approximately 14% of all sheltered households

- **Families were particularly likely to be housed the night before becoming homeless:** over half were either in their own housing unit (18%), staying with family (27%), or staying with friends (12%).
- On average, families stay in shelter longer than individuals
- **39% were African American.** This is almost 3 times their share of the US population, and 1.7 times their share of the US population living in poverty.

3. Trends 2007 - 2009

- The total number of sheltered people over the course of the year decreased slightly (-2.2%), while household composition continued to shift: Homelessness among persons in families increased by 19,000 (3.6%) from 2008, and 62,000 (13%) from 2007. At the same time, homelessness among individuals not in families decreased by 58,000 (5.3%) from 2008, and over 80,000 (7.2%) from 2007.
- The number of persons who were chronically homeless (counted at a single point in time decreased by 10% from 2008.

4. Causes and Contributing Factors

There is no single estimate of the number of individuals and families at risk of becoming homeless, as people become homeless for a variety of reasons. Some indicators of risk are:

a. High cost of housing in relation to income

- The problem of housing affordability for the poorest households is documented periodically by HUD's Office of Policy Development and Research. HUD's most recent "worst case needs" report, based on American Housing Survey data collected by the Census Bureau in 2005, shows that 5.9 million households - including 2.32 million families with children and 542,000 non-elderly disabled households - are renters without housing assistance, with incomes below 50% of the area median, and paying more than half their income for rent or (less frequently) living in severely substandard housing. And the problem has been getting worse. The number of worst case needs households rose from 4.76% of all households in 2001 to 5.5% in 2005.²
- Overall, the distribution of worst case needs is very similar to the distribution of very low income renters nationwide. Households with worst case needs are more likely to live in poorer neighborhoods. 31% of renters with worst case housing needs were living in the 20% of neighborhoods with the highest poverty rates.
- A January 2010 HUD review of characteristics of US rental housing found that from 2001 to 2007 the nation's affordable unassisted rental housing stock decreased by 6.3%, while the high-rent rental housing stock increased 94.3%. This translates into a loss of more than 1.2 million affordable

² U.S. Department of Housing and Urban Development, Office of Policy Development and Research. (2007, May). *Affordable Housing Needs 2005: Report to Congress*. Washington, DC.

unassisted rental units from 2001 to 2007.³

- Households with extremely low incomes make up 24% of all renters in the US.⁴ By 2008, the average extremely low income (ELI) renter household spent an extraordinarily high proportion of its income on housing costs, largely because the 9.2 million households in search of affordable rental housing were competing for only 6.1 million affordable units. Even before the current economic crisis, 70% of extremely low income renter households spent more than half of their income on rent.⁵
- Conditions in the nation's assisted housing stock have been considerably tighter than the overall rental market in recent years. Vacancy rates in project-based Section 8 developments have not exceeded 5%. Public housing vacancies fell 2% from 2006 to 2008.⁶

b. Unemployment and marginal employment

- Loss of a job or marginal employment directly affects a household's ability to pay for housing. The national unemployment rate in March 2010 was 10.2%, with rates in 28 metropolitan areas of at least 15%.⁷
- Securing and retaining employment is difficult for people who face significant and multiple barriers to employment. Mental health and physical health play central roles in the employment of people who are homeless or at risk for homelessness. People who are homeless often lack skills in stress management and social interaction, independent living skills, and skills for vocational engagement. Substance use disorders, alone or in combination with disabilities, substantially reduce the income people receive from work. Competitive employment is further impeded by receipt of disability payments (and concomitant adverse work incentives) and by race. Barriers such as lack of transportation and educational credentials are prevalent among homeless people in both urban and rural areas.⁸

³ Collinson, R. & Winter, B. (2010, January). *U.S. Rental Housing Characteristics: Supply, Vacancy, and Affordability*. HUD PD&R Working Paper 10-01. Washington, DC: U.S. Department of Housing and Urban Development.. "Affordable" here means affordable to households earning at or below 60% of the local area median income (AMI), excluding subsidized units or no cash rent units. High rent defined as affordable to households earning at or above 100% of AMI.

⁴ Pelletiere, D., (2009, November 30). *Preliminary Assessment of American Community Survey Data Shows Housing Affordability Gap Worsened for Lowest Income Households from 2007 to 2008*. Research Note #09-01. Washington, DC: National Low Income Housing Coalition.

⁵ Wardrip, K., Pelletiere, D., & Crowley, S. (2009, April). *Out of Reach 2009*. Washington, DC: National Low Income Housing Coalition.

⁶ Collinson, R. (2010, January).

⁷ U.S. Department of Labor, Bureau of Labor Statistics. (2010, April 28). Metropolitan Area Employment and Unemployment Summary. Retrieved May 4, 2010 at <http://www.bls.gov/news.release/metro.nr0.htm>

⁸ Long, D., Rio, J., & Rosen, J. (2007, September). Employment and Income Supports for Homeless People. *Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research*. Washington, DC: U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development.

- The employment barriers faced by homeless families are generally similar to those of other low-income families. The key issues are transportation, child care, educational limitations, and substance abuse.

c. Living in overcrowded or substandard housing

- Many people enter homelessness from housing shared with friends or family. Interpersonal conflict (which may or may not be related to overcrowding) is often cited as the reason people had to leave when staying with friends and family. It is not known how many families living in “doubled up” or overcrowded conditions will eventually enter homelessness. The US Census defines “overcrowded” as household occupancy of more than 1 person per room.
- 12% of all individuals that moved between March 2008 and March 2009 joined an existing household, which has been steadily increasing from 9.5 % in March 2005. This increase in household size may be caused by households doubling up in response to the foreclosure crisis, job loss, and the ongoing lack of affordable housing stock in many regions.⁹
- According to federal data on the children and youth identified as homeless and enrolled in public schools in the 2007-2008 school year, only 22 percent lived in shelters. 65% lived doubled-up with other family members or friends, 7% lived in motels, and the remainder lived in unsheltered locations.¹⁰
- Rural renters are twice as likely to live in substandard housing as their urban counterparts (12% of rural versus 6 % of urban renters).¹¹

d. Re-entry from incarceration

- Every year, over 650,000 people are released from prisons and more than 7 million individuals are released from jails in the United States.¹² Nationally, about 54% of homeless persons in shelters report histories of incarceration — 49% report previous time spent in jail and 18% report previous time spent in prison.¹³

⁹ Collinson, R. (2010, January).

¹⁰ National Association for the Education of Homeless Children and Youth. (no date). *Facts About Homeless Education*. Retrieved April 19, 2010 at <http://www.naehcy.org/facts.html#howmany>. The federal definition of homelessness used by all public schools in the United States includes children and youth who lack a fixed, regular, and adequate nighttime residence. This definition specifically includes children and youth living in shelters, transitional housing, cars, campgrounds, motels, and sharing the housing of others temporarily due to loss of housing, economic hardship, or similar reasons.

¹¹ Robertson, M., Harris, N., Fritz, N., & Noftsinger, R. (2007, September). Rural Homelessness. *Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research*. Washington, DC: U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development.

¹² Minton, T. & Sabol, W. (2008, June 6). *Jail Inmates at Midyear 2007*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

¹³ Burt, M., et al. (1999, December 7). *Homelessness: Programs and the People They Serve: Findings of the National Survey of Homeless Assistance Providers and Clients*. Washington, DC: Urban Institute.

- Many aspects of homeless life have become restricted and “criminalized,” to where acts of subsistence and survival, especially in public places, are illegal and can lead to incarceration. While these offenses are often minor, failure to pay fines or follow through with court appearances can lead to incarceration.¹⁴

e. Mental Illness and Substance Addiction

- In its Interim Report to the President in 2002, the President’s New Freedom Commission on Mental Health declared, “... the mental health delivery system is fragmented and in disarray ...lead[ing] to unnecessary and costly disability, homelessness, school failure and incarceration.”¹⁵
- Of the more than two million adults in the U.S. who have at least one episode of homelessness in a given year, 46% report having had a mental health problem within the previous year, either by itself or in combination with substance abuse.¹⁶
- A 23-city survey¹⁷ found that 26% of their homeless population suffered from a serious mental illness – by contrast, 6% of the US population suffers from serious mental illness. The cities reported the top three causes of homelessness among individuals to be substance abuse (cited by 68 percent), lack of affordable housing (60 percent), and mental illness (48 percent).

f. Domestic Violence

- Violence against women is a principal cause of women’s homelessness. Between 22% and 57% of homeless women report that domestic or sexual violence was the immediate cause of their homelessness, depending on the region and type of study.¹⁸

The geography of homelessness

¹⁴Metraux, S., Roman, C., Cho, R. (2007, September). Incarceration and Homelessness. *Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research*. Washington, DC: U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development.

¹⁵The President’s New Freedom Commission on Mental Health. (2003, July). *Achieving the Promise: Transforming Mental Health Care in America*. Washington, DC.

¹⁶Burt, M. (2001). *What will it take to End Homelessness?* Washington, DC: Urban Institute Press.

¹⁷The United States Conference of Mayors. (2008, December). *Hunger and Homelessness Survey: A Status Report on Hunger and Homelessness in American’s Cities, a 25-City Survey*. Washington, DC.

¹⁸National Law Center on Homelessness and Poverty. (2008, September). *Some Facts on Homelessness, Housing, an Violence Against Women*. Retrieved April 19, 2010 at http://www.nlchp.org/content/pubs/DVHomelessnessFacts_September20081.pdf

1. **Homelessness is heavily concentrated in urban areas.** Based on the forthcoming 2009 Annual Homeless Assessment Report, more than two-thirds of all sheltered homeless people were located in principal cities (68%), with 32% located in suburban or rural jurisdictions.¹⁹
 - In 2008, nearly 1 in every 66 persons living in principal cities in the United States accessed a homeless shelter, compared to about 1 in every 450 persons living in suburban or rural areas.
 - Homeless individuals were more likely than families to be in urban areas.
 - More than half of all homeless people on a single night in January 2009 were found in just six states: California, New York, Florida, Texas, Washington, and Georgia.

Ten Continuums of Care with the highest number of households experiencing homelessness on a single night in January 2009

Continuum of Care	State	Households	% all homeless households
Los Angeles City & County	California	39,649	9%
New York City	New York	26,387	6%
Las Vegas/Clark County	Nevada	12,019	3%
New Orleans/Jefferson Parish CoC	Louisiana	7,170	2%
Santa Ana/Anaheim/Orange County	California	7,012	2%
Seattle/King County	Washington	6,628	1%
Georgia Balance of State	Georgia	6,519	1%
Texas Balance of State	Texas	6,423	1%
Atlanta/Roswell/DeKalb, Fulton Counties	Georgia	6,252	1%
Metropolitan Denver Homeless Initiative	Colorado	6,189	1%
Total		124,248	27%

2. **Rural homelessness tends to have a distinctive profile.**²⁰

¹⁹ U.S. Department of Housing and Urban Development (2010), 2009 AHAR, forthcoming

- Most rural people without homes live in cars, with relatives in overcrowded settings, or in substandard housing. Rural areas have fewer shelters or resources for people to turn to, but individuals possess more extensive extended family and friend networks.
- Most rural homeless individuals are experiencing homelessness for the first time and tend to remain homeless for shorter periods.
- Most rural homeless are married, white, working females, often with families.
- Rural areas have a rate of unsheltered persons in families almost double that of urban areas.²¹
- 30% of rural households (approximately 6.2 million homes) have one or more serious household problems that endanger health or safety of inhabitants.
- Rural America also experiences housing instability among large Native American and farm labor populations.
 - In 1990, the US Census reported that 32.5% of households on American Indian Reservations and Trustlands (excluding Alaska) were overcrowded, and 40.4% of households in Alaska Native Village Statistical Areas were crowded. In comparison, in the United States as a whole, only 4.9% of households were crowded.²²
 - A 2006 survey of tribes in northern Minnesota found that over 1200 American Indians were homeless or near-homeless within six reservations. 63% of survey respondents were living in overcrowded housing, with the average number of residents per room at 1.5.²³

3. Trends from 2007-2009

Between 2007 and 2008, the sheltered homeless population grew substantially in suburban and rural areas, then declined slightly in 2008. In principal cities, the sheltered population experienced a continual decline from 2007 to 2009, with a total decrease of 13%.²⁴ This was a change from the trends from 2005-2007 when homelessness in major cities increased by 4%.

²⁰ Council for Affordable and Rural Housing. (2007, January/February). Homelessness in Rural America. *CARH News*.

²¹ National Alliance to End Homelessness. (2009, September 29). *Geography of Homelessness, Part 3: Subpopulations by Geographic Type*. Retrieved April 19, 2010 at <http://www.endhomelessness.org/content/article/detail/2529/>

²² Native American Indian Housing Council. (2001). *Too Few Rooms: Residential Crowding in Native American Communities and Alaska Native Villages*. Washington, DC.

²³ Wilder Research. (2007, November). *Homeless and Near-Homeless People on Northern Minnesota Indian Reservations: 2006 Study*. Retrieved April 19, 2010 at <http://www.wilder.org/download.0.html?report=2018>

²⁴ U.S. Department of Housing and Urban Development (2010), 2009 AHAR, forthcoming.

Fifteen states with the most persons experiencing homelessness on a single night in January 2009

State	Individuals	Persons in Families	Total	% All Homeless Persons
California	106,985	26,144	133,129	20.7%
New York	24,557	36,510	61,067	9.5%
Florida	34,432	21,167	55,599	8.6%
Texas	22,564	14,197	36,761	5.7%
Washington	12,086	10,696	22,782	3.5%
Georgia	14,365	5,995	20,360	3.2%
Oregon	10,443	6,866	17,309	2.7%
Massachusetts	7,057	8,425	15,482	2.4%
Colorado	7,401	7,867	15,268	2.4%
Pennsylvania	7,384	7,712	15,096	2.3%
Arizona	9,959	4,762	14,721	2.3%
Nevada	12,769	1,709	14,478	2.3%
Illinois	7,475	6,580	14,055	2.2%
Michigan	7,857	6,148	14,005	2.2%
New Jersey	5,962	7,207	13,169	2.0%
Total	285,334	164,778	450,112	70%

Impact of homelessness on States and communities

The impact of homelessness is felt in many ways by neighborhoods, municipalities, counties, and states. Areas of primary impact within local communities:

1. Emergency rooms, hospitals and Medicaid²⁵

- Most communities experience a small number of individuals who repeatedly and excessively utilize hospital emergency department and inpatient services as their primary source of medical care. In general, frequent users experience chronic physical conditions, mental illness, substance abuse disorders, or homelessness, and most have some combination of these conditions.
- Hospital emergency departments are a community resource, and the only health care resource that, by law, must serve everyone, regardless of a patient's ability to pay. Providing emergency department and inpatient hospital services can be extremely expensive. Frequent users' hospital visits account for disproportionate costs and time for emergency departments, drain state and county health care resources, and increase stress on emergency department staff.
- The Center for Health Care Strategies reports that 5% of total Medicaid beneficiaries drive up to 50% of total Medicaid spending.

2. Educational systems

- By the time homeless children reach school age, their homelessness affects their social, physical and academic lives. Homeless children's academic performance is hampered both by poor cognitive development and by the circumstances affecting their homelessness. They are four times more likely to have developmental delays, and two times more likely to have learning disabilities. Homeless children are more likely to school poorly on math and reading tests, and are more likely to be held back a year in school.²⁶

3. Neighborhoods and downtown business districts

- The visibility of homelessness on the street and aggressive panhandling may discourage shoppers from visiting downtown areas and contribute to perceptions that neighborhoods or downtown districts are unsafe or undesirable.

4. Jails, court systems and community safety

- Prisons and jails treat more people with mental illness than hospitals and residential treatment facilities combined, making our jails and prisons the primary provider of mental health care in the US. 43% of defendants with mental disorders were homeless when committing the crime for which they were

²⁵ The Lewin Group. (2008, October). *Summary Report of Evaluation Findings: A Dollars and Sense Strategy to Reducing Frequent Use of Hospital Services*. San Francisco, CA: Frequent Users of Health Services Initiative; and Corporation for Supportive Housing. (2009). *Frequent Users of Public Services: Ending the institutional circuit*. New York.

²⁶ Better Homes Fund. (1999). *Homeless Children: America's New Outcasts*; Sandel, M., Sharfstein, J., & Shaw, R. (1999, March). *There's No Place Like Home: How America's Housing Crisis Threatens Our Children*. San Francisco: Housing America; and Hart-Shegos, E. (1999, December). *Homelessness and its Effects on Children*. Minneapolis, MN: Family Housing Fund.

arrested.²⁷

- Among the 20,000 mentally ill parolees exiting California prisons each year, about 3,500 become homeless. 94% return to prison within 24 months.²⁸
- The cycle of arrest, removal, incarceration, and re-entry is predominantly concentrated in the poorest communities and neighborhoods.²⁹

5. Shelters

- Communities in the US spend significant dollars on providing shelter and temporary housing to people who are homeless. They operate 211,222 year-round emergency shelter beds and 205,062 transitional housing beds serving people who are homeless, for a total of 416,284 beds. These are split about half and half between beds for families and those for individuals. Communities also operate over 57,000 seasonal and overflow beds or vouchers.
- 70% of shelter beds and 62% of transitional beds are located in principal cities; the remainder are in suburban and rural areas. The overall proportion of beds dedicated to homeless individuals and persons in families has remained fairly constant since 2006.
- People who are turned away from shelters because the shelters are full or for other reasons often find refuge in abandoned buildings, cars, parks, under bridges, or other spaces not meant for habitation.

Typical features of state and community plans to end homelessness

Over the past fifteen years, federal policy has stimulated the development of three types of community networks and planning bodies to address homelessness. Each of these bodies is designed to change the systems that impact people who are homeless or at risk of becoming homeless:

1. Continuums of Care

- A Continuum of Care is a local or regional system for providing housing and services appropriate to the whole range of homeless needs in the community, from homeless prevention to emergency shelter to permanent housing. In 1995, HUD implemented the Continuum of Care approach to streamline the existing competitive funding process under the McKinney-Vento Homeless Assistance Act and to

²⁷ Corporation for Supportive Housing. (2009). *Getting Out with Nowhere to Go: the Case for Re-entry Supportive Housing*. New York.

²⁸ Corporation for Supportive Housing. (2009). *Getting Out*

²⁹ Travis, J., et al. (2001, June). *From Prison to Home: the Dimensions and Consequences of Prisoner Re-entry*. Washington, DC: Urban Institute Justice Policy Center.

encourage communities to coordinate more fully the planning and provision of housing and services for homeless people. Over the years, Continuums have moved toward significantly greater planning and involve more players.

- By 2001, the vast majority of cities, counties and states were organized into one of the more than 450 Continuums of Care. Continuums of Care are often, but not always, the implementing vehicles for community Ten-Year Plans to End Homelessness.
- A 2002 HUD-sponsored evaluation of 25 high-performing Continuums of Care found that the continuum process stimulated significantly increased communication and information-sharing among homeless service providers and with mainstream entities, which has led to increased coordination of programs and services.³⁰

2. Municipal, county, or statewide Ten-Year Plans to End Homelessness

- In 2000, the National Alliance to End Homelessness released “A Plan, Not a Dream: How to End Homelessness in Ten Years.” Drawing from research and programs around the country, the plan incorporated a major shift in orientation and emphasis, from managing homelessness to ending it. It served as a model for planning by local communities.
- In 2001, ending chronic homelessness in 10 years became a goal of the Bush administration, and the USICH was revitalized. USICH challenged cities to create plans to end chronic homelessness; this challenge was later expanded to include all homelessness.
- At the close of 2008, 860 cities and counties across the country had partnered in developing 355 local and regional Plans to End Homelessness.³¹
 - 234 of these plans are completed, representing 185 city or county plans (79%), 25 state plans (11%), and 24 regional plans (10%).
 - Of those completed, the vast majority (84%) are designed for a length of 10 years. The first 10-year plans will start to reach their expiration date in 2012 unless they are extended or amended.
- **Primary strategies outlined in the plans**³²
 - **Homelessness prevention.** An overwhelming majority address emergency prevention (e.g., one time rental or utility assistance, landlord negotiation, etc.) and over 80% outline systems prevention activities such as discharge planning from correctional facilities, foster care systems, or mental health

³⁰ Burt, M., et al. (2002, May). *Evaluation of Continuums of Care for Homeless People: Final Report*. Washington, DC: U.S. Department of Housing and Urban Development.

³¹ National Alliance to End Homelessness. (2009, September). *A Shifting Focus: What's New in Community Plans to End Homelessness*. Washington, DC.

³² National Alliance to End Homelessness. (2009, September). *A Shifting Focus*.

facilities.

- **Permanent Housing.** Over 90% include strategies to provide permanent housing, including permanent supportive housing.
 - **Income.** Over 80% include strategies to increase income and employment.
 - **Rapid Re-housing and Shortening Homelessness.** More recent plans have placed greater emphasis on strategies to move homeless people quickly from shelter to housing and shorten the length of homelessness (68%, as compared with 56% of earlier plans).
 - **Outreach and Links to services.** While the majority of plans include strategies to engage people living on the streets and to link people with services, fewer recent plans include these in favor of strategies to prevent and shorten homelessness.
- A 2007 analysis of ten year plans by NAEH found that about a third of the plans focus exclusively on ending chronic homelessness, but the majority (66%) target all homelessness.

3. State-level Interagency Councils on Homelessness

- From 2001 to 2005, federal agencies worked together to organize Policy Academies to help States to begin planning to end homelessness. Nine Policy Academies and one National Learning Meeting were held, attracting teams of representatives from mainstream state agencies. Every state and two territories sent teams to at least one of the Policy Academies, which either focused on ending chronic homelessness or ending family homelessness.
 - In tandem with this process, USICH encouraged every State and territory to establish by legislative authority or Governor's Executive Order a State Interagency Council on Homelessness with representation at the Cabinet level from the mainstream income support, health care, behavioral health, human services, veterans, corrections, transportation, education, and labor departments and agencies. **To date, Governors of 53 states and territories have taken steps to create State Interagency Councils on Homelessness.**
 - State Interagency Councils have taken the lead in several states to sponsor the development of 10-year plans to end homelessness.
4. Continuums of Care, Ten-year planning bodies, and State Interagency Councils vary in composition and level of activity by community. The level of integration between these three planning entities also varies.

Ways in which communities have experienced success in implementing plans to end homelessness

The research on successful practices in implementing plans to end homelessness is limited, as the majority of plans were created only within the past five years. Because most of the early plans originally focused on ending chronic homelessness, several of these communities have made more documented gains in this area than in others, particularly through the creation of permanent supportive housing.³³ Research has identified effective systems change practices used by these communities that hold promise for replication in other places.³⁴

1. Strategies that facilitate implementation

- **Having someone whose job is system change** – the Coordinator role. Several communities have recognized the critical importance of having one or more people who serve as the “glue” to the implementation process: facilitating, coordinating, stimulating, reminding, organizing, assessing progress, bringing in new players, and keeping the many actors moving in the right general direction.
- **Re-orienting the Continuum of Care.** Ending homelessness in 10 years involves changes in the ways that providers of homeless assistance do their work. Communities have found that enlisting the involvement and advocacy of providers in supporting change, and providing them help in making the change, has been critical.
- **Matching homeless clients with appropriate housing and services.** When a community is sufficiently advanced in creating appropriate housing and service models to end homelessness, it may encounter the problem of ensuring that people who need to be served are matched appropriately with the level of services that they need. Several communities have created mechanisms to facilitate this matching and targeting, although it is still an imperfect science.
- **Simplified funding mechanisms.** A few communities have been successful in creating mechanisms to assemble funding resources in one place and to provide a single application process or a single resource coordinator to manage funding.
- **Employing cross-system strategies.** A growing body of research has demonstrated that targeted interventions employing cross-system strategies can make better use of limited public resources by interrupting patterns of repeated rounds of institutional and emergency care through various systems.³⁵ Examples of such cross-system strategies include data sharing between agencies to identify high cost

³³ Several large cities reported sizable declines in the number of persons who were chronically homeless between 2007 and 2008. These include New York City (-26%), Phoenix (-20%) and Philadelphia (-8%).

³⁴ Burt, M. & Spellman, B. (2007, September). Changing Homeless and Mainstream Service Systems: Essential Approaches to Ending Homelessness. *Toward Understanding Homelessness: The 2007 National Symposium on Homelessness Research*.

³⁵ Corporation for Supportive Housing. (2009). *Frequent Users of Public Services: Ending the institutional circuit*. New York.

frequent users and target services; integrated services by multidisciplinary teams; linkages between hospital or jail and community providers to support “in-reach” and coordinate care; and partnering housing creation with service planning.

2. Factors affecting the likely success of local efforts to change systems

▪ Context of the local community and state

- **Taking advantage of a trigger event.** Some communities have found that a trigger event – such as downtown redevelopment, new law or ordinance, or a lawsuit - has been an opportunity to mobilize advocacy and commitment to new approaches to ending homelessness.
- **Capitalizing on frustration within the funder or provider community** with the ineffectiveness of the current system can increase receptivity to change.
- **Using data demonstrating the impact and cost effectiveness of strategies** can influence policymakers, especially when the data is relevant to one’s own community,
- **Economic and social climate.** The economic condition of the community and the community’s support for efforts to end homelessness may impact the ability to secure public support for systems change.

▪ Interest and commitment of key stakeholders

- **Involving stakeholders beyond the “usual suspects.”** Communities that have succeeded in involving a wider variety of stakeholders – such as mayors, county executives, business associations, business improvement districts, faith communities- have found their presence to be useful in many ways, including championing plans, building public support, and securing funding.
- **Engagement of philanthropy.** Nationally, foundations (community, family, and corporate) and United Ways have become increasingly active in funding and providing leadership for community efforts to end homelessness. This participation is fueled by collaboratives such as Funders Together which provide technical expertise and support to philanthropy in supporting community plans to end homelessness.
- **Involving agencies with resources and decision-making authority.** Local communities seldom control key resources or are in a position to make policy decisions essential to ending homelessness. A city will be dependent on cooperation from county agencies that control services. Cities and counties will be dependent on state agencies and their policies, especially those affecting housing and health care resources. Localities have increased their chances for success by bringing these agencies to the table.

Those that have had the most success recognize that mainstream agencies need to be seriously involved in broader-scale planning and coordination efforts and spared the details of the Continuum of Care application process. Key components to successful integration are strong leadership in the

homeless assistance system and a commitment from both mainstream agency leadership and homeless-specific program and service providers to work together.³⁶

- **Involving citizens.** Some communities have used Homeless Connect and other methods to foster greater human connection between people experiencing homelessness and community volunteers.
 - **Governance and management structure.** A community is more successful if its efforts are intentional and it establishes a leadership, decision-making, and management structure that fits its anticipated goals and processes.
 - **Scope of the desired change.** The extent to which there is a shared vision for ending homelessness will affect the success of system change. For some communities, it has been more strategic and feasible to focus on solutions for a particular subpopulation (such as people experiencing chronic homelessness); for others, it has been important to establish a broader vision to bring critical partners to the table.
 - **The community's starting point and the scope of its vision.** The process by which a community implements its plan is most significantly affected by the level of communication, coordination and collaboration that is in place when it begins, and the scope of its vision. Communities are most successful when they focus on actions that will affect changes in these five areas:³⁷
 - **Power** – there are designated positions – people with formal authority – responsible for the new activity.
 - **Money** – routine money is earmarked for the new activity in a new way, or there is a pattern of recurring special funding on which most people in the system can rely.
 - **Habits** – people in the system interact with each other to carry out the new activity as part of their normal routine – not just in response to a special initiative or project.
 - **Technology or skills** – a growing cadre of skilled practitioners exists throughout the delivery chain, practicing methods that were not previously common and setting a standard for effective delivery of results.
 - **Ideas or values** – There is a new definition of performance or success, and often a new understanding of the people to be served and the problem to be solved. The new definition and understanding are commonly held among most or all of the actors in the system, such that they are no longer in great dispute.
3. **Accountability and benchmarking.** In 2006, NAEH developed an implementation strength score based on whether a plan:
- Identified performance measures
 - Set a timeline

³⁶ Burt, M., et al. (2002, May).

³⁷ Burt, M., et al. (2002, May); and Greiff, D., Proscio, T., & Wilkins, C. (2003, July). *Laying a New Foundation: Changing the Systems that Create and Sustain Supportive Housing*. New York: Corporation for Supportive Housing.

- Identified specific funding sources
- Identified bodies responsible for the implementation of each strategy

They found that **implementation of plans is a challenge for many communities**, as many have not incorporated these business principles. Most of the scores fell between 0 and 2 (the highest being 4). Overall, communities scored higher on their plans to create permanent housing and data systems, and lowest on plans to shorten homelessness and implement rapid re-housing strategies.³⁸

Primary obstacles that communities experience in implementing their plans

1. As changes in political leadership have occurred, states and jurisdictions have had variable success in renewing State Interagency Councils and continuing support for the Ten Year Plans. Additionally, many states and cities have reported that the state/local resources to support implementation have been reduced or eliminated due to the recession and declining revenues.
2. In the 2002 HUD-sponsored evaluation, the 25 high-performing Continuums of Care consistently said that the **principal challenge facing their community in preventing and eradicating homelessness continues to be centered on the lack of permanent affordable housing**. Each community also identified at least one of the following groups as being hard to serve with existing resources
 - chronically homeless persons with mental illnesses and/or substance abuse problems
 - youth
 - large families and/or families with teenage sons
 - ex-offenders.³⁹
3. State-level participants in federal Policy Academies provided the following feedback on what would help them move forward:⁴⁰
 - **Increase collaboration among Federal, State and Territory partners**
 - Increase coordination at the Federal level by creating common data elements, funding streams, and definitions for homelessness
 - Provide guidance on how to integrate multiple plans and councils
 - **Support different approaches to meet varying need**
 - Tailor assistance for rural areas by conducting research to document effectiveness of rural models
 - Regionalize funding, planning, and delivery of services and housing

³⁸ National Alliance to End Homelessness. (2006, November). *A New Vision: What is in Community Plans to End Homelessness?* Washington, DC.

³⁹ Burt, M., et al. (2002, May).

⁴⁰ U.S. Department of Health and Human Services, Health Resources and Services Administration. (2004). *A Report on the Homeless Policy Academies National Learning Meeting: Executive Summary*. Washington, DC.

- Provide resources for planning and capacity-building
- **Address gaps in and supply of affordable housing stock**
 - Increase funding for housing by providing funds for operation and supportive services, not simply housing
 - Invest in provider capacity to access resources and develop housing
 - Maximize resources by involving public housing authorities in the change process; fully utilize Section 8
- **Increase access to mainstream system resources**
 - Enhance coordination and institute policy changes by creating universal application and eligibility processes for all Federal programs;
 - Expand presumptive disability for people who are homeless
 - Create State and Territory mandates to set aside resources for homelessness
 - Mandate that publicly-funded institutions cannot discharge to homelessness
 - Provide income supports and housing options for people with primary substance abuse diagnosis; institute a Medicaid waiver to serve homeless people; provide universal health coverage
- **Integrate data systems and reporting requirements**
 - Improve use of data as a planning tool by creating a cross-walk of all Federal programs and funding; think strategically about the use of technology and potential barriers; share strategies for using data to identify needs, make a case, and show cost savings.