

# NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

Prepared for the City of New Haven

December 2015

# NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

## *Acknowledgements*

This report is written for the persons that are at risk for homelessness, are homeless, or have previously been homeless. It is their human right and our public duty to do the best that we can do to provide the most effective services. This report was prepared by Denise Stevens, Ph.D., President MATRIX Public Health Solutions, Inc., and commissioned by the City of New Haven (Mayor Toni Harp, Dr. Martha Okafor, Community Services Administrator) with support from the Community Foundation for Greater New Haven, the Melville Charitable Trust, Housing Authority of the City of New Haven (Karen DuBois-Walton, Executive Director), United Way, and the Board of Education (Susan Weisselberg, Director Wrap Around Services).

## Special thanks to:

- Greater New Haven - Opening Doors Co-Chairs (Reverend Bonita Grubbs, Executive Director, Christian Community Action Agency and John Bradley, Executive Director, Liberty Community Services)
- Sarah Fox – Manager, Advocacy & Community Impact Initiatives, Connecticut Coalition to End Homelessness
- Bidisha Nath, M.D. – Intern City Hall
- New Haven Homelessness Advisory Committee
- Homeless Providers
- Community Stakeholders
- Homeless individuals who shared their stories and challenges

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## Introduction

This report presents the results of an in-depth analysis of the current system of care for the homeless population in New Haven, Connecticut and its contiguous towns. The scope of this work included gathering prevalence data, identifying funding sources, outlining the current system of care, identifying gaps and barriers, and presenting recommendations.

Specifically, this report: 1) provides a description of the current continuum of care delivery system for homeless persons; 2) presents the results of a needs assessment (through a situational and environmental analysis) to identify gaps and barriers; 3) examines data, policies, procedures and practices used by homeless shelters, transitional, supportive housing organizations, Housing Choice Voucher (Section 8) and Low Income Public Housing programs of the housing authority, Board of Education, as well as Fresh Start (prison re-entry); 4) investigates 'best practices' nationally and compares and contrasts to current work in New Haven; and 5) synthesizes information learned across points 1 through 4 with the goal of developing a New Haven plan of action to guide both current (i.e., expenditure of the City's \$1.1 million in general funds) as well as future investments (i.e., seeking external funding) towards ending homelessness in New Haven.

The types of questions addressed include:

- a. What is the prevalence of homelessness in the New Haven area and how does it compare and contrast to other similar cities in the state and nation?
- b. What are the characteristics of the homeless population in terms of socio-economic factors (e.g. race/ethnicity, education, age, gender, employment, etc.), veteran status, prison re-entry, primary health and behavioral health issues?
- c. What is the prevalence of people at risk of being homeless and on waiting lists for housing subsidies (e.g., Section 8), and how do their unstable housing or risk factors impact homelessness and our systems of care for ending homelessness?
- d. What is the prevalence of youth/students with housing instability and how does our system of care address their needs?
- e. What types of services are currently being provided to the homeless population and those at-risk of being homeless from a full continuum of care perspective?
- f. What are our strengths and gaps and barriers in service delivery that need to be addressed in order to prevent people from being homeless, support those who are homeless to get stable housing, and assist those placed in housing to maintain their housing and live productive lives?

## Relevant Background

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 is the federally mandated legislation that governs Housing and Urban Development (HUD) funding to states and communities. The HEARTH Act amended and reauthorized the McKinney-Vento Homelessness Assistance Act with substantial changes, including new definition of homelessness, an emphasis on prevention services, an increase in emphasis on performance, and a focus on coordinated access and assessment. The goals of the HEARTH Act include:

- No one (single adult or family) is homeless longer than 30 days
- Reduce new episodes of homelessness
- Reduce return entries into homelessness

OPENING DOORS is the strategic plan that accompanies the HEARTH Act that guides the work of federal agencies as it relates to preventing and ending homelessness. HUD, through its Continuum of Care programs, places priorities on certain activities at the state and communities level, to restructure their crisis response system to embrace coordinated access and rapidly house homeless persons. States and communities around the country have been responding to these changes adopting the Opening Doors framework and developing continuums of care (COC) that reflect a focus on housing first. The City of New Haven is part of the Greater New Haven – Opening Doors COC.

Performance criteria against which states and communities are judged and obtain funding for include:

- Number of people who become homeless
- Length of time homeless
- Returns to homelessness
- Jobs and income
- Thoroughness in reaching homeless population

In order to meet these new goals, objectives and outcomes driven by the federal requirements, system transformation has been underway in the Greater New Haven Area. The system of organizations providing services to the homeless must now shift their thinking from providing emergency shelter and support, to providing housing and connecting people served to longer term support including job readiness and financial stability. Homeless shelters whose mission was to provide shelter, food and case management, are now in the position of finding ways to get their clients into housing as quickly as possible, in order to align with the federal funding mandate.

In this report data is presented that includes information specific to the City of New Haven, and when available, the surrounding contiguous communities.

## Methods

The needs assessment was structured as a situational and environmental analysis of the current system of care for the homeless populations in New Haven and the surrounding communities. A combination of qualitative and quantitative approaches was used to understand and analyze the system of care including:

- Extensive secondary document review including grantee proposals, meeting minutes of ongoing relevant initiatives, provider survey results, web documents locally, regionally, and nationally
- Literature review on evidence-based and promising practices
- On-site attendance at over 10 public committee meetings to gather information on current initiatives, review the development of policies, procedures, guidelines and action steps
- Key-informant interviews with over 15 stakeholders to obtain specific information about the system of care components (e.g. shelters, transitional housing, permanent supportive housing, wrap around services), as well as gaps and barriers
- Direct observation of shelters and clients
- Data gathering and analysis including data on prevalence, housing stock, finances, gaps and barriers (e.g. Community Forum with 37 participants)

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## Results

### 1. Prevalence - Comparisons Between New Haven, the State and the Nation

Table 1 illustrates that the general composition of the homeless in New Haven is similar to that of the State of Connecticut based on Point in Time Estimates conducting in January 2014. There were 566 homeless individuals counted in New Haven (compared with 619 in Hartford and 237 in Bridgeport). Consistent with the state, 52% of the population identified reported a substance abuse history and 41% a history of mental illness. New Haven County had the highest percent in the state for homeless families. Of note is the 124 chronically homeless<sup>1</sup> individuals that became a focus for the 100 Day Challenge to End Chronic Homelessness whose results will be described later in the report.

Table 1: Prevalence of Homelessness (Point in Time Estimates, 2014)

	New Haven	State of Connecticut	Nation
Single Adults	347 (61%)	2278 (64%)	387,845
Adults in Families	94 (17%)	513 (14%)	222,197 (includes children)
Children in Families	125 (22%)	775 (22%)	
Homeless Veterans*	33 (7%)	221 (6%)	58,063
Chronic Homeless*	124 (28%)	708 (20%)	92,593
Youth under 18*	0	5 (0.1%)	46,924
Substance Abuse History*	229 (52%)	1440 (52%)	
Mental Illness History*	180 (41%)	1172 (42%)	
Domestic Violence History*	20 (4%)	389 (14%)	
<b>Total</b>	<b>566</b>	<b>3571</b>	<b>610,042</b>

*Source:* Point in Time Survey Emergency Shelters & Transitional Housing, Connecticut Coalition to End Homelessness Report, 2014 and National Coalition to End Homelessness 2013). National counts for PIT are not available therefore these are estimates based on 2013 person counts (not shelter). \*Subsets of total count.

The January 2014 Point in Time Estimates (PIT) presented in Table 1 reflect the counts of homeless that were staying in emergency shelters and transitional housing. Every second year the PIT includes counts of those observed on the streets as well as in shelters. These estimates (i.e., street counts and PIT institution) are typically viewed as underestimates of the true counts of the homeless population

<sup>1</sup> Chronic homelessness is a long-term or repeated homelessness of a person or family headed by a person with a disability (NAEH).

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because they do not include ‘doubling up’ where individuals and families are able to find shelter on the count night with family or friends who take them in temporarily due to the extreme weather conditions as well as the fact that homelessness is a dynamic process where people can enter into and out of the system ‘episodically’ throughout the year.

### 2. Housing Inventory New Haven and New Haven Region

Currently the City of New Haven has **emergency shelter** space to accommodate 456 individuals across a variety of shelter types including family units (45 units with 155 beds), adult units (53 designated for females only), as well as special units designated for youth (4) and veterans (3)(see Table 2).

There are an additional 123 beds available in the New Haven region (e.g. Milford, Derby and 2 Domestic Violence Shelters unspecified locations but outside of New Haven). In addition during the cold weather months, an additional 123 beds are made available as seasonal and overflow beds and motel vouchers may be provided for short term stays through a few organizations.

Table 2: Housing Inventory for the Homeless: City of New Haven and New Haven Region

Type	Emergency	Permanent Supportive	Transitional
Family Beds	155 (45)	397 (43)	107
Family Units	45 (14)	130 (19)	37
Adults	174 (55)	700 (205)	106
Veteran	3 (12)	100 (117)	26
Youth	4		18
Seasonal	87 (23)		
Overflow	36		
<b>Total</b>	<b>456 (123)</b>	<b>1197 (248)</b>	<b>213 (0)</b>

*Source:* Balance of State Continuum of Care Report for New Haven County July 2014 (surrounding community area separated out in brackets)

Table 3 presents the breakdown of Emergency Shelters by name of organization, types of shelter provided and current capacity. In general, the City of New Haven is the main hub for addressing homelessness in New Haven County. There are proportionally more service providers in the city than in any other community within the county. The prevalence of homelessness in Meriden, Middletown and Waterbury is significantly lower. In this report data is presented that reflects the towns contiguous to the City of New Haven. There are 4 emergency shelters outside of the city and 2 of them are for victims of domestic violence.



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Table 3: Emergency Shelters and their Capacity in New Haven and New Haven Region

Name	Type	Capacity
New Haven		
Christian Community Action	Families – Hillside Davenport Families – Hillside Sylvan	38 (7 family units) 47 (10 family units)
Columbus House	Single – Abraham’s Tent (seasonal) Single – HCHV/EH Single – Medical Respite Single – Overflow Shelter	12 76 12 75 (6 plus during no freeze)
Emergency Shelter Management Services	Single – Males	75 (98 during no-freeze)
New Reach	Families - CareWays Shelter Families - Life Haven* Families - Martha’s Place	33 (10 family units) 33 (15 family units) 24 (3 family units)
Youth Continuum	Single Youth - Male & Female	4
New Haven Region		
Area Congregations Together - Derby	Singles – Spooner House Families – Spooner House Seasonal	26 10 (2 family units) 8
Beth-El Center. - Milford	Singles Families Seasonal	17 17 (6 family units) 15
BH Care	Families – Domestic Violence Families – Domestic Violence	15 (3 units) 15 (3 units)

\*Life Haven has the potential to serve 20 families in 20 units (bathrooms are undergoing renovations)

The system of care for the homeless goes beyond just emergency shelter and transitional housing units (temporary for up to 24 months) to also include Permanent Supportive Housing (PSH) and Rapid Rehousing. With respect to Rapid Rehousing during the period 6/1/13-6/30/14 there were 70 households that received support (7 single adults and 63 families). Rapid Rehousing is an initiative that was established to quickly move families and individuals from the street into affordable housing with subsidies provided. This strategy forms the basis for communities that have undertaken 100-Day Challenges to end homelessness (refer to Appendix 3).

There are different types of PSH including: a) traditional single-site model; b) scattered-site models; c) clustered scattered-site models; d) public housing-based models; and e)integrated models of affordable-supportive housing. “Integrated affordable supportive models and supportive housing developed in partnership with Public Housing Authorities (PHAs) are the newest approaches to creating PSH that: a) tap the prolific development capacity of the mainstream affordable housing sector, b) can further increase PSH availability, and c) create more integrated and “normalized” settings for formerly homeless tenants.”<sup>2</sup>

<sup>2</sup> Corporation for Supportive Housing ([www.csh.org](http://www.csh.org))

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As of July 2014 there are 1197 permanent supportive housing units in the New Haven area (representing scattered site housing and facilities) and 213 transitional housing units that house homeless individuals and their families in more stable settings across the community. Over the past several years there has been a push nationally for federally funded continuum's of care to transform transitional housing units (by definition lengths of stay up to 2 years) into permanent supportive housing units as the latter have been shown to be more effective for addressing the complex needs of the homeless. The PSH unit types and the organizations responsible for them represent a broad array of service provider specializations including those that are capable of addressing homeless individuals with serious mental illness, substance use/abuse histories, HIV/AIDS, chronically homeless, and veterans.

The Transitional Housing Programs are run by:

- Christian Community Action (Stepping Stone – 51 beds)
- Columbus House (Harkness House, On the Move – 33 beds)
- Continuum of Care (Norton Street Parkway Project – 12 beds)
- Liberty Community Services (Transitional Living Program - 16 beds)
- New Reach (48 beds)
- The Connection (Pendleton – 22 beds)
- US Department of Veteran Affairs (Brownell House – 9 beds)
- Youth Continuum (Umoja – 18 beds)

The New Haven based Permanent Supportive Housing Units are run by:

- Columbus House
- Community Renewal Team
- Continuum of Care
- DMHAS – Shelter Plus Care (individuals and families)
- Fellowship Place
- Leeway
- Liberty Community Services
- New Reach
- The Connection Inc.
- The Work Place
- Veteran's Administration

Organizations responsible for the 148 Permanent Supportive Housing Units outside of New Haven include (note the majority are VA):

- Beth-El Center
- BH Care
- Columbus House – scattered sites
- Leeway – Welton
- Veteran's Administration

Other identifiable housing stock outside of the shelter system include:

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- a) Affordable Housing – Opening Doors is working with local landlords to incentivize them to participate in affordable housing by providing up to 70% of the rent directly to the landlord with the tenant paying 30%. In the fall of 2014 Opening Doors held their first landlord – provider meeting to discuss challenges and the need for more landlords to participate. In addition there are affordable properties managed by larger property companies that include:
  - 15 properties for the elderly with 1 and 2 bedrooms available (outside of NH and in region have additional 18 properties)
  - 14 properties for families (outside of NH have additional 3 for families)
  - 5 properties for the disabled (outside of NH have additional 2 for disabled)
  - 0 properties for health care
- b) Public Housing – The Housing Authority of the City of New Haven (HANH) currently has 2,590 units of low income public housing throughout the City of New Haven for low income households with 6% or 167 units are set aside for homeless prevention with turnover of 15-20/yr. Additionally HANH has 3,310 Housing Choice Vouchers (Section 8 subsidy units) leased and 11% or 370 units are set aside for homelessness prevention/supportive housing.
- c) State Department of Housing – Rental Assistance Program (RAP) is managed by D’Amelia and Associates and provides rental support to low-income families (who must contribute 40% of their income towards rent). Individuals and/or families are able to apply to this program and may choose to live in communities throughout the area.

### 3. Composition of Emergency Shelters

In order to understand more about the population of homeless individuals in New Haven and how they compare to the rest of the state shelter providers were asked to share Housing Management Information System (HMIS) data for a one-year time interval (7/1/13-6/30/14)(Table 3). The City of New Haven currently contracts with two providers to support single homeless adults. Emergency Management Shelter Services (EMHS) has 75 beds, its capacity increases during no freeze nights, and it is open daily 365 days a year. Columbus House (HCHV-EH) has 81 beds and is open 365 days a year. In addition Columbus House provides an Overflow Shelter which is open from approximately November 15<sup>th</sup> – May 1<sup>st</sup> each year. This shelter has 75 beds however additional cots are added during no freeze nights. The shelters are wet shelters. Taken together, during the coldest months of the year New Haven has the capacity to house across three emergency adult shelter 261 single adults and during the no-freeze nights even more. During no freeze nights the shelters have been able to accommodate over 300 individuals.

Comparisons between the two city funded shelters suggest that the populations are slightly different from one another. Columbus House appears to house more chronically homeless, mentally ill, and white clients compared to Emergency Management Shelter Services that has more clients new to shelter, are African American or other (e.g., Asian, Hispanic) and reporting substance abuse or criminal justice involvement.

Table 4 presents information on the 3 Family-Based shelters funded by the City (New Reach is the provider for 3 shelters) and 2 not funded by the City (Christian Community Action has 2 sites). The

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capacity of these family based shelters includes 45 units capable of accommodating 45 families. The other shelters within the New Haven surrounding area include Beth-El that includes 6 family units and Spooner House with 2 family units. BH Care has 6 units to support victims of domestic violence. For the entire region there are 59 units available for families.

Table 3: Composition and Utilization Rates in New Haven Emergency Shelters Adults (7/1/13 – 6/30/14)

	Columbus House (Overflow Shelter)	Emergency Management Shelter Services	Columbus House (HCHV-EH)*
Units	75	75	81
Beds	75	75	81
Nights	174**	365	365
% Utilization	112	90	86
New to Shelter	295	447	311
Chronic Homeless	203	58	183
Adults Served	591	920	498
% Criminal Justice	56.8	61.0	21.4
% Mental Illness	20.0	21.6	62.6
% Substance Abuse	40.0	60.0	60.8
% Age 31-50	53.0	52.0	45.7
% Age 51-61	27.0	23.5	32.3
% White	52.0	30.7	52.8
% African American	45.0	43.9	43.3
% Other	3.0	25.4	3.9
<b>Total Served</b>	<b>591</b>	<b>920</b>	<b>498</b>

Source: HMIS DSS CNH; \*includes 12 step-down beds; \*\*11/15/13-5/7/14

The primary reason for why families have entered the shelters based on HMIS reporting is that their expenses exceed their income. Martha's Place accommodates families where there are mental health issues (56.3%) and more chronic homeless families. During this needs assessment data collection time period, family-based shelters are already reporting high capacity and they are currently turning away up to 20 families/night. The changes currently occurring within the system of care allows for both diversion of families from the shelter system (e.g. prevention) as well as the identification of families eligible for

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rapid rehousing (e.g., quickly moving episodically homeless into housing). These are effective strategies that will help reduce this burden however more permanent and/or affordable family housing is needed.

Table 4: Composition and Utilization Rates in CNH Funded Shelters Families (7/1/13 – 6/30/14)

	Careways Shelter	Life Haven	Martha's Place	Christian Community Action
Units	10	15	3-family units	17
Beds	33	40	24	85
Nights	365	365	365	365
% Utilization	81.0	90.0	98.0	80.3
New to Shelter	158	219	125	174
Chronic Homeless	5	2	25	0
Adults Served	69	110 (3 single/107 family)	146 (130 single/16 family)	92
Children Served	128	160	21	134
% Age 18-30	59.0	67.3	30.5	45.6
% Age 31-50	39.0	31.0	39.0	53.4
% White	23.0	29.0	41.0	10.2
% African American	67.0	66.0	51.0	79.2
<b>Total Served</b>	<b>197</b>	<b>270</b>	<b>167</b>	<b>226</b>

Source: HMIS

### 4. Special Populations

#### a. Youth

According to the Board of Education, there are approximately 424 youth that are/have been identified as homeless. These are youth that are estranged from their families and considered to be unaccompanied youth that meet criterion from homelessness. This information is captured by volunteer Homeless Liaisons located within each of the 19 high schools. Feedback from these liaisons is that many of the youth double up staying in other homes and not in shelters. Youth Continuum is the lead agency in the City that addresses the needs of homeless youth providing case management and

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linking youth to appropriate wrap around services such as behavioral health, primary care, substance use/abuse treatment as well as addressing basic needs, job placement, education, obtaining subsidies and shelter. During the baseline period of 7/1/13-6/30/14 Youth Continuum conducted 163 intakes, referred 148 youth to shelters, provided mental health services to 88, referred 49 to primary care, and assisted 39 in obtaining employment (33 part-time and 6 full-time). Youth Continuum has 4 emergency shelter beds and 18 transitional beds.

Addressing the needs of youth is a statewide challenge. The Department of Children and Families through their Chafee Foster Care Program provides up to \$1,300,000 statewide for former foster youth. The state has recently funded 50 units of permanent supportive housing for youth aging out of care and at risk for homelessness. However it is clear that much more needs to be done with youth to meet their housing and employment needs.

### b. Special Populations: Criminal Justice

The Department of Corrections discharges inmates with a plan that includes their housing status upon exit. The New Haven Parole Office works with the contracted residential and non-residential programs in the city to track and monitor those who have exited the prison system and who are on parole. The support for those discharged last year includes:

- Residential work release programming (158 participants)
- Scattered site/temporary supportive housing units (26 units)
- Family re-entry programming (Behavioral Health New Haven) (650 participants)
- Employment and support programming (Columbus House – Starting Over) (300 participants)
- Social reunification (Families in Crisis) (229 participants)

Data for this report was provided by the Department of Corrections for New Haven County and for the City of New Haven in order to understand the potential population of those recently involved in the criminal justice system and where they are discharged once their sentence is complete. During the timeframe of 6/1/13 – 7/30/14, there were 4,384 releases/discharges from CT DOC to New Haven County and 1401 to the city of New Haven (32% of the total)(Table 5). Other cities in New Haven County with the highest releases/discharges were Meriden (27.1%) and Waterbury (10.9%). Across New Haven County only 1% of those released were female, in contrast with New Haven, where approximately 8% were female ex-offenders.

Table 5: Releases/Discharges in New Haven County and New Haven (6/1/13-7/31/14)

	New Haven	New Haven County
End of Sentence	950	3177
Half-Way House	147	333
Nursing home	1	3
Probation (all types)	200	513
Transitional Placement	16	53
Transitional Supportive	87	285
Totals	1401	4378

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Table 6 presents the known destination at discharge for those individuals whose data is available<sup>3</sup>. Although imprecise, it nonetheless may serve as a useful guideline for the types of places that people go to upon exit from the system. The majority at discharge reported either self-sponsor (returning to their own homes) or sponsor (family member/friend). At a minimum about 12% (39 individuals) are either homeless or are released to shelters. There is speculation that these numbers are most likely underestimates of the true counts for homelessness. Moreover, they do not include those that may have reported sponsorship but find themselves out on the streets when family members turn them away. With respect to planning for the shelter system if we were to extrapolate the 12% to the 1401 released annually (using the timeframe above as a baseline), then approximately 168 individuals might be released each year into New Haven shelters.

Table 6: Known Places of Discharge New Haven County and New Haven (6/1/13-7/31/14)

	New Haven	New Haven County
Self-Sponsor	138	466
Sponsor	110	451
Shelter	33	47
Sober House	22	42
Supportive Housing	9	27
Homeless	6	9
Totals	318	1042

Although there was a substantial variety in the types of offenses committed by those engaged in the criminal justice system in New Haven County and New Haven the majority fell under the following main categories (Table 7) and there were very few severe UCR I level crimes committed (higher level and more severe crimes)<sup>4</sup>. The table reflects the top 6 crimes and all of the remaining fall far below 3.0%. This is helpful for understanding the types of support services that may be required for those upon discharge and enter into the homeless system of care.

Table 7: Types of Crime Committed (Controlling Case)(6/1/13-7/1/14)

	New Haven	New Haven County
Violation of Probation/Conditional Discharge (linked to previous offense e.g. possession, robbery)	18.6	20.5
Sale of Narcotics	11.8	9.9
Special Parole	5.6	4.9
Burglary 3 <sup>rd</sup> Degree	4.1	4.2
Operating Under Influence of Alcohol/Drugs		4.0
Narcotic possession	3.6	3.9
Larceny – 6 <sup>th</sup> degree	3.4	

<sup>3</sup> Note that the data represents only a portion of those released due to the limitations of the data currently gathered at the DOC. A new system is under development that will allow for more refined data extraction.

<sup>4</sup> Although more than one crime might have been committed the data reflects the controlling offense.

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### c. Veterans

In January of 2014 according to the PIT estimates there were 33 homeless veterans identified. Examining data on homeless veterans in the state and in the New Haven region, there has been a significant decline in the number of homeless veterans, with the biggest drops occurring since 2011. The state is rapidly moving towards its goal of ending veteran homelessness. The shift in the last few years has been to focus on housing first through the use of HUD-VASH funding where many veterans are now receiving services including linkage to wrap around services and supportive and/or stable affordable housing. HANH offers 85 VASH vouchers.

## 5. Current System of Care for the Homeless

The system of care for the homeless in New Haven is similar to the structure of systems of care for the homeless in many urban cities around the country. There are emergency shelters with length of stay up to 90 days, transitional housing and permanent supportive housing units. A growing practice nationally is to transform transitional housing units into permanent supportive housing units. Shelter stays are supplemented with case management services (e.g., referrals, assistance with subsidies) that may vary by shelter depending on staffing and availability. The new philosophy is to move clients out of shelter and into affordable housing (e.g., rapidly rehousing) or permanent supportive housing as quickly as possible. For certain types of shelter clients in New Haven there is access to the following options when they leave the shelter during the day:

- Liberty Community Services Women's Program (6 days/wk)– access to food, clothing, telephone, internet, housing referrals, referrals to case management, assistance with job searches, wellness programs, recovery groups, special programming, i.e. trauma groups.
- Liberty Community Services Safe Haven Day Program (6 days/wk) – must have a mental health diagnosis; provided with access to food, employment services, housing referral, transportation, laundry, telephone, internet, groups (e.g., relapse prevention).
- Taking Initiative Center (7 days/wk) – for those with active addiction (and disconnected from substance abuse services) provided access to food, clothing, transportation, laundry, telephone, internet, medical services (a nurse comes in once/wk).
- Fellowship Inn (5 days/wk) – for those with mental health diagnosis and active addiction there is access to food, case management, employment services, housing referral, transportation, laundry, telephone, internet, skill building, recreational activities and medical services (nurse APRN once per week does screening and primary care referrals).
- Cornell Scott- Hill Health Center provides 24-hour health care treatment to those that are homeless. They provide referrals to local mental health and substance abuse treatment providers (e.g. CMHC, Grant Street Partnership, APT Foundation, South Central Rehabilitation Program). In addition, onsite services are provided to some of the shelters and staff have been paired up with shelter outreach.

In alignment with federal requirements, the New Haven system of care is focusing on housing first as a priority. Opening Doors Connecticut (and its regional affiliate Greater New Haven Opening Doors (GNH - OD) has been serving as the leadership/governing body to guide systems change transformation that is



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currently in the early stages of change. It is comprised of a Steering Committee that includes providers, consumers and other stakeholders in the system. There is a committee structure in place to address components of the systems transformation and a service provider resource guide has been developed. GNH-OD obtains leadership and guidance from the Balance of State (managed by Department of Mental Health and Addiction Services (DMHAS) and the Department of Housing (DOH) who initiates the NOFA for OD-CT that brings funding into the state linked to HUD-COCs) and the Connecticut Coalition to End Homelessness. The goals are consistent across the state: a) end veteran homelessness by 2015; b) end chronic homelessness by 2016; and c) prevent and end homelessness for families, youth and children by 2020. The system has been undergoing significant transformation, restructuring its resources towards: a) rapid rehousing; b) permanent supportive housing; and c) building a centralized access network (CAN). The prior system was focused on shelter and case management.

At the end of the summer of 2014 GNH-OD completed a 100-Day Challenge whose goal was to house 75% (107) of chronically homeless individuals. As part of the challenge individuals were assessed using the VI-SPDAT of whom 114 were provisionally matched to housing (pending documentation, housing availability, other paperwork) and 40 were housed. As part of the lead up to the 100-Day Challenge providers had to be trained on the VI-SPDAT and begin to implement this assessment process into their daily activities. The VI-SPDAT<sup>5</sup> is a nationally recognized tool that helps to determine the medical vulnerability and chronicity of homeless individuals as well as the most appropriate type of housing based on their current needs and severity. The higher the score the higher their vulnerability and need for supportive housing environments. The most recent update on the results of the 100-Day Challenge effort include 116 housed and 89 pending housing (with certificates) for a total of 205 which far exceeds the original goal. The characteristics of the population assessed are presented in Figure 1 below (the first group of 778 assessed using the VI-SPDAT).

As part of the 100-Day Challenge a coordinated access housing placement system was established (Figure 2) in order to streamline individuals into housing based on their VI-SPDAT scores. This type of collaborative process was new to providers and reflects a critical step towards initiating the new system of care for addressing homelessness in New Haven and the region. The coordinated housing placement system developed through the effort were institutionalized by memorandum of understandings executive in December 2014 with eight housing and/or outreach providers participating to-date. The second critical step has been the development of a coordinated entry system through United Way 211.

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<sup>5</sup> VI-SPDAT (Vulnerability Index – Service Prioritization and Decision Assistance Tool).  
[http://100khomes.org/sites/default/files/SPDAT\\_Evidence\\_Brief%20\(1\).pdf](http://100khomes.org/sites/default/files/SPDAT_Evidence_Brief%20(1).pdf)

## VI-SPDAT Scores

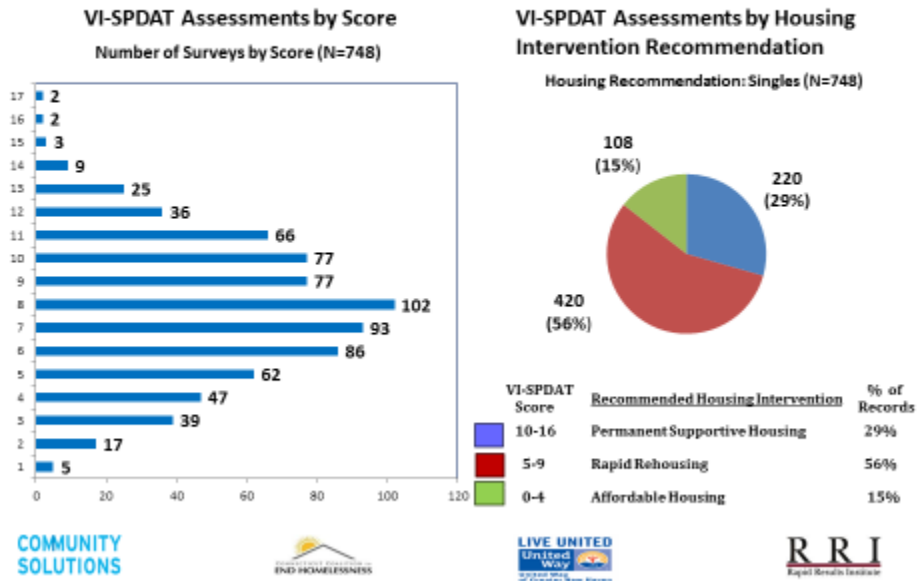


Figure 1: Assessment Strategy for Housing the Homeless (VI-SPDAT)

## The Coordinated Access Housing Placement System (CAHP)



Figure 2: Coordinated Access Housing Placement System (CAHP)

## NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

As part of this newly emerging system known as the Coordinated Access Network (CAN), collaborative case conferencing is occurring among the multiple providers/stakeholders involved in the system of care. The stakeholders involved in collaborative case conferencing include shelter providers, Housing Authority of the City of New Haven, federally qualified health clinics, Yale New Haven Hospital, and CCEH. Therefore, along with the introduction of VI-SPDAT (assessment), a process has been developed for case prioritization and matching, all the way through to housing.

The coordinated entry is guided through the partnership with United Way 211. The intent is for United Way 211 to provide diversion and prevention services to at-risk individuals and families. This strategy of focusing on prevention and diversion is relatively new. For those that can't be diverted shelters will be contacted to meet with the individual or family to assess for diversion opportunities or intake into emergency shelter. This new system will unfold in January 2015 and will be re-examined after 6 months. In order to get to this stage the committees of GNH-OD have had to work on establishing policies and procedures, share current practices, and develop partnership agreements. In parallel, there are several critical data system efforts underway led by CCEH, to structure the system in a way to be able to obtain more accurate estimates of prevalence and link the intake and assessment processes in a streamlined way.

More recently, in order to address concerns regarding the availability of housing stock, the Housing committee for GNH-OD has reached out to landlords to obtain their input and insight. As part of this process a weblink has been set up <http://www.nhregionalsupportivehousing.blogspot.com/2014/08/coordinated-access-and-housing.html> for landlords to place their open units. A first of its kind meeting was held with landlords to discuss challenges of providing housing to unique populations.

### 6. Comparisons to Evidence-Based and Promising Practices

The National Alliance to End Homelessness (NAEH) (and their accompanying Homelessness Research Institute) are the leading experts in homelessness research, advocacy and policy. In addition, the National Coalition to End Homelessness is a strong advocacy organization representing networks of providers and consumers across the nation. Both together provide support at the national level that can benefit local, regional and statewide systems of care. The NAEH has published guidelines on essential practices to ending homelessness. The Ten Essentials: A Guide to Ending Homelessness includes:

- A. Plan – A structure must be in place (with money, staff, facility) to bring together stakeholders, conduct a needs assessment, identify strategies, and develop a plan with action steps, responsible parties, and outcomes.
- B. Data – A system must be in place for organizations to be trained, data collected and monitored and quality control conducted for HMIS and other software utilized in order to be able to track and monitor successes and outcomes over time.
- C. Emergency Prevention – Services must be available to those who are precariously housed, facing eviction and/or falling behind on rent in order to divert them from homelessness.

## NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

- D. Systems Prevention – A strategy must be in place for those exiting institutions (including hospitals, jail, foster care, residential programs) with a pathway to housing established.
- E. Outreach – Targeted outreach should occur to those on the streets, engaging them, and bringing them into services.
- F. Shorten homelessness – Homeless assistance programs should focus on minimizing lengths of stay in shelter and reduce repeat homeless episodes.
- G. Rapid Re-housing – A strategy should be in place to provide housing counseling, financial assistance (e.g. security deposit, short-term rent), and links to long-term housing supports to help them remain in housing.
- H. Permanent Housing – Develop permanent supportive housing and a local housing subsidy program (e.g. identify affordable housing units and subsidies for homeless people).
- I. Services – Provide case management, substance abuse counseling, mental health treatment and relationships with these systems.
- J. Income – Provide benefits advocacy (e.g., assistance with obtaining subsidies like TANF, SSI, Medicaid, Medicare), job training, job placement.

The Needs Assessment process reviewed New Haven’s capacity across all of these 10 essentials and New Haven is actively engaged in all of these activities and in some cases has gone beyond these to include special projects such as respite housing for medically fragile homeless individuals and healthcare for the homeless (e.g., Cornell Scott – Hill Health Center). One area of weakness is job training and placement.

In addition to these 10 Essentials, New Haven and our surrounding providers have been trained in and are implementing evidence-based and promising practices recognized at the national level. The evidence-based practices<sup>6</sup> include Permanent Supportive Housing and Housing First approaches (long term housing and wrap around support), Rent Subsidies (Housing Choice Vouchers – Section 8), Motivational Interviewing (to reach and engage the homeless into services), Integrated Treatment (for Co-Occurring Disorders). The promising practices that our providers are engaged in include Rapid Rehousing (crisis response), Homeless Prevention and Diversion (before homelessness occurs), Coordinated Entry & Assessment, and the VI-SPDAT.

Specific examples of evidence-based practices, promising practices, and communities receiving recognition for their work on homelessness can be found in Appendix III. They have been categorized according to: a) Specific Effective Strategies to End Homelessness; b) Communities Engaged in Similar Processes to New Haven (but further along the continuum of change); c) Communities Addressing Income & Employment; d) Special Populations – Veterans; e) Special Populations – Youth; f) Communities Addressing Foreclosure; g) Other – Exemplary Programs Targeting Specific Issues. Many of these have the potential to be role models for New Haven and/or may serve as starting points for local innovation.

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<sup>6</sup> Critical Time Intervention is the only practice that at the time of the assessment it was unclear if any provider was using this evidence-based practice (the closest to this might be Columbus House – Medical Respite from Yale New Haven Hospital Systems and the Continuum – Yale Psychiatric Hospital).

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## 7. Financial Analysis

A questionnaire was sent to organizations in the greater New Haven area providing services to homeless individuals and families. The questionnaire was designed to collect the following types of information:

- Types of housing/shelter provided to homeless clients
- The number of beds or housing units by type of housing/shelter
- The number of clients served and occupancy rates by type of housing/shelter
- The total funds received by each agency by funding source (note - some of the funding received by agencies could be for services other than housing/shelter for the homeless)
- The allocation of funds by type of housing/shelter
- The range of services (in addition to housing/shelter) provided to homeless clients

A total of eight organizations provided information either through a response to the questionnaire and/or through interviews. The following is a summary analysis of the data received. A list of responding organizations is included in Appendix II.

### Sources of Funding

In total, responding organizations reported receiving a total of \$25.5 million of funding in the most recent year (note - not all funds received were used to provide services to homeless clients since some organizations provide other services). A breakdown of their funding by source is provided in Figure 3.

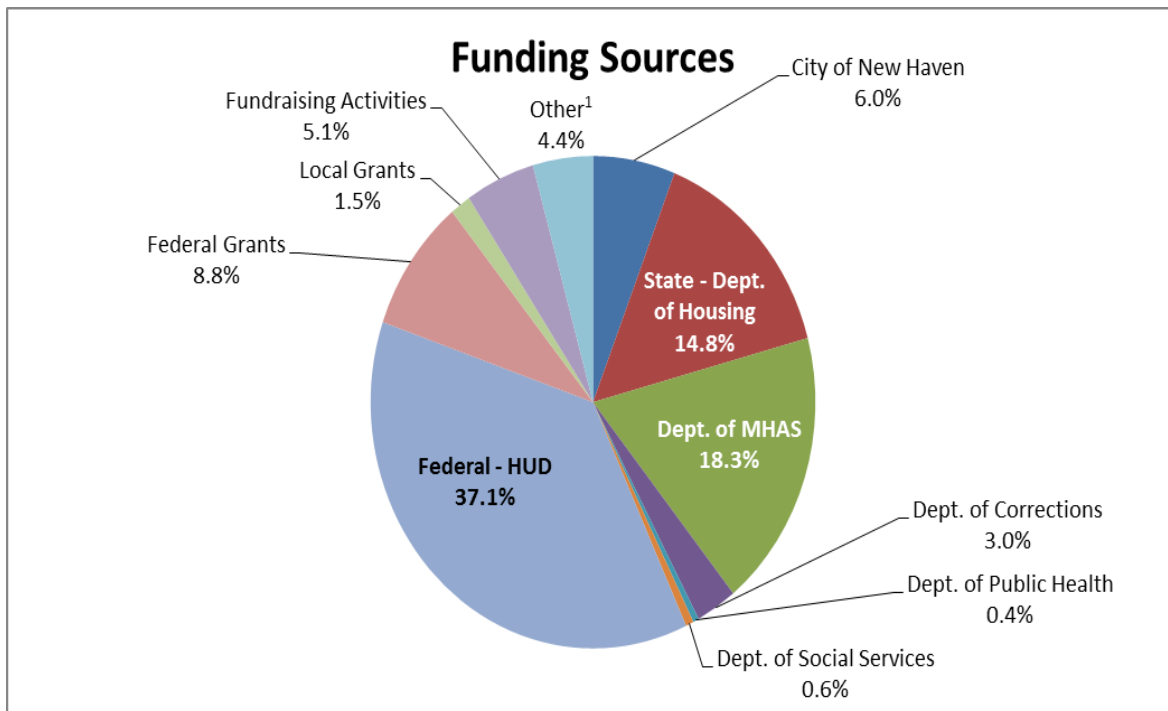


Figure 3: Funding Sources <sup>1</sup>Other funds are primarily derived from fees charged for services but also includes a grant from United Way for one respondent

# NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

The federal Department of Housing and Urban Development (HUD) is the largest single source of funding with most of it being used for permanent supportive housing. The single largest recipient of Federal HUD funds is the Housing Authority of the City of New Haven which reported receiving \$6.8 million specifically for homeless prevention activities (72% of all HUD funds received by responding organizations). The State of Connecticut provides an equal amount of funding from five different agencies with the Departments of Mental Health and Addiction Services (18.3%) and Housing (14.8%) being the most significant funders.

Including Federal grants, State and Federal funds account for 83% of all funds used to provide housing/shelter to homeless individuals and families with the bulk of the difference coming from the City of New Haven (6%), fundraising efforts by the organizations (5.1%) and other revenue sources (4.4%). The majority of the other revenue is generated from user fees for services provided.

### Use of Funds by Housing Type

Of the \$25.5 million funds received by the responding organizations, \$19.3 million (76%) was used to provide housing and services to homeless clients. There are a number of different types of housing provided by these organizations (some determined by the specific populations that each serves). The following is a distribution of the use of funds by type of housing provided.

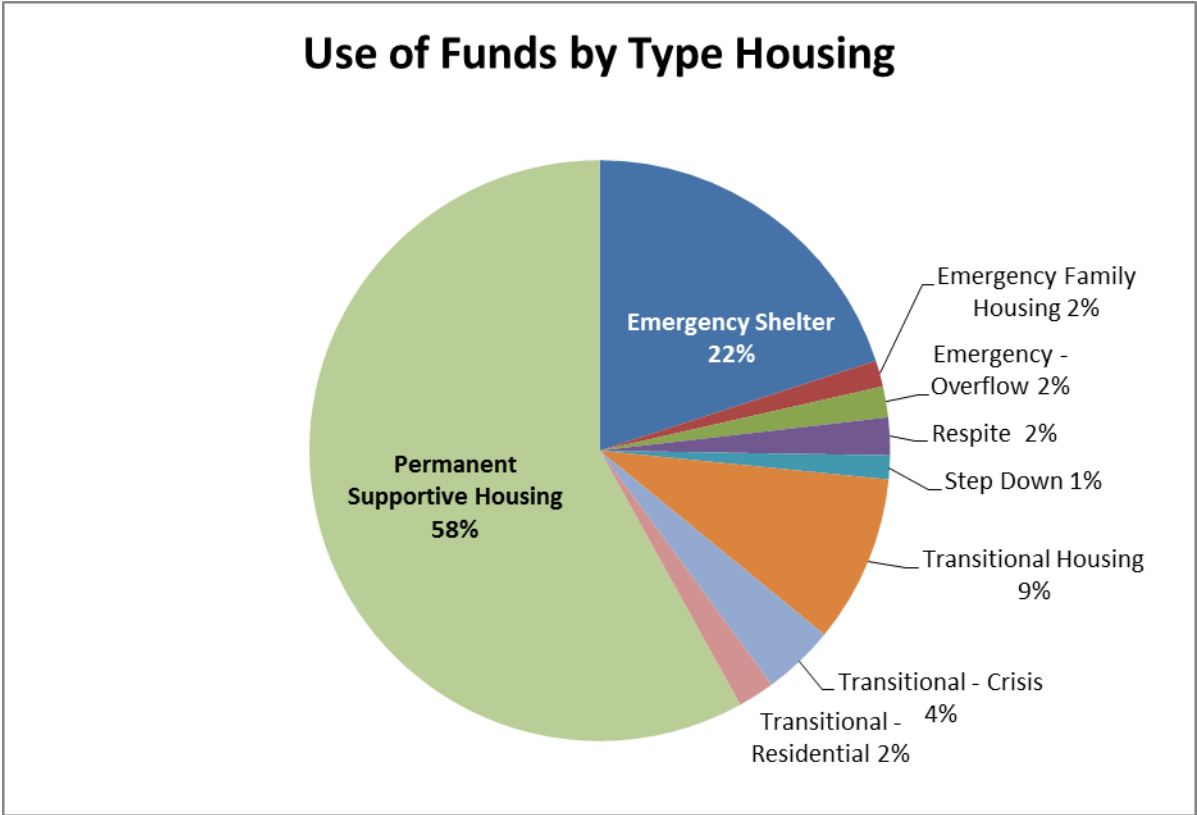


Figure 4: Funding by Housing Type

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While there are unique types of housing programs, the housing provided tends to fall into one of three broad categories: permanent supportive housing, transitional housing and emergency shelters. The predominant form of housing provided is permanent supportive housing which accounts for 58% of the total funds expended for housing services. Emergency shelter services (emergency shelters, emergency overflow shelters, emergency family housing) is the next largest category of housing accounting for 26% of all funds. Transitional housing (including crisis and residential housing for individuals with mental health or disability needs and veterans) accounts for a total of 15% of funds.

### *Cost of Providing Services to the Homeless by Type of Housing*

One of the objectives for collecting the information requested in the questionnaire was to attempt to determine the relative cost of each type of housing service provided to homeless individuals and families. Because of the inherent differences in the types of housing services (permanent supportive housing, transitional housing and emergency shelters) and differences in populations served by each of the responding organizations, analyzing costs by type of housing does not lend itself to a straightforward apple to apple comparison. Furthermore, the costs reported by responding organizations in some cases include the provision of services (case management, transportation, employment services, etc.) that are not uniformly provided by all organizations. The information presented in this section of the report is intended to provide an understanding of cost differences in the types of housing services but does not provide a definitive assessment of relative cost-effectiveness of each solution.

The following chart provides the average cost per unit per day for the different types of housing solutions delivered by the responding organizations (note - a unit can be a bed in an emergency shelter or an apartment for a family; it is beyond the scope of this analysis to control for these variables).

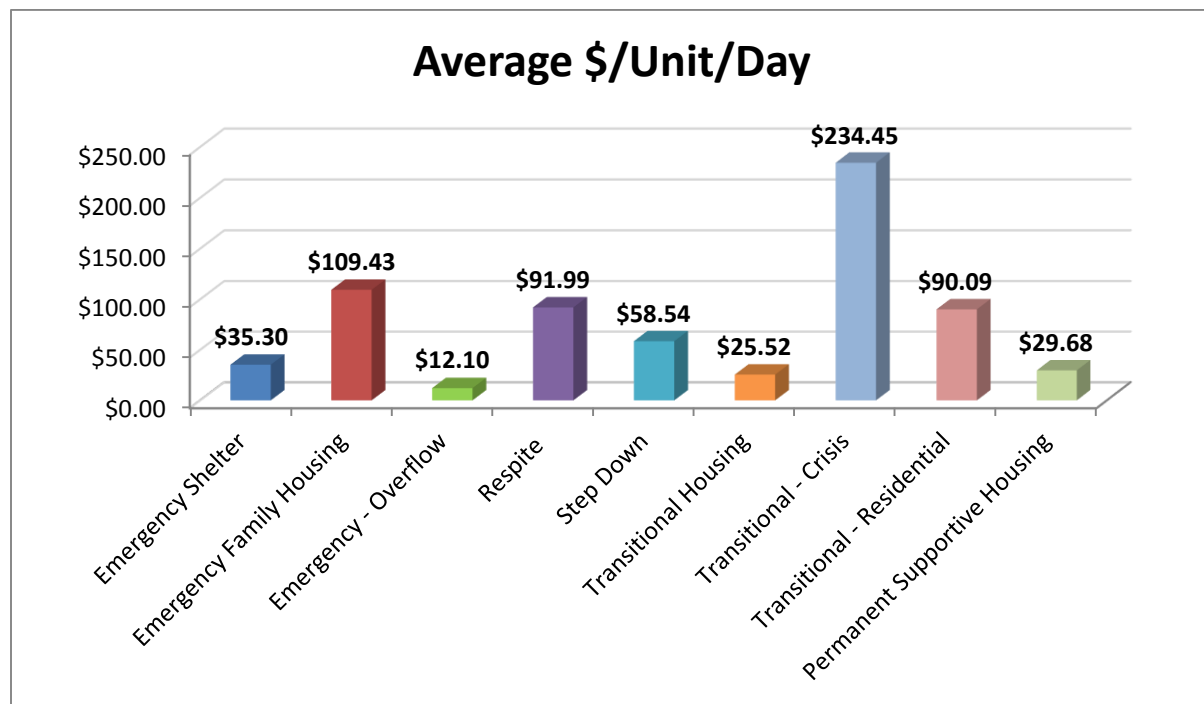


Figure 5: Average cost per unit per day

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Based on data reported by the responding organizations, occupancy rates generally were in the 95-100% range although there were a few instances where occupancy rates were in the 80-85% range (note - it is likely that occupancy rates reported by respondents are not consistent and may not factor in occurrences when units might be unavailable due to problems with heating, plumbing or other reasons). For three categories of housing (emergency shelter, transitional housing and permanent supportive housing), there was more than one organization providing cost information. The following table provides some perspective into the variation in cost within each category.

Table 8: Cost by Housing Type  
**Average Cost by Housing Type**

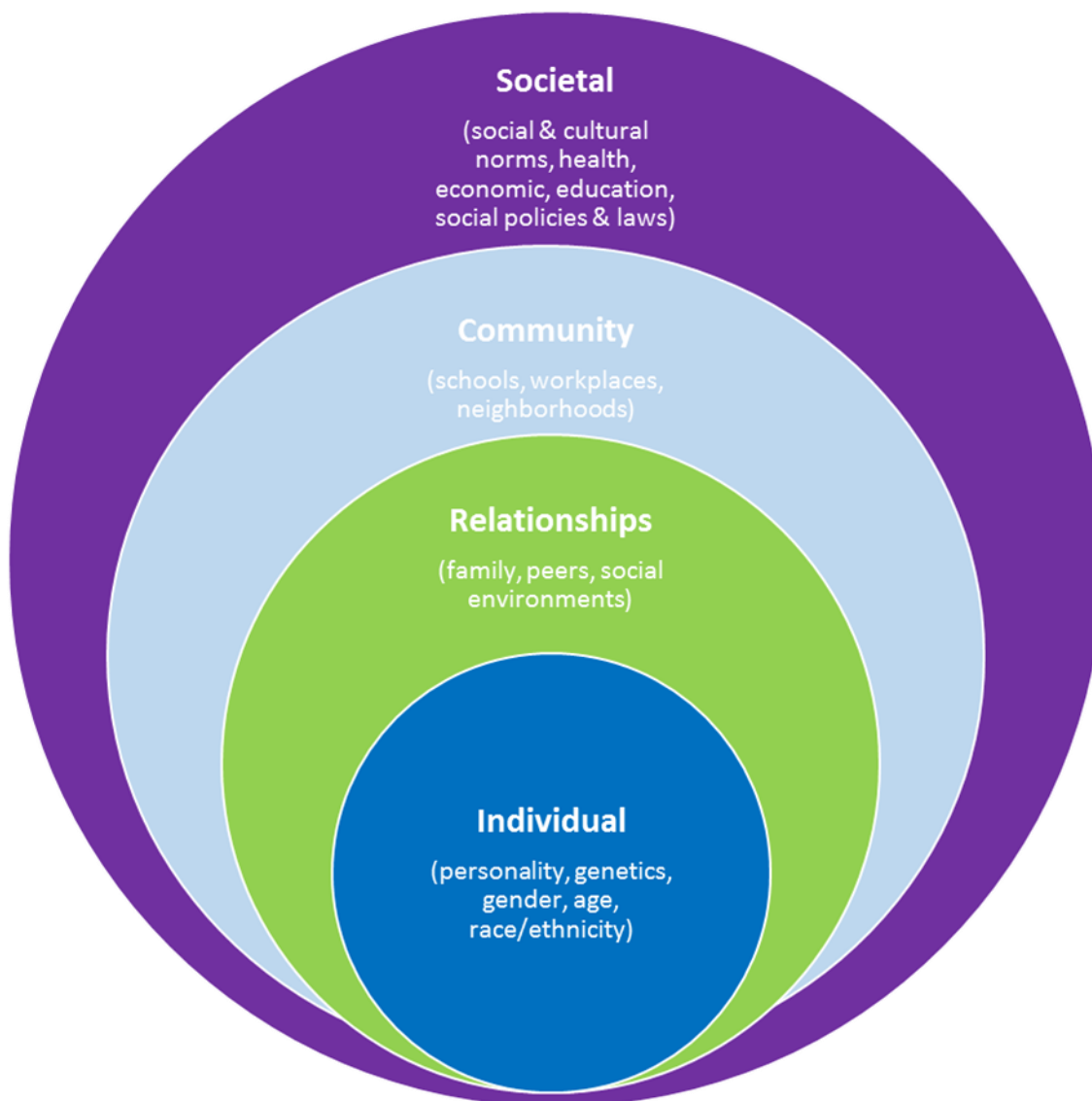
Type Housing	# of Responding Providers	# of Units	Average \$/Unit/Day	Low \$ per Unit/Day	High \$ per Unit/Day
Emergency Shelter	4	299	\$35.30	\$20.34	\$72.84
Transitional Housing	3	193	\$25.52	\$8.86	\$108.38
Permanent Supportive Housing	4	1,032	\$29.68	\$13.35	\$37.76



## 8. Development of a Theoretical Framework

An observation that was made early on in the needs assessment was the absence of a logic model or theoretical framework to guide this long-term community change process (an identified gap). Based on an extensive literature review, the model that makes the most sense for this homelessness initiative is one that is based on socio-ecological model of health (Figure 6). This model suggests that homelessness is the result of the complex interplay between a number of risk factors including individual, social, cultural, economic, biologic, and environmental. In order to tackle the root causes of homelessness and solve the problem, these factors must be taken into consideration.

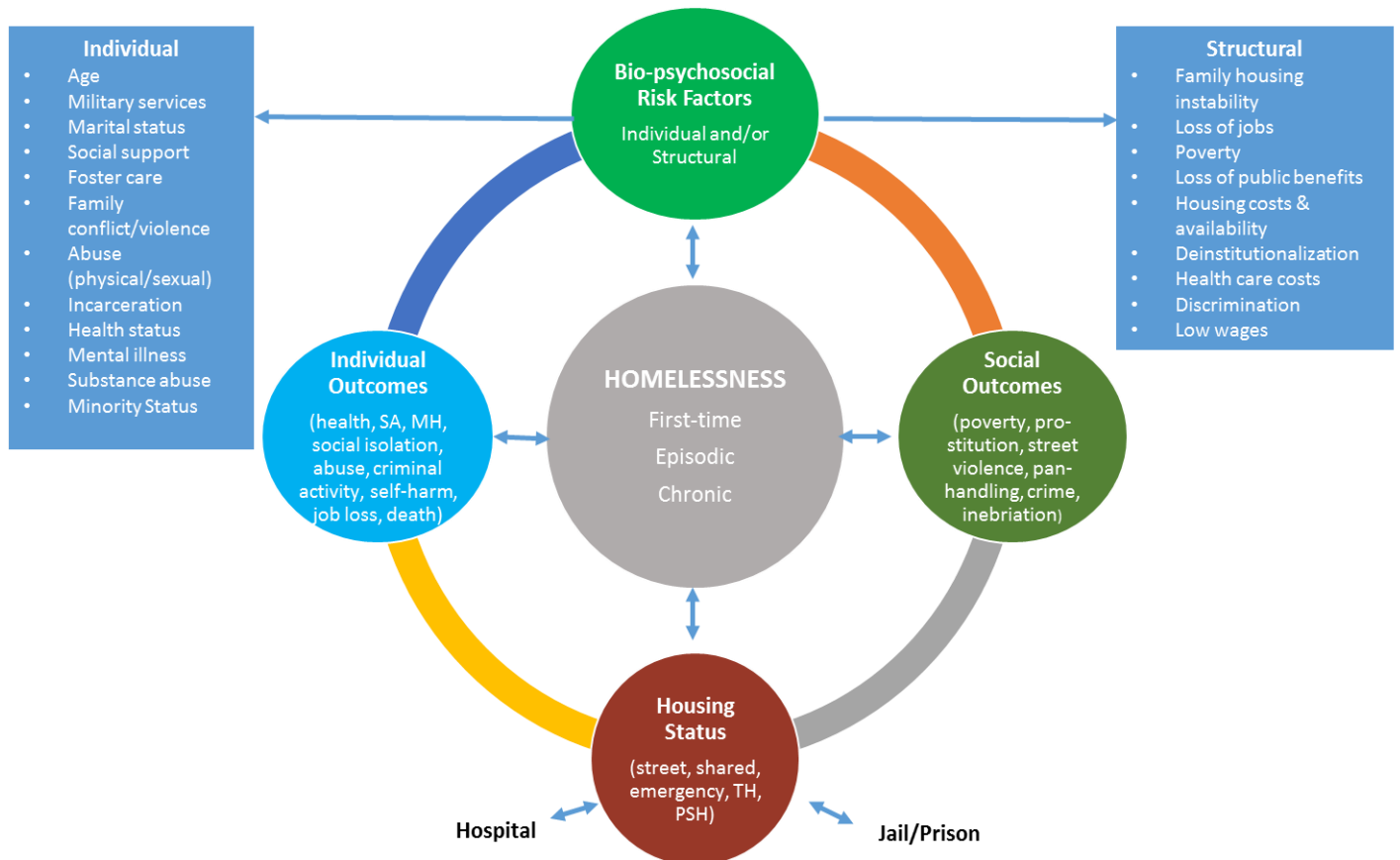
Figure 6: Socio-Ecological Model of Homelessness



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Figure 7 takes this model one step further and presents a conceptual map that takes into consideration the multifactorial nature of homelessness by focusing on: 1) the fluidity of homelessness (e.g. a one-time event, episodic, and/or chronic); 2) multiple entry points into the system (e.g. street, hospital, jail, substance abuse/mental health treatment); 3) potential individual factors leading to homelessness that must be addressed to resolve it; 4) potential structural factors leading to homelessness that must be addressed to resolve it; and 5) outcomes associated with homelessness (e.g. poor health, prostitution). This conceptual map is adapted from Roger Nooe & David Patterson, 2010<sup>7</sup>.

Figure 7: Conceptual Map of Homelessness



A logic model for this community transformation initiative is presented in on the next page. This was developed in order to provide the stakeholders with a framework for thinking about how they will continue to measure and monitor their progress moving forward. It serves as a guideline for thinking through both short-and longer-term indicators of success and outcomes. Note that the community has adopted a structure to monitor performance of the regional CAN that will track key performance measures at the provider and system levels.

<sup>7</sup> Roger Nooe & David A. Patterson, Ecological Model of Homelessness; Journal Human Behavior in Social Environments, 2010)

# NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

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**Activities**

- Outreach and engagement
- Temporary emergency shelter
- Case Management
- Housing Placement Assistance
- Education/vocational support
- Substance Abuse/Mental Health treatment
- Address physical health needs
- Intensive support services
- Housing stabilization services
- Landlord identification and recruitment services

**Activities**

- Ongoing case management, substance abuse/mental health/physical health support as needed
- Educational/vocational support
- Job training and placement services
- Financial planning services
- Landlord assistance services

**Outputs & Outcomes (select)**

**Outputs**

- % individuals engaged in system of care and support (case management, substance abuse/mental health, medical)
- % individuals housed
- % completing educational/vocational, job training/placement services
- % landlords recruited
- % completing financial planning services

**Outcomes (short & intermediate)**

- 90 % retained in housing > 12 months
- 80 % obtained educational/vocational goals
- 70% employed (full-and part time) or have income gain due to training
- 80% obtaining mental health and physical health goals

**Long-term (5-10 years)**

- 90% housing maintained
- 80% job/Income maintained
- 80% physical and mental health maintained
- 75% financial goals met (e.g. savings)

**Assumptions:**  
 System of care is developed and functional with coordinated entry, coordinated exit to housing (whether diverted or placed in community housing), and appropriate metrics to monitor and track flow through the system

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## 9. Strengths Identified in the System

### a) Effective Collaboration

- For the first time homelessness system providers and other community stakeholders are coming together to work collaboratively towards a common set of goals to end homelessness rather than just manage it. This extends to one of the first meetings between landlords and providers to address unique challenges.

### b) Emerging Systems Wide Processes

- Processes for collaboration have been developed for the Coordinated Access Network (CAN) including a governance structure, memorandum's of agreement, coordinated access (through United Way 211), coordinated housing placement (CAHP), data systems and monitoring protocols, and sharing of policies and procedures.
- A more advanced uniform data collection system has been developed and will soon be launched (CaseWorthy).
- The 100 Day Challenge has gone beyond its original target goal of 107 and has housed 116 with 89 additional individuals/families with certificates ready to be housed.
- A 'backbone' structure is emerging that includes a leadership and accountability framework (Opening Doors – Greater New Haven).

### c) Strong Financial Support

- The amount of funding coming into the City of New Haven through federal, state, private and philanthropic funding to support homelessness is over \$25,500 million per year.

### d) Utilization of Evidence-Based and Promising Practices

- The City of New Haven providers are implementing the National Alliance to End Homelessness 10 Essentials and are providing evidence-based and promising practices to address the challenges that our homeless population face. In addition there are some creative strategies and partnerships to address healthcare for the homeless (e.g. Hill Health, YNHH, and Columbus House).

## 10. Gaps and Barriers Identified

The gaps and barriers identified here represent the combined analyses across the key informant interviews, community forum results (which echo many of the themes below; see Appendix III), literature review, document reviews (including the results of the provider surveys), and new data gathered.

### a) Overarching Conceptual Framework for Social Determinants of Homelessness

- Although components of the system of care are being systematically addressed, there is a need for a more comprehensive framework – a bigger picture perspective that allows stakeholders involved and stakeholders that may wish to invest to see a beginning, middle and an end. This has partially been addressed in section 7 above (Development of a Conceptual Framework). The gold standard for systems change transformation is the

## NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

‘Collective Impact’ Model<sup>8</sup> that has a 5 pillar approach. These include: 1. Common Agenda – create a shared vision; 2. Shared Measures – agree to track and monitor progress for continuous improvement; 3. Coordinating Collective Efforts – engage in mutually reinforcing activities to maximize results; 4. Continuous Communication – building trust and relationships through constant interactions; 5. Strong Backbone – including a team to drive the process). This assessment has revealed that this systems transformation initiative is addressing many of these components however there has been an emphasis on coordinated access and much more work is needed within each of these pillars with respect to the entire system. Clarity around the ‘backbone structure’ needs to occur.

- The conceptual framework needs to go beyond homelessness to address social determinants including education, income, job training, skill development and employment.

### b) Housing Availability

- Insufficient **emergency housing** to meet current families in need as well as youth (from Provider Surveys, Interviews with stakeholders, data tables).
- Insufficient **affordable housing** to meet the short and longer term needs of homeless individuals and families as well as those on waiting lists for public housing. There is a need to clearly provide definitions of ‘affordable’ that make sense and align with true market value. It is clear from the first meeting with landlords that there are barriers that need to be overcome, including lack of clarity around ‘fair market value’ and the need for direct links to providers to assist with challenging renters.
- Insufficient housing solutions to address the special needs of prison re-entry individuals many of whom require extensive remedial education, skill development, job training, and employment.
- There is a need for coordinated efforts to reach, engage and motivate landlords including a mechanism for continuous feedback to keep landlords motivated and engaged.

### c) Collaboration – Expanding the Table & Sharing Resource & Practices

- If we consider the conceptual framework and logic model as a guideline, the needs assessment process has identified additional partners that interface with the current system that should be considered moving forward. These include those involved with the criminal justice systems for both youth and adults (Department of Corrections, Probation, Parole), Department of Children & Families, Department of Health, Department of Social Services, Department of Development Services, criminal justice system providers, educational system providers, faith based organizations and workforce development providers. The assessment revealed that some of these providers want and need to be engaged in this system transformation as it impacts the populations they serve. It serves the additional purpose of aligning community initiatives in order to avoid duplication and redundancy. The collaborative table pulled together for the recent Promise Zone initiative includes a core set of anti-poverty stakeholders.
- Once the CAN system is up and running and more stable, future work could focus on creating opportunities to share resources and practices. For example, many might benefit

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<sup>8</sup> [http://www.ssireview.org/articles/entry/collective\\_impact/](http://www.ssireview.org/articles/entry/collective_impact/)

## NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

from learning about different financial models and strategies for shifting the structure and function of their organizations to adapt to the changing system (e.g. staff re-tooling, financial restructuring).

- There is a need to address myths and misunderstandings in order to remove barriers and build trust – e.g., “New Haven is the dumping ground for serious ex-offenders” (the data suggests otherwise), “Shelter X staff only accept certain types of homeless” (the data suggests otherwise).

### d) Support Services - Sustaining Persons in Housing

- There appears to be insufficient service coverage for special populations – In a survey distributed by Greater New Haven Opening Doors to 44 direct service providers (including 1 homeless person), only 59% of the respondents reported that they agreed that there were programs and services in place to serve the needs of identified sub-populations including domestic violence survivors, veterans, youth, seniors and immigrants. Moreover, this is supported in data tables above. With respect to veterans there was some concern raised about their need to be able to have a ‘community of veterans’ to support each other which may be a challenge with ‘scattered site’ housing (Homeless Advisory Committee).
- There is a need to address sustaining people within their housing (46% of providers reported that their clients were successfully supported in their housing)(Provider Survey). In order to address this adequate support services, as well as income, education and employment must be addressed as broader systems issues. .
- There is a need to address discharge/exit (only 32% of providers agreed that they had comprehensive and effective discharge plans for their clients)(Provider Survey and stakeholder interviews).

### e) Data Monitoring and Continuous Quality Improvement

- The current quality of the data identified for the needs assessment has had substantial limitations. Until the new system is in place up-to-date information must be obtained from individual providers which is time consuming and burdensome. The new data system should help overcome some of the existing limitations.
- A strategy needs to be established for data monitoring and reviewing data on a regular basis as part of continuous quality improvement. This needs assessment has attempted to establish some baseline data using the timeframe of 7/1/13-6/30/14. The CAN has included data monitoring as part of their framework which will be extremely helpful, however this is only one part of the larger system.
- Data on housing inventory varies (shelter, TH, PSH) and requires further systems level coordination (ideally one repository of information).

## Recommendations

- a) Develop the Theoretical and Conceptual Framework
  - The community needs to develop an agreed upon framework for moving forward including realistic and measurable outcomes and determine whether the focus should be exclusively on homelessness or on factors that interface with homelessness (e.g., social determinants).
- b) Determine the 'Backbone Structure'
  - A strong backbone structure is essential in order to drive this broad systems transformation effort forward. Greater New Haven - Opening Doors with its current structure as a volunteer effort may not be in the position to do this without becoming a more formal entity with funding and staffing to support their efforts. They would need to be willing to take on a broader systems initiative (beyond addressing current HUD requirements) that includes additional partners as suggested above.
- c) Support the re-tooling of providers and services to better meet the needs of the people who are currently homeless, at risk of becoming homeless, or exiting homelessness
  - Support the development of tools and structures that support a transparent, collaborative delivery of services
  - Support opportunities for providers to update staff training and infrastructure, and program designs to better align with the needs of people at-risk of becoming homeless, currently homeless, or exiting homelessness
  - Encourage the continued implementation of Housing First and Coordinated Access to increase results for clients and improve access to services
- d) Examine state and local policies and programs for opportunities or barriers to achieve the federal goals and HEARTH performance targets
  - Advocate for policies that increase access to earned income (job growth), increased wages, and unearned income
  - Increase access to benefits, examine the impact of "benefit cliffs, and advocate for greater access to childcare and transportation subsidies
  - Increase access to affordable, particularly deeply-affordable, housing
  - Increase the connection to, accountability, and incentives for allied providers to provides services to increase earned income, unearned income, and housing and family stability to people currently experiencing homelessness, at-risk of homelessness, or exiting homelessness
- e) Develop a data monitoring strategy and continuous quality improvement strategy for the system of care for the homeless
  - A system and a strategy need to be developed to allow for an understanding of future needs for more effective planning purposes. We need to know more about the

## NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

characteristics of those that are stable in housing, who falls out of housing, and who is at risk for falling out of housing among other areas of interest. This will help to identify whether support services are sufficient and if new services are needed.

- Continuous quality improvement strategies need to be developed to test the new system transformation components.
- f) Address the housing stock challenge by working with city, state and federal stakeholders and policy influencers in identifying more affordable housing opportunities including expanding the number of publically-funded subsidized units.
- g) Develop and/or support existing strategies for reaching, engaging and motivating landlords in order to identify more affordable housing units (e.g. strengthen the work that is just beginning).
- A media campaign could be developed that focuses on identifying landlords and addressing housing myths.
  - Effective outreach and communication strategies could be enhanced/developed in order to identify more affordable housing opportunities and maintain landlords through the development of a grievance process and/or 'flex fix fund' to allow them compensation for property damage..
  - A thorough analysis of legal/policy barriers to motivate existing landlords/new landlords is needed.
- h) Continue to Build Partnerships and Share Resources
- In addition to adding new partners to the collaborative table, utilize existing resources such as those offered through Partnership for Stronger Communities – HOME Connecticut Campaign for Affordable Housing (technical assistance) & Corporation for Supportive Housing (currently addressing youth homelessness issue).
  - Strengthen and expand the current web-based presence to share resources, evidence-based practices, ideas from the field.
- i) Prioritize and develop strategies to address the needs of sub-populations
- The needs assessment identified a shortage of emergency shelter and stable housing for families, youth, single females, and prison re-entry sub-populations. More detailed information needs to be gathered on how many units need to be identified to support the gaps. Exact numbers won't be available until the CAN has been in effect for 6 months – 1 year.
  - For any new strategies developed, innovation should be a focus that takes advantage of the incredible resources available in New Haven and our capacity to engage in innovation.
- j) Examine the funding streams and how funding is distributed in more depth
- The needs assessment has only provided an outline on funding sources and has not included those that fall under other anti-poverty initiatives or that other partners or stakeholders may be engaged in (e.g. workforce development, education, urban re-development). A closer analysis may reveal opportunities to reduce redundancy and identify opportunities to fund innovation.



## NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

- k) Align funding streams to better meet community needs and effectively execute on state and federal standards
  - Convene funders of services in the region (public and private) to ensure that available resources align with the services and infrastructure needed to end homelessness and increase housing stability
  - Monitor the alignment of funding with changes in the needs of the homeless population
  
- l) Innovation
  - In order to address income and employment consider changing the language from ‘housing first’ to both ‘housing and work first’ for the segment of the homeless population who want to and need to work in order to live in stable housing.
  - Take advantage of the enormous local assets (universities, businesses, non-profits, government) and develop innovative models to simultaneously address housing, income, and health/wellness for those at risk for homelessness or are homeless. Create a ‘grand challenges’ concept that allows stakeholders across multiple disciplines to work together, think outside of the box, and compete against one another for solutions that are pragmatic and fundable. The Connecticut Department of Housing has Community Investment Account Funding to support innovation.

## APPENDICES

- i. Community Focus Group Summary**
- ii. Financial Analysis – Summary Information**
- iii. Summary of Evidence-Based, Promising and Effective Practices**

# NEEDS ASSESSMENT ON HOMELESSNESS IN NEW HAVEN

## APPENDIX I

### **Community Focus Group Summary Based on the Preliminary Results of the City of New Haven Needs Assessment and Environmental Scan Presentation on Homelessness (November 5<sup>th</sup>, 2014)**

A total of 37 individuals representing a broad array of service providers, individuals, and government agencies either directly or indirectly involved with addressing issues of the homeless in the City of New Haven and surrounding area attended the presentation. Following the data presentation, participants engaged in a 20 minute breakout session where small groups were formed and they were charged with answering the following question – *“What do you see in an effective system of care to end homelessness in New Haven?”* The following key themes emerged and corresponding clusters of comments.

- a) Addressing housing capacity
  - Housing capacity vs lack of mobility
  - Voucher available – but no place to go
  - More housing vouchers/rehab/entities
  - Develop landlord relationship
  - More certificates for housing subsidy
  - Relationship between city of New Haven and developers to rehab abandoned buildings
  - Need low expectation/low stress emergency shelter options for people not ready to accept more
  - More affordable housing
  - Identify available space for underserved – beds, schools, churches
  
- b) Addressing space capacity for special populations
  - Identify youth homelessness as issue need solutions
  - Address needs of those involved/previously involved with criminal justice system
  
- c) Understanding and addressing current system issues
  - Help is not futuristically directed on homelessness systems
  - Need to look at frequency of returns
  - Focus on housing retention
  - Need a system that helps focus on self-sufficiency
  - Collaboration among different systems
  - Increased communication between housing systems and organizations
  - Redefine agency services
  - Not every program is going to address every need or fit every population
  - We need to have intervention that address the documented population – eg: RRH is an intervention for population who have income or has potential for income
  - PSH should be reserved for population who need a ....(?)
  - Flexible system of care – some people fall through the cracks and their needs cannot be met at the shelters

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- Housing case management
  - MH/SA treatment services
  - Retraining staff to meet the needs of the client population
  - Sharing of resources and information among all agencies
  - Outreach community collaboration with friendly groups
  - Need housing resources for those with legal backgrounds or are in transitional housing
- d) Addressing sustainability
- Strengthen ability of families to sustain independence
  - Need a system that helps focus on self-sufficiency
  - Tie in jobs training/employment
  - Increase funding
- e) Focusing on homeless prevention
- Is there a way to predict who will become homeless
  - Housing clients in recovery friendly housing - e.g. high drug rate area
  - Public education about homelessness

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## APPENDIX II

### Funding Sources

Table A1 illustrates the broad array of funding that is *directly or indirectly* linked to addressing the needs of the homeless population in Greater New Haven. These funds reflect the need to address the spectrum of homelessness including those at risk (prevention and diversion funds), emergency shelter, permanent supportive housing, through to affordable and fair market housing vouchers and incentives. Statewide the HUD COC funding is \$32,212,898. The COC funding is primarily to be used for rental assistance and/or leasing with approximately 15% for support services. DMHAS spends approximately \$16,000,000 statewide on permanent supportive housing for approximately 2500 units. The Department of Housing provides approximately 650 RAP certificates for supportive housing which is approximately \$6,500,000 as well as an additional \$10,000,000 for shelter services. HUD-VA provide approximately 700 units of HUD-VASH (need to find out value?). Recent goals outlined in the NOFA COC are to continue to convert transitional housing into permanent supportive housing and rapid re-housing opportunities. The plans include addressing chronic homelessness for 165 individuals, adding 18 new supportive housing units, a 17 unit site (City of New Haven and the Housing Authority of the City of New Haven), 44 more units of family housing, and 10-15 VA-VASH certificates for veterans (HANH provides 35 vouchers to veterans). Based on Table 1 below which is a conservative estimate, there is more than \$9,000,000 per year of funding in the New Haven area to support the homeless (and another \$4,000,000 in indirect funding).

Table A1: Funding Sources 2014

## What are our Funding Resources?

Entity	Amount
<i>Direct Funding</i>	
HUD – Emergency Shelter Grants Program (ESG)	284,941
HUD – Continuum of Care	1,798,025
HUD – Housing Opportunities for Persons with AIDS Program	~600,000
City of New Haven – General Funds	1,100,000
Connecticut Department of Mental Health and Addiction Services ( <i>Shelter Plus Care Program</i> )	>5,000,000
Housing Authority of New Haven (\$1,603,200 LIPIH; \$3,240,000 Housing Choice Vouchers; \$501,366 support services)	\$5,344,566
Connecticut Department of Housing (HOPWA – Liberty and Columbus)	1,100,000
Philanthropic Organizations (UW, FFGNH, Melville)	>400,000
Connecticut Department of Social Services (rental assistance)	
Connecticut Department of Veteran Affairs	
Connecticut Department of Children and Families (Chafee Foster Care Program)	
<i>Indirect Funding (linked to Affordable Housing Stock &amp; Revitalization)</i>	
HUD – Home Investment Partnerships Program	1,047,817
HUD – Community Development Block Grants	3,493,881
HUD – Section 8 Moderate Rehabilitation Single Room Occupancy Program	
TOTALS	>20M
STATEWIDE	>68M

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*Sources:* Housing and Urban Development; State of Connecticut; DMHAS

Respondents to the questionnaire requesting information from organizations providing services to homeless individuals and families in the greater New Haven area:

- Christian Community Action
- Columbus House
- Continuum of Care
- Emergency Shelter Management Services
- Fellowship Place
- Liberty Community Services
- New Haven Housing Authority
- New Reach

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## APPENDIX III: EVIDENCE-BASED, PROMISING AND EFFECTIVE PRACTICES

### A. SPECIFIC STRATEGIES

#### 1. Critical Time Intervention (CTI)

*Population - Mental illness following discharge from hospitals, shelters, prisons and other institutions*

The principal goal of CTI is to prevent recurrent homelessness and other adverse outcomes during the period following placement into the community from shelters, hospitals, and other institutions. It does this in two main ways: by strengthening the individual's long-term ties to services, family, and friends; and by providing emotional and practical support during the critical time of transition. An important aspect of CTI is that post-discharge services are delivered by workers who have established relationships with patients during their institutional stay. Typically these workers are bachelor's or master's level individuals operating under the supervision of an experienced clinically trained professional. Once the worker has established a relationship with the client and begun to organize his or her support plan, the post-discharge phases of the intervention are delivered as follows: (1) Transition to the community, (2) Try-out, and (3) Transfer of care. CTI was originally developed and tested by researchers and clinicians at Columbia University and New York State Psychiatric Institute with significant support from the National Institute of Mental Health and the New York State Office of Mental Health. On the strength of rigorous experimental evidence supporting its effectiveness, the model has been identified as a "top-tier" social program by the Coalition for Evidence-Based Policy. CTI is listed in the National Registry of Evidence-Based Programs and Practices and is currently being applied and tested in the US and abroad. Link: <http://www.criticaltime.org/model-detail/>

#### 2. Rapid Results Initiatives – 25 Cities

*Population: Homeless veterans and chronically homeless individuals*

Rapid Results Initiatives (RRI) have been occurring throughout the country and are considered as evidence-based practices. They are highly structured and choreographed 100-day projects that sometimes turn into large-scale programs and projects, in ways that create local ownership and accountability for results, and that inspire innovation and collaboration among stakeholders at the local level. The strategy for creating sustained impact has three elements: "1. Getting started quickly with 100-day projects that produce tangible results – and that help local last-mile stakeholders "act their way into a new way of thinking". We iterate on this start-up element of the strategy, adjusting the design with each cycle of 100-day projects, until we – and local leaders – lock into a "business model" that can be scaled and sustained. 2. Engaging local leaders and coaching them to drive continued progress, building on the initial waves of 100-day projects. 3. Training and developing local "Rapid Results coaches" that can provide on-going coaching and facilitation support for local leaders and for 100-day project teams.----each city will hold a local Community Design Workshop to design/strengthen their Coordinated Assessment and Housing Placement (CAHP) system, as well as set 100-day goals around building and testing that system."

Link: <http://rapidresultsinstitute.info/what-we-do/our-mission>

#### 3. 100,000 Homes Campaign

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*Population: Chronically homeless and medically vulnerable*

The 100,000 Homes Campaign began in 2010 and recently ended in July 2014. The goal was to provide permanent homes for 100,000 chronic and medically vulnerable homeless individuals. Over 175 communities around the country participated using this Housing First approach. The underlying premise includes: “Housing First: Permanent housing that happens first and fast, so that no one must battle disease, disability, mental illness or substance abuse without the safety and stability of a home. Know Who’s Out There: Communities where every homeless person is known by name because someone has deliberately gone out on the streets to find them, assess their needs and meet them where they are at. Track Your Progress: Local, multi-sector teams that use regularly collected, person-specific data to accurately track their progress toward ending homelessness for their most vulnerable neighbors. Improve Local Systems: Housing and service systems that are simple and easy to navigate, while targeting resources quickly and efficiently to the people and families who need them most.”

Link: <http://100khomes.org>

#### **4. Permanent Support Housing - Corporation for Supportive Housing (New York, NY)**

*Population – Chronically homeless*

“Permanent Supportive Housing (PSH) is the most effective vehicle known for ending homelessness among people experiencing chronic homelessness. Research and evaluation has demonstrated that PSH is not only the most effective means of allowing the most vulnerable individuals to permanently exit homelessness, but that it is highly cost-effective. • Focus on Chronic Homelessness – Key to maximizing PSH’s effectiveness is to ensure that the units are targeted to the subset of homeless individuals who, without PSH, will remain homeless persistently and for the long-term. (The same targeting principle applies when providing PSH to homeless families or to individuals experiencing episodic homelessness, where PSH is reserved for those households who have chronic health and behavioral health challenges and who require those ongoing wrap-around services to successfully remain housed.) CSH believes that the focus on chronic homelessness which has been adopted by the federal government, as well as many states and local communities, is critical to ending homelessness. Coupled with this focus are housing and services models (“low threshold”, “housing first”) that assertively target and recruit more challenging tenants, such as those considered “resistant” to services or those who have multiple barriers to entry. • Targeting Frequent Users or High Utilizers of Emergency Public Services – Many communities are successfully targeting services and housing to the subset of chronically homeless individuals who are frequent users of avoidable and high-cost emergency public services (e.g. jails, EDs, hospitals, detox and treatment programs, psychiatric centers, etc.). Implicit in these programs is the recognition that many chronically homeless people experience homelessness as an “institutional circuit,” and that chronic homelessness is not a separate and distinct policy problem, but one belonging to a variety of policy sectors/spheres. By reaching this subset of chronically homeless individuals, PSH becomes a vehicle for helping states and communities reduce avoidable public spending on services that do not ultimately change the trajectories and improve outcomes among people experiencing chronic homelessness.”

Link: <http://www.csh.org/ny>



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### 5. Strategies to End Homelessness - Common Ground (New York, NY)

Common Ground in a report covered preferred strategies, based on evidence to end and prevent homelessness. The recommendations fell into three categories: a. Integrating housing and services; b. Integrating housing for the hard to house into all government assisted housing initiatives; and c. Supporting local plans to end homelessness. The recommendations reflect the need to address multiple agencies and multiple financing systems.

“Recommendation 1. Determine appropriate measures for Hard to House need and track and report on an annual basis.

Recommendation 2: With White House support, HUD must play a leadership role in a federal inter-agency initiative to create a national system to house the Hard to House. Similar to the New York-New York III Agreement (outlined below), this system would match service and housing dollars for the Hard to House, allowing for local flexibility and innovation. HUD should increase the allocation of Section 8 and other agency resources to advance this interagency effort. Regional offices should be empowered to play a coordinating role with other federal agencies and with state and local governments in linking housing and service funds to specific projects. Persuading Medicaid to extend their services to cover case management and other housing support services will not be an easy lift: HHS has for years resisted the linkage of Medicaid to housing. Yet the clinical and fiscal benefits to Medicaid itself are now well established. There are thoughtful, disciplined ways to create greater flexibility in the use of Medicaid that would reap significant savings for federal and state governments. For instance, limiting Medicaid funded housing services to SSI recipients, and certain narrowly defined other groups (homeless or chronically ill individuals who are high cost patients, for example) would be a way to move the issue forward. HUD’s partnership with the Department of Veterans Affairs through the Veterans Affairs Supportive Housing (VASH) program is in some respects a model that HUD might follow with other government agencies...In building on this model, we would urge a more flexible design than the current VASH program, and allow project basing of Section 8, and for community organizations to provide support services on a contracted basis rather than require that only VA employees perform the work. With these caveats, we can imagine the VASH model being applied successfully, for example, to transitioning youth or the chronically homeless, with HHS providing services funds matched to HUD Section 8 vouchers and private landlords providing many of the housing units.

Recommendation 3: Make HUD a center of housing innovation. Allow regulatory flexibility to encourage new housing arrangements suitable for the Hard to House. Establish a “Hard to House” Coordinator position within the agency.

Recommendation 4: Use HUD’s leverage to challenge exclusionary local housing practices. Link HUD grant priorities and other assistance to communities’ openness to supporting housing for the Hard to House.

Recommendation 5: Provide incremental, flexible Section 8 voucher authority to enable expanded access to privately owned housing. As an immediate budget item, target significant, incremental Section 8 resources to the Hard to House, beginning with those families and individuals who are now homeless. Allow flexible terms to maximize participation by a wide range of landlords and service providers.

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Recommendation 7: Establish the statutory flexibility to allow and encourage the production of housing for the Hard to House in FHA multifamily programs. Devise and include such objectives in tandem, to the extent that needed operating subsidies and supportive services can be bundled with the relevant insurance or capital advances.

Recommendation 8: Broaden the class of eligible recipients beyond the elderly and disabled to include the Hard to House to qualify for HUD's Multifamily Housing Service Coordinators grant program. Allow all developments offering housing for the Hard to House to apply residual receipts, excess income and/or budget-based or special rent adjustments to support on-site resident service coordinators as a standard practice.

Recommendation 9: Engage the Treasury Department, Congress, and states as feasible, in including Hard to House objectives in enhancements and applications of the Low Income Housing Tax Credit program. Although HUD has no direct policy or administrative control over the LIHTC program, it can help shape additional statutory and regulatory changes that would support the production of new housing for the Hard to House. A particular opportunity is to work with Congress and the Treasury Department to provide for the allocation of additional credits or a tax credit bonus on a pro rata basis for projects that include Hard to House units.

Recommendation 12: Fully fund the implementation of ten high quality Ten Year Plans. Treat these communities as laboratories for testing new strategies and bringing proven approaches to scale. Enable each community to draw up to \$20 million in new resources to fully implement their plans.

Recommendation 13: Finish the job of ending chronic homelessness. Direct HUD resources toward housing the 127,000 remaining chronically homeless, and creating 90,000 additional units of supportive housing nationwide.

Recommendation 14: HUD should partner with the Department of Veterans Affairs to expand the VASH program and develop housing for Hard to House and other veterans at their campuses throughout the country, using HUD financing, insurance programs and technical expertise.

Recommendation 15: Align Continuum of Care process with Ten Year Plans The goal is clear: HUD homelessness funding should support a uniform community strategy that focuses on housing rather than shelters or other short term assistance. While HUD examines the role of the CoC, there are administrative measures that could better align CoC funding with Ten Year Plans in those communities where both are operative. HUD should announce its expectations that these plans be aligned and focus on housing. It is also the case that the Ten Year Plans are of uneven quality, and that not every community has a plan. Thus more important than the specific mechanism, a Ten Year Plan or the Continuum of Care, are outcomes. We urge HUD to base its decisions on McKinney-Vento funding on how many chronically homeless persons and other Hard to House homeless households will be housed as the result of the investment made.

Recommendation 16: Adjust McKinney-Vento eligibility criteria to preserve access to housing and services for the formerly incarcerated who were chronically homeless or homeless prior to incarceration.

Recommendation 17: Create incentives for communities to identify the homeless who are at greatest risk for premature death; who have been trapped in homelessness the longest, and who are the most

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costly to public systems. Allow communities who have systematically identified these individuals to obtain waivers from standard HUD marketing procedures in order to prioritize these Hard to House households for housing placement.

Recommendation 18: As a final recommendation, a plan for evaluation of major new initiatives should be designed and implemented so as to enable Federal officials to track the work underway, to identify and communicate successes and to make course corrections as needed.”

Link: [www.commonground.org](http://www.commonground.org); [www.upenn.edu/penniur/pdf/RetoolingHUD-Chapter3.pdf](http://www.upenn.edu/penniur/pdf/RetoolingHUD-Chapter3.pdf)

### B. COMMUNITIES THAT HAVE ENGAGED IN SIMILAR PROCESSES TO NEW HAVEN

**Los Angeles:** Pursuant to the goal of ending homelessness through collaboration and the retooling of the crisis response system, the Los Angeles Homeless Services Authority, in partnership with the City and County of Los Angeles, is pooling resources to fund the Family Solutions Centers (FSC). These facilities will provide **coordinated entry**, intake assessment, and housing and supportive services interventions to homeless families and families at-risk of homelessness across the various regions of Los Angeles County. In collaboration with mainstream resources and targeted homeless resources, this new integrated Countywide system will provide the appropriate level of services and housing to each family in need. The ultimate goals of this coordinated system will be to divert families from becoming homeless and to end families’ homelessness as rapidly as possible. Los Angeles also conducts vehicular outreach to homeless families living in cars, vans, and campers, providing families with rapid re-housing support to help them return to stable living environments. In 2013 more than 20 organizations joined together to create the Skid Row Coordinated Entry System, in alignment with the Home for Good campaign in Los Angeles. The goal of the movement is to make systematic changes in order to foster collaboration. Home for Good is a blueprint to end chronic and veteran homelessness in Los Angeles County by building the most efficient and effective system in the region’s history. It’s a plan meant not simply to put an end to someone’s life on the street but, rather, to provide homes as a means to an individual’s vital integration into our communities.

**Louisville:** The City’s Rx: Housing program is part of the national 100,000 Homes Campaign which aims to house 100,000 vulnerable and chronically homeless individuals and families across the nation by July 2014. The program identifies persons living on Louisville’s streets, ranks them according to vulnerability, and begins working to house them based on the ranking. To date, the program has housed 115 disabled, vulnerable homeless persons in permanent housing, and resources have been provided for more. It has also led to an agreed-upon list of the most vulnerable persons for all supportive housing in the community. Single Point of Entry is the City’s new process for reserving a bed at any local homeless shelter. A shelter reservation can be made 365 days a year by simply contacting 637-BEDS. This process insures that shelter is reserved for those in greatest need, creates a way for institutions like hospitals and jails to prevent the release of homeless persons to the streets, and allows staff to work to prevent people from becoming homeless in the first place by making referrals to homeless prevention services in the community. Finally, because the process also includes a scan card system, the length of time for shelter check-in has been greatly reduced and the data on homeless persons served is better than ever. Single Point of Entry also provides referrals to other community services, making available more shelter for those in greatest need. The free number for reserving a bed is advertised at day shelters, night

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shelters, hospitals, jails, and homeless prevention agencies. Finally, the program coordinates with the 2-1-1 system to make sure it is able to make referrals as needed.

**Norfolk:** Norfolk launched a central intake system for homeless families in January 2007. This system coordinates services for families in crisis and creates a single point of entry for those services. The City also established the Homeless Action Response Team (HART) within the Norfolk Department of Human Services to assist families in crisis. HART completes a thorough assessment of the families' strengths and needs, a risk assessment, and housing barrier screening. Social workers assist each family in the development of a service plan and provide case management services. HART also maintains the shelter waiting list for Norfolk's three shelters and provides shelter diversion, homelessness prevention, and stabilization services. Rapid Re-housing funding sources include HUD grants, TANF assistance, and other State human services-designated funding sources. In September 2012, through collaboration with regional partners, a regional central intake system for single adults was initiated. This new centralized housing intake process aimed to streamline access to permanent and transitional housing programs in the City by eliminating barriers and duplication of services. These systems will continue to evolve. A mobile central intake program for single adults was developed as a community partnership of Norfolk's Department of Human Services, Community Services Board, and Office to End Homelessness; Access Aids Care; and Virginia Supportive Housing. This program can continue to expand through 2013 with additional funding and staffing.

Source: Conference of Mayors 2013 Status Report on Hunger & Homelessness

### C. COMMUNITIES THAT ARE ADDRESSING INCOME AND EMPLOYMENT

**Trenton:** Working cooperatively with community partners, the Rescue Mission of Trenton has reduced client barriers to social, medical, and legal services. This year the Mission moved beyond providing for basic needs such as shelter, food, hygiene, clean clothes, and a respite from the elements for homeless persons by developing an enriched services shelter program that increases emergency service clients' access to social services, including health care. The Mission's facilities and patterns of use make it an accessible environment in which outreach and education services can be provided to the homeless population. The Mission recently implemented a program to connect eligible clients to income development and access to health care. Through a cooperative effort with the Mercer County Board of Social Services, Henry J. Austin Health and Princeton Theological Seminary, the Mission instituted a project to increase the number of shelter clients applying for benefits. (About 63 percent of admissions report no income or benefits.) The keys to the success of this project have been in the on-site provision of services and the interagency coordination of care. A Board of Social Services social worker performs on-site intakes on Tuesday evenings, the Health Center provides medical appointments, and Seminary students assist clients with their applications that evening and return to escort them to their appointments. When benefits have been secured, the Board of Social Services and Rescue Mission staffs work to connect shelter clients experiencing homelessness with housing. Another example of a successful partnership involves Greater Trenton Behavioral HealthCare, which sends a homeless outreach worker to the Rescue Mission each week. The Mission's Supportive Services Manager identifies clients who are in need of mental health support and medication and the outreach worker meets with them, setting up appointments for them to enroll as Greater Trenton clients and receive psychiatric care. Appropriate case management and housing options are made available to the clients once

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they have enrolled. This process has made it possible for many clients to move from the shelter into housing.

Source: The U.S. Conference of Mayors 2013 Status Report on Hunger & Homelessness

### D. SPECIAL POPULATIONS - VETERANS

The following are a select subset communities that have worked towards ending chronic homelessness among veteran populations are reporting/have been successful in doing so. Many have engaged in the national multi-agency initiative, promoted through Rapid Results Housing Boot Camps, to house 100 chronically homeless persons, including veterans, in 100-day periods.

**Asheville:** The HUD-VASH coordinator and case managers partner with local faith communities to support homeless veterans' move into housing. These faith communities collect furniture and household goods for the veterans' new homes; goals are to provide a warm welcome to the veterans, ease their transition into permanent housing, and lighten the burden of the many details that go along with setting up a new household.

**Boston:** At the New England Center for Homeless Veterans, the Veterans Training School offers comprehensive employment assessment for veterans who are homeless, unemployed, or underemployed by providing them with intensive and individualized assessment and the tools they need to move toward self-sufficiency. The school provides: pre-vocational courses in business and computers; vocational courses in commercial driver's license, security officer training, and culinary arts; life skills courses in money management; and self-esteem classes. An Information Resource Center provides: a computer lab with Internet access, a resource library, one-on-one computer instruction, job search assistance, online application assistance, assistance in obtaining online e-mail accounts, resume writing, and JumpStart Workshops.

**Memphis:** Alpha Omega Veterans Services provides a range of housing options for veterans experiencing homelessness. The organization, which focuses on peer-based strategies, has a strong sense of community in its permanent housing programs and has shown strong performance in assisting veterans to obtain employment. Most of the staff members are former program participants.

**Saint Paul:** The Minnesota Assistance Council for Veterans (MACV) provides homeless or near homeless veterans and their families with homelessness prevention and re-housing assistance. MACV attempts to forestall imminent homelessness for families impacted by a one-time, non-repetitive – but nonetheless consequential – event such as an illness, unemployment, or an accident. Services include rental/mortgage assistance, security/damage deposits, utility assistance and, as appropriate, transportation assistance while the veteran is being stabilized. To be eligible for assistance, a client must be a veteran with an honorable discharge and 181 days of active duty service. The veteran must be a Minnesota resident (for a minimum 30 days) and homeless or at imminent risk of becoming homeless, and must be motivated to make positive change. Generally, assistance is provided on a one-time basis and the payment made is considered sufficient to resolve the crisis. Paramount in MACV's service delivery is outreach – to food shelves, shelters, community centers and clinics providing services to individuals and families – including regular outreach and collaboration with the Union Gospel Mission, Dorothy Day Center, and Salvation Army in Saint Paul. As a direct result of its community education and

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outreach, MACV connects with more veterans than ever before, and many veterans are referred to MACV's housing program by service organizations operating in the communities surrounding MACV's regional offices. Currently, an estimated 42,870 veterans live in Ramsey County. Of these, approximately 420, including nearly 120 families, will experience an episode of homelessness sometime during the year. In 2012, MACV provided intensive case management and direct services to 74 veterans and families in Ramsey County – the majority of them from Saint Paul. The average cost to prevent homelessness is \$500-700 for each veteran served. Re-housing services can be much higher, depending on the individual veteran's situation. MACV's multi-faceted, comprehensive approach focuses on the unique needs of homeless veterans, veterans in crisis, and their families. These veterans also can access MACV's additional programs and services (funded by other sources) to aid in achieving long-term stability. These services include life skills and job training, employment assistance, transitional and permanent supportive housing, and civil legal assistance. MACV offers a supportive, drug-free environment in which services help veterans reach full recovery. Programming and services provide for basic needs – including housing/shelter, health care, food and clothing – and provide “next steps” to assist them in developing the skills necessary to secure employment and create and sustain economic independence. In 2009-2012, the City's Homelessness Prevention and Rapid Re-Housing Program allocated funds to MACV for both prevention and re-housing services. During 2010-2011, the City, MACV, and the Ramsey County Housing and Redevelopment Authority also worked together to create supportive housing for six homeless veterans returning from Iraq and Afghanistan. HRA used NSP-1 funds for property acquisition, and MACV provides ongoing support services. During 2012, MACV opened a second house to provide supportive housing for women veterans. Finally, during 2009-2013, the City has allocated some ESG funds to MACV for homelessness prevention services, and MACV continues to be a strong partner with the City/County's Heading Home Ramsey Program.

**Trenton:** Working cooperatively with community partners, the Rescue Mission of Trenton has reduced client barriers to social, medical, and legal services. This year the Mission moved beyond providing for basic needs such as shelter, food, hygiene, clean clothes, and a respite from the elements for homeless persons by developing an enriched services shelter program that increases emergency service clients' access to social services, including health care. The Mission's facilities and patterns of use make it an accessible environment in which outreach and education services can be provided to the homeless population. The Mission recently implemented a program to connect eligible clients to income development and access to health care. Through a cooperative effort with the Mercer County Board of Social Services, Henry J. Austin Health Center, and Princeton Theological Seminary, the Mission instituted a project to increase the number of shelter clients applying for benefits. (About 63 percent of admissions report no income or benefits.) The keys to the success of this project have been in the on-site provision of services and the interagency coordination of care. A Board of Social Services social worker performs on-site intakes on Tuesday evenings, the Health Center provides medical appointments, and Seminary students assist clients with their applications that evening and return to escort them to their appointments. When benefits have been secured, the Board of Social Services and Rescue Mission staffs work to connect shelter clients experiencing homelessness with housing. Another example of a successful partnership involves Greater Trenton Behavioral HealthCare, which sends a homeless outreach worker to the Rescue Mission each week. The Mission's Supportive Services Manager identifies clients who are in need of mental health support and medication and the outreach worker meets with them, setting up appointments for them to enroll as Greater Trenton clients and receive psychiatric care. Appropriate case management and housing options are made available to the clients once they have enrolled. This process has made it possible for many clients to move from the shelter into housing.

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**San Antonio:** The American GI Forum National Veterans Outreach Program (NVOP) continues to promote its housing initiative by expanding the opportunities for veterans in the area of affordable housing. With support from the Home Depot Foundation, the National Community Stabilization Trust, and Bank of America, NVOP has already started rehabilitation of homes for those veteran households pursuing affordable home ownership through the Veterans Homeownership Program (VHP). In addition, NVOP has been instrumental in strengthening community efforts in support of the program. Recently, NVOP fostered a partnership with USAA, one of the oldest military financial institutions in the country, to establish financing and homebuyer guidance for those veterans interested in homeownership. NVOP was also able to increase community involvement by developing collaborations with other non-profits, such as Avenida Guadalupe and the Financial Empowerment Center, to educate the veteran population on the requirements and steps necessary to repair credit and develop personal budgeting plans. With the initial selection made for the first phase of veteran homes, NVOP is in the process of assisting with resources and guidance regarding the homebuyer process and has provided case management services to those clients needing additional attention to address the blemishes on their credit reports. NVOP also has been pleased by the response to the VHP. As a result of intensive outreach efforts, contacts by interested veterans have doubled since the program's inception. Also, NVOP has recently been granted an expansion of areas in which homes are available through the program. Homes are projected to become available in Austin, San Marcos, New Braunfels, Corpus Christi, the Eagle Ford Shale area, and El Paso. In response to the demand of clients for affordable housing, NVOP intends to see the VHP continue to expand and eventually offer other permanent housing opportunities, such as multi-family units.

**San Francisco:** Given the high cost of housing in the San Francisco community, and the very difficult challenge homeless veterans face in trying to secure their own housing, project-based solutions have been especially effective in connecting homeless veterans to the housing and services they need, and stabilizing them on the long term. One building, Veterans Commons, has been financed with a variety of local and federal resources, and has been exemplary. It permanently houses 75 chronically homeless and disabled veterans in a supportive environment with comprehensive on-site services, including case management, mental health, and medical care. The building, which opened in November 2012, was a historic site owned by the City and for years had been used as a storage facility. The project took six years and cost approximately \$30 million. One resident described the building's residents saying: "A lot of us don't have the best social skills when it comes to doing normal things. Now we get all this help. It blows my mind." "We are the type of people who don't ask for help," he says. "Veteran Commons has done a lot for me. I can't praise them enough." The project has had exceptionally high stability rate of veterans so far. As a result of their monthly meetings, the San Francisco Homes for Heroes Team, a collaboration of local community based organizations, federal agency staff from the Department of Housing and Urban Development, the Department of Veterans Affairs, and local human services, housing authority and public health staff are exploring methods for increasing the number of project based housing units for the most vulnerable homeless veterans in the community.

Source: The U.S. Conference of Mayors 2013 Status Report on Hunger & Homelessness

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### E. SPECIAL POPULATIONS - YOUTH

**San Francisco:** Community Housing Partnership (CHP) will provide permanent housing to 44 transition age youth (ages 18-24 at time of placement) in a single room occupancy hotel with integrated on-site supportive services designed to increase positive exits from supportive housing through employment. This five-year pilot program, funded by a grant from the City and County of San Francisco, is being combined with funding from HUD. The building owner completed a major rehabilitation of the building in 2013. It has 44 SRO units, most with shared baths and a limited number with private bathrooms. The first floor includes the front desk (staffed 24/7), manager's office, tenant lounge, a large community kitchen, and laundry facilities. On-site supportive services offices are located in the building. The building will be master leased and managed by CHP. In this pilot program, CHP will also provide support services focusing on housing stability, increasing self-sufficiency, and supporting individual tenants who can move on to other stable housing – opening up units for placements of other chronically homeless young adults. Referrals, which will come from Family and Children Services Division programs, will focus on transition-age youth who are exiting the Foster Care system and those in emergency shelter programs that serve this population. Tenant engagement in services and individual tenant progress over time will be measured in the analysis of this 5-year pilot effort.

**Tulsa, Oklahoma** – Mental Health Association - “The two central keys to ending homelessness and preventing people from becoming homeless, center on the development of adequate and appropriate types and levels of affordable housing, coupled with best practice models of wraparound services that help the individual stabilize into the community. These two baseline components operate best from a “housing first”, or rapid re-housing model that work both to end an existence of chronic homelessness, and to prevent people who lose their housing from languishing and becoming chronically homeless. However, to provide for the housing needs of the target population, a community must have adequate stock of safe, affordable, and decent housing that is located in areas of the community that have relatively easy access to public transportation, grocery shopping, pharmacy services, mental and physical health care, and employment opportunities. In Tulsa, we have utilized what we call our “debt free” model by raising millions of private dollars which have allowed us to leverage public brick and mortar funds, together with HUD Continuum of Care and state appropriated fee-for-service dollars. To address the housing needs of Tulsa’s transitional age youth coming out of foster care and state custody, our fundraising effort, called Building Tulsa Building Lives has raised funds to purchase two apartment buildings dedicated to young adults that are owned and operated by Youth Services of Tulsa. Beyond the development of small apartment buildings scattered around the metro Tulsa area, we have utilized a mixed income/population model with each of our independent apartments having one-half of the units dedicated to availability for “market rate” renters, helping to maintain diversity and community integration. To address the spiritual needs of our residents, we have hired an individual who outreaches to faith communities who are located in the areas of our properties. This outreach helps congregations become better educated about the people who live in our properties and to encourage them to reach out to our residents, to provide them with assistance and to encourage them to participate in their respective faith communities. This effort is also helping to move the faith communities away from a “feed the homeless” mentality and transform them into an “engage the formally homeless,” mindset, and to help these individuals reintegrate into the full fabric of the community. we utilize best practice models in the form of accessing the services of three Programs of Assertive Community Treatment (PACT Teams) who work with the mental health/substance abuse needs of our residents, delivering services at the housing location when needed. We are now in the early stages of implementing use of



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the Seeking Safety model of addressing trauma and substance abuse issues to our residents coming out of years of homelessness.”

Link: <http://mhaok.org>; [http://usich.gov/resources/uploads/asset\\_library/ExpertsB](http://usich.gov/resources/uploads/asset_library/ExpertsB)

Source: **The U.S. Conference of Mayors 2013 Status Report on Hunger & Homelessness**

### F. COMMUNITIES ADDRESSING FORECLOSURE

**Chicago:** The City, through its Home Ownership Preservation Initiative (HOPI) collaborative, has been working for a number of years to address the myriad issues associated with foreclosure. With respect to prevention, HOPI initiatives provide for accredited housing counselor services, emergency service referrals, and outreach programming. Additionally, families and individuals renting in multi-unit housing whose owners are in the process of foreclosure can obtain information about their legal rights and resources available by calling 311 and asking to be connected with one of the Foreclosure Assistance Information for Renters (FAIR) agencies.

**Los Angeles:** In December 2012, the Los Angeles City Council extended, through December 31, 2013, the Foreclosure Eviction Ordinance (No. 180441) which prohibits lenders who foreclose on any rental unit in the City from evicting tenants without a legal reason permitted under the City's Rent Stabilization Ordinance (RSO). Although the RSO prohibited eviction of tenants merely due to foreclosure, prior to adoption of this Ordinance no protection existed for tenants living in properties exempt from the RSO, including single-family homes. For homeowners facing foreclosure, the City has also established a hotline which provides people with information about remediation programs.

**Boston:** Boston has a Comprehensive Foreclosure Prevention Initiative that has continued to support robust programs and partnerships to reduce foreclosure through the Boston Home Center. This includes a regularly offered Options for Reducing Monthly Mortgage Payments Workshop, a free one-session workshop that will help homeowners learn how to prevent foreclosure, and the Don't Borrow Trouble® Foreclosure Prevention Program that has become a national model that provides consumer outreach, information, and counseling to help Boston homeowners avoid predatory lending and foreclosure. Services include counseling, intervention, and workout strategies. The City has robust foreclosure counseling partnerships with five NGO's, including Mattapan Family Service Center/Action for Boston Community Development, the Codman Square Neighborhood Development Corporation, ESAC Boston, Nuestra Comunidad Development Corporation, and the Urban Edge Community Development Corporation.

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**Nashville:** A number of local agencies do foreclosure counseling and in some instances provide emergency relief payments. THDA, the State housing finance agency, has a “Hardest Hit” program which targets homeowners who have become unemployed or underemployed through no fault of their own, as well as those who are on long-term disability or Social Security disability. The event must have occurred since January 1, 2008. The program was expanded to add divorce and death of spouse as hardship reasons. Locally, Hardest Hit is administered by Woodbine and AHR, but applications are submitted first by the consumer at [www.KeepMyTNHome.org](http://www.KeepMyTNHome.org). United Way provides financial support for Residential Resources and for programs at Catholic Charities, Conexion Americas, Ladies of Charity Welfare Agency, Martha O’Bryan, Matthew 25, Oasis Center, Old Hickory Christian Community Outreach, Park Center, Salvation Army, St. Luke’s, and the ARC of Davidson County. All of these programs either assist with foreclosure prevention or aid a family with funds to remain in housing (paying for utilities, rent,/mortgage, etc.).

**Saint Paul:** For 20-plus years the City has maintained a nationally- recognized Mortgage Foreclosure Prevention Program which provides intensive case management, housing counseling, financial budget counseling, foreclosure prevention assistance (assistance with loan modifications, loan forbearances, etc.), and referrals to community resources.

**San Antonio:** The City has continued its Housing Counseling Foreclosure Prevention Program in partnership with HUD, Treasury, Federal Deposit Insurance Corporation (FDIC), Federal Reserve Bank, Fannie Mae, and the State and Local Foreclosure Prevention Task Force. The program provides foreclosure intervention counseling to delinquent homeowners facing foreclosure, using a Housing Counseling grant to work with FHA homeowners and area lenders on loan modifications to avoid foreclosure and prevent homelessness. Counselors work with delinquent homeowners in developing crisis budgets to qualify them for loan modifications under HUD’s Home Affordable Modification Program (HAMP) and U.S. Treasury regulations for the Making Home Affordable Program. Delinquent homeowners have the opportunity to meet face to face with their lender or a HUD-approved housing counselor to complete a “workout plan,” thereby avoiding possible foreclosure. The City partners with the San Antonio Board of Realtors, San Antonio Apartment Association, San Antonio Housing Authority, and Haven for Hope of Bexar to place foreclosed homeowners in suitable housing to avoid homelessness. The program utilizes Emergency Solutions Grant (ESG) funding to provide financial assistance to families to secure rental housing, if necessary.

**San Francisco:** The City has created the Housing Trust Fund as a set-aside from the City’s General Fund, in part to provide ongoing funding for housing stabilization for individuals who are at risk of or have lost their homes to foreclosure. The Trust Fund is providing \$700,000 to fund eviction prevention counseling, rapid re-housing counseling, and tenant-based rental assistance and move-in costs to these individuals and families. Through the Fund, the City is also providing \$300,000 for expanded foreclosure counseling services and door-knocking rapid response services to all individuals receiving notices of default from the City’s Assessor-Recorder’s Office. In addition, the City has set aside \$500,000 for a mortgage assistance program that will complement the existing Keep Your Home California program to provide additional resources for individuals at risk of losing their homes.

Source: The U.S. Conference of Mayors 2013 Status Report on Hunger & Homelessness

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### G. OTHER - EXEMPLARY PROGRAMS TARGETING SPECIFIC ISSUES

In **Charleston**, Crisis Ministries' Homeless Employment and Learning Program (HELP) offers adult education, GED classes and testing, WorkKeys classes and credentialing, ServSafe training and testing, and general employment support and guidance for persons transitioning out of homelessness. These services have helped 87 percent of participants attain permanent housing over the last year; 95 percent have gained, increased, or maintained their income.

In **Charlotte**, MeckFUSE (Frequent Users Systems Engagement) seeks out individuals who have experienced a minimum of four shelter or jail visits within a five-year period. The goal of the program is to decrease the usage of the county jail and shelters and provide access to affordable housing, substance abuse treatment, and physical and mental health services.

In **Denver**, the Denver Housing Authority continues its commitment to Denver's Road Home, each year providing Section 8 vouchers through its local preference program, and public housing units through its Family Housing Program. Two additional service providers were added to the local preference program in 2012, one of which focuses on re-entry programs and will help address the needs of two underserved populations – single unaccompanied women who are homeless, and recently released ex-offenders.

In **Providence**, Home Base is a two-year-old **Housing First** program that provides immediate access to permanent housing and wrap-around services designed to allow clients to remain in their housing. Funded by the Substance Abuse and Mental Health Services Administration and run by the Providence Center, a community mental health center, the program is serving more than 70 clients.

**Asheville:** Over the past year the City has seen an increase in families experiencing homelessness. Local faith communities that had become concerned about this increase wanted to explore ways to be part of permanent solutions – this in addition to their on-going charity work in support of emergency shelters. Over several months, a coalition of churches met with local service providers and local officials to explore ways churches could help ease family homelessness. As a result, the coalition is now using one of its sites as a pilot project that involves renovating under-used facility space. The initial renovation will produce two two-bedroom apartments for homeless families in need of affordable, permanent housing. The project, which involves the faith communities, the City, and a homeless housing provider, is scheduled for completion early in 2014. The City plans to use it as a model for additional efforts by other faith communities and non-profits.

Source: The U.S. Conference of Mayors 2013 Status Report on Hunger & Homelessness