

2009

# Homeless to Homes

## Putting an End to Homelessness

A comprehensive plan for the City of Cincinnati and Hamilton County, Ohio to ensure homeless single individuals have access to appropriate shelter facilities and comprehensive services which facilitate their movement from shelter to permanent housing.

A system wide paradigm shift

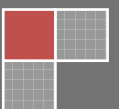
New requirements for homeless providers

New requirements for those with statutory authority

New cooperative efforts among funders -public and private

New expectations for those who are homeless

Empowering change



# Homeless to Homes

*Changing how our community responds to individuals who are homeless.*

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## Introduction and Comments from the Steering Committee

This plan represents only the beginning. It is the summary of recommendations made by local and national experts in the homeless services field, local funders, and community stakeholders including representatives of service providers, government agencies, NGOs, businesses, and faith-based organizations. This plan represents hundreds of hours of research, discussion, deliberation, and debate.

It is the first time in our region that a plan for ending homelessness used actual data of homeless persons in the community. We identified real numbers, real ages, and real special needs early on and these data became a foundation for the work. Because this plan was created using a “blank slate” problem solving method, it reflects what the steering committee and working subcommittees believe are the best of what could and should happen for homeless single individuals in the community.

The plan represents a significant shift in the ways our community responds to those who are homeless. The Homeless to Homes report responds to the need for a new, comprehensive plan that changes how our community provides homeless housing and services, how homeless individuals are expected to respond, and how public and private funding systems can work cooperatively and with a clear emphasis to support the initiatives of this plan.

As the homeless persons who participated in the “Homeless Think Tanks” repeatedly pointed out, their chance for success in moving to housing often lies in relationships with a case manager or shelter staff who know and personalize their situation. We heard the frustrations and impediments they encounter as they seek services, especially for those who are homeless as a result of disabling conditions like mental illness, substance use disorders, or physical incapacities.

The Steering Committee recommends that the members of the Council of the City of Cincinnati (“City Council”) read and review the plan in full before taking action. It is only when you take in the context of the data, the work of the subcommittees, and the appendices that you have a complete picture of the complexities of the issues, the recommendations that have been made, and the careful balance that has been created to support the movement of persons from homelessness into appropriate housing. To that end, the Steering Committee recommends that the City Council avoids “cherry picking” only certain elements or pieces from the plan to the extent possible.

Further the Steering Committee recommends City Council consider the following actions, once the plan is approved.

1. Establish a **Transition Team** to prioritize the recommendations within this plan for implementation, using the same cross-functional representation of interests on the Transition Team as the committee that constructed the plan initially. The implementation of the recommendations needs to be transitioned so as not to cause additional hardships for homeless individuals or result in an increase in street homelessness.
2. As part of the transition process, an additional effort must be undertaken to further identify **Best Practices** and medical services for the homeless. This means examining the research and looking around the country for agencies and organizations that have service delivery models and programs that achieve notable success.
3. The Steering Committee recognizes community concerns over safety related to the siting of shelters. As part of the transition process, **Minimum Standards for Shelter** must be developed (as discussed on page 9) and shelters must then pledge to adhere to those standards for public funding. Additionally, the Transition Team should include in its work a cooperative effort to work with representatives from existing shelters and other stakeholder groups to engage in site feasibility studies. The Steering Committee recommends that new shelters should not be sited next-door or across the street from (i.e. adjacent to) an existing school. Definition of school and adjacent must be clearly defined and researched. Further the transition process must address the safety factors in siting new shelters in the future.

4. The Steering Committee recommends that City Council direct the City of Cincinnati Administration to incorporate the Homeless to Homes plan as the basis for the Homeless/Special Needs section for homeless individuals within the **2010-2014 Consolidated Plan** of the City (and has been the tradition – as the identical section included within Hamilton County’s Consolidated Plan).

### **Problem Statement**

Cincinnati is a leader in services for the homeless in many ways. However, there are opportunities to better serve homeless single men and women. Shelters currently provide a place to stay and facilities to meet basic needs. However, the shelters struggle with the number of people presenting as homeless into the system on a daily basis and the shelters face many challenges to provide best practice services to support an exit to homelessness. Beyond the shelter system, three other items were identified as contributing factors to homelessness: 1) the availability of appropriate housing, especially for special needs subpopulations to facilitate their exit from the streets or shelters; 2) the accessibility of mental health and substance abuse services for all those in need to address the special issues that precipitate or perpetuate their homelessness; and 3) the funding to sustain efforts to make significant and lasting improvements to the system. Additionally, agencies serving the homeless are challenged to increase communication and resolve conflicts with their host neighborhoods in more proactive and productive ways.

### **Ordinance**

On October 8, 2008 City Council approved Ordinance 0347-2008<sup>1</sup> which directs the Cincinnati Continuum of Care for the Homeless (CoC)<sup>2</sup> to “immediately address the inadequacy of the current provision of services for single homeless individuals in the City of Cincinnati, and to put in place a comprehensive plan to implement such services.” Further, the ordinance states “the plan must ensure that as a critical segment of the homeless community, single homeless men and women, will have access to safe, appropriate shelter facilities and that such facilities will provide comprehensive services necessary for homeless individuals to obtain and maintain housing.” This ordinance, combined with Council’s instructions to “take a blank slate” approach, set the framework for the Homeless to Homes planning process.

### **Response**

To comply with the request of City Council, the CoC convened a Steering Committee and seven subcommittees to undertake a comprehensive planning approach<sup>3</sup>. This document represents the work of those groups.

- Section 1 is the Steering Committee report which contains: 1) the recommendations of the Subcommittees that the Steering Committee choose to move forward as recommendations to City Council; and 2) recommendations that address the issues the City Council’s ordinance mandated be included.
- Section 2 includes reports from the Subcommittees. Each Subcommittee presented a snapshot of the data they utilized to develop their plan to the Steering Committee, along with draft plans. The Steering Committee reviewed the work of each Subcommittee at least twice, providing suggestions to the Subcommittees for changes and clarification. The final version of each Subcommittee’s report, as accepted by the Steering Committee, is included here. Acceptance of

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<sup>1</sup> Refer to Appendix 1 for the complete text of Ordinance 0347-2008

<sup>2</sup> Refer to Appendix 2 for background information on the Cincinnati/Hamilton County Continuum of Care for the Homeless

<sup>3</sup> Refer to Appendix 3 for process and participant information

the report means the Steering Committee agreed the Subcommittee covered the relevant topics and used an appropriate process. It DOES NOT mean that members of the Steering Committee agree with or approve every recommendation in a Subcommittee report.

**Background on the Current System**

The current system for homeless individuals can be described simply as follows (see also Table 1):

1. Single homeless persons go to an emergency shelter designed for individuals, which currently have 422 shelter beds for single individuals. Shelters are expected to work with homeless individuals to find housing, obtain an income, or address other issues that contribute to or cause homelessness. Many shelters do not have adequate staffing to provide case planning and supportive services for everyone sheltered.
2. Individuals leaving the shelter with “positive outcomes” exit to one of the following places: mainstream housing (either subsidized or market rate), transitional housing for the homeless, or permanent supportive housing for the homeless. Additionally, some may go to live with family or friends and a few go to a long-term treatment program which, for them, may be a positive outcome. There are currently 229 transitional housing beds and 863 permanent supportive housing units utilized by single individuals in the CoC.
3. A subset of the homeless population is individuals who are unable to accept being sheltered and/or who have been banned from a shelter. Outreach workers in the community are expected to engage with these individuals and provide connections to services, treatment, and/or housing.

**Table 1. The Continuum of Care (CoC) Inventory of Housing for Homeless SINGLE INDIVIDUALS in Cincinnati/Hamilton County**

| <b>Current Inventory by Housing Type</b> | <b>Beds for Individuals</b> | <b>Beds for Families</b> |
|--|-----------------------------|--------------------------|
| Emergency Shelter                        | 422 (+ 20 DV* beds)         | 185 (+45 DV)             |
| Transitional Housing                     | 229 (+9 DV beds)            | 82 (+60 DV beds)         |
| Permanent Supportive Housing             | 863                         | 456                      |

\* DV = Domestic Violence

To address the charge outlined by City Council in the ordinance, the Homeless to Homes Steering and Subcommittees reviewed the following elements of a successful system for homeless individuals:

1. The **emergency shelter system** to ensure access to appropriate and immediate shelter facilities, services, and housing for homeless single men, women, and young adults (ages 18 through 24).
2. The **transitional and permanent supportive housing system** to ensure access to appropriate housing post-shelter for persons with longer term or special needs and which would reduce the current log-jam at exit because of an inadequate supply of transitional and permanent supportive housing.
3. The **street outreach service delivery system** to ensure access to appropriate shelter facilities, services and/or housing for individuals living on the streets.
4. The **mental health and substance use disorder treatment systems** to ensure that homeless, single individuals with mental health and/or substance use issues—who make up the largest subgroup of homeless, single individuals—have access to best practice services to meet their needs while in shelter or when they are in permanent supportive housing.
5. The **funding system**, including the majority of public and private funders, has been engaged with the planning process and has prepared ways to financially support the efforts of the plan.

### Background on Outcomes

Since the Continuum of Care for the Homeless (CoC) process began in 1996, the Department of Housing and Urban Development (HUD) has used an outcome-oriented system to determine the success of a funded program and of the CoC as a whole. Over the years the clarity from HUD about outcome expectations and the community's ability to capture accurate data related to outcomes through its Homeless Management Information System (HMIS) has improved.

To date CoC-funded programs (Transitional Housing, Permanent Supportive Housing and Service Only) are required to address three main goals, established by HUD:

1. To help program participants obtain and remain in permanent housing;
2. To help participants increase skills and/or income. Meeting this goal will allow the participants to secure an income to live as independently as possible; and
3. To help participants achieve greater self-determination. The condition of homelessness itself can be damaging to one's self-determination; achieving a greater sense of self-determination enables the participant to gain needed confidence to make the transition out of homelessness.

Grantees report progress in achieving these goals annually to HUD through their Annual Progress Reports (APR). Within the local CoC grant process Goal 1 (housing) and Goal 2 (income) as identified above have been measured and scored for every grantee, as the program is considered for renewal. Outcome measure scoring success is required for the program to be refunded. The entire HUD/CoC funded community's outcomes are measured and scored annually by HUD in order for the CoC to receive funding.<sup>4</sup> Local outcomes for the HUD goals are shown in Table 2.

**Table 2. Current HUD benchmarks for outcomes on CoC-funded projects**

| <b>Objective</b>  | <b>Local 2008 Achievement Level</b> | <b>2009 Proposed Goal</b> |
|---|-------------------------------------|---------------------------|
| Increase the percentage of homeless persons staying in (supportive) permanent housing over 6 months to at least <b>71.5%</b>                          | <b>82%</b>                          | <b>85%</b>                |
| Increase the percentage of homeless persons moving from transitional housing to permanent housing (supportive or mainstream) to at least <b>63.5%</b> | <b>71%</b>                          | <b>73%</b>                |
| Increase the percentage of homeless persons employed at exit to at least <b>19%</b>   | <b>28%</b>                          | <b>30%</b>                |

It is recommended that the City and all funders should require that outcome measures: 1) be used by all agencies and organizations that receive funding; 2) be widely and publicly shared; and 3) be the basis for improvement plans developed by agencies when the community or an agency does not meet one or more benchmarks.

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<sup>4</sup> Refer to appendix 4 for 2007 outcome reporting.

## Steering Committee Recommendations

### *Emergency Shelter Beds*

Consistent with the Consolidated Plans of the City and County since 2000, the Steering Committee does not recommend adding any new shelter beds to the Housing Inventory. However, we recommend that the beds be reconfigured into emergency shelters with services as described below. The Steering Committee also recommends that a Request for Information (RFI) or Request for Proposal (RFP) system be used to identify the providers of shelters, as necessary for the implementation of this plan.

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| <p style="text-align: center;"><b>Emergency Shelter Bed Inventory for Single Individuals</b><br/><b>Current Inventory = 422 beds<sup>5</sup></b><br/><b>Inventory Currently Under Development = 0</b><br/><b>NEW Beds Recommended by HTH = 0</b><br/><b>Homeless to Homes Inventory = 422 emergency shelter beds</b></p> |
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1. A 40-bed, City-wide **Safe Walk-In Shelter** is recommended to provide emergency refuge on a walk-in basis for single men and women who cannot or will not engage with workers to develop a case plan. [This recommendation structures 40 beds within the housing inventory as “safe beds”.]
2. A 40-bed **Single Women’s Shelter** facility is recommended to separate single women from single men [This recommendation moves beds for single women from existing facilities within the emergency shelter inventory but does not add beds to the inventory.]
3. A 25-bed **Young Adult Shelter** is recommended to separate young adults (those ages 18–24) from the older adult population. [This recommendation moves 25 beds from the single men’s emergency shelter inventory.]
4. Three redesigned general shelters for single men are recommended to accommodate the range of single homeless men within the community. The three shelters are identified as: **Men’s A** (50 beds); **Men’s B** (50 beds); and **Faith Based** (50 beds). It is recommended that one of these general shelters be located adjacent to the Safe Walk-In Shelter to provide some flexibility in meeting the needs of the population of single homeless men. [This recommendation rearranges the current bed configuration for single men but maintains the total number of beds in the single inventory.]
5. **Mt. Airy Shelter**, a one-of-a-kind facility, is recommended for expansion to accommodate approximately 96 men. The shelter must continue to provide substance use disorder treatment [This recommendation rearranges the current bed configuration for single men and maintains the total number of beds in the single inventory.]
6. There are no recommendations to change the **specialized shelters** which include: the City’s Cold Shelter; the Center for Respite Care, a 15-bed medical shelter for people post-hospitalization or in need of medical attention; Off-the-Streets, a 10-bed shelter specifically for women who are involved in prostitution; St. Francis-St. Joseph Catholic Worker House, a 16-bed Catholic Worker-model facility; and Lighthouse Youth Crisis Center a 20-bed shelter for homeless, single individuals under age 18. The Hamilton County Mental Health and Recovery Services Board Quick Access Program, while not a shelter has 10 emergency housing rooms for people with chronic mental illnesses and who have a case manager. We also recommend no changes to this program.

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<sup>5</sup> Refer to Appendix 10 – CoC 2008 Housing Inventory of Emergency Shelters

7. Individuals presenting to shelters as established couples (married, common law, or long-term partners) will be referred to the Family Shelter system for intake.
8. Gender-specific programs shall place clients in housing based on self-reported gender identification.
9. It is recommended that all agencies maintain and enforce a policy of non-discrimination in the provision of client care based on the following: age, race, color, religion, sex, sexual orientation or gender identity and expression, marital status, geographical, national or ethnic origin, HIV status, disability, or veteran status, and that this be added to the Standards for Shelters.

#### *Emergency Shelter Facilities and Standards*

1. All shelters for single individuals, with the exception of the Safe Walk-In Shelter, must use an Intake/Exit method of housing to facilitate outcome measurements.
2. All shelters will record all relevant data within the Homeless Management Information System (HMIS).
3. The renovation or construction of any shelters for individuals should be designed to give people the smallest group sleeping rooms feasible, rather than use large, dormitory-style sleeping rooms.
4. The City Department of Community Development, Hamilton County Community Development, the CoC, the Greater Cincinnati Coalition for the Homeless, City of Cincinnati and/or County Health Departments, and the Cincinnati Police will jointly revise Minimum Standards for Shelters to be “Shelter Program, Operations, and Facility Standards.” All shelter facilities will be required to pass these new standards to be eligible for funding from either the City or the County that requires Consolidated Plan Certification or is from the general funds. The Standards should address at least the following items:
  - a. Building: health, safety, and public appearance standards (interior and exterior)
  - b. Program: shelter policies and procedures, grievances, etc.
  - c. Staffing: Case Management to Client ratio, 24/7 staffing
  - d. Confidentiality: Case management offices, filing location, HMIS data station
5. Site Recommendations for all new shelter programs are as follows: The type (apartment units vs. group living), scale (number of units, number of persons per unit), and the general location of all new transitional housing must fit the needs of the participants. The housing must be readily accessible, either within walking distance or easily accessible by bus and near a bus line, to community amenities that the participant population normally requires including: grocery stores and recreation, medical, training, mental health or substance use disorder treatment, and mainstream benefit/resource facilities. The Transition Team should work cooperatively with shelters and other stakeholders to conduct site feasibility studies. The Steering Committee also recommends that new shelters should not be located next-door or across the street from (i.e. adjacent to) an existing school. The definitions of “school” and “adjacent to” must be clearly researched and defined. Further, the transition process must address the safety factors in locating new shelters in the future.
6. Outcomes for emergency shelters are recommended to be monitored based on the following HMIS data points: number of homeless persons housed, average length of stay (targeted at 30–60 days), number of persons achieving transitional or permanent housing upon exit, number of persons increasing income upon exit, and number of persons obtaining employment upon exit. Further, it is recommended that the CoC establish a standard for recidivism—or return to homelessness after placement in transitional or permanent housing—that will be measured in addition to the aforementioned outcome points.

### *Transitional Housing*

The Steering Committee recommends an increase in Transitional Housing<sup>6</sup> beds for single individuals. We recommend both site-based and scattered-site transitional housing units and services in order to facilitate the movement from emergency shelter into housing. Existing requirements by the City and HUD for funding of Transitional Housing mean that no additional processes, including an RFI/RFP, are required. “Good Neighbor Agreements” and site recommendations are included.

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| <p style="text-align: center;"><b>Transitional Housing Bed Inventory for Single Individuals</b><br/><b>Current Inventory = 229 beds</b><br/><b>Inventory Currently Under Development = 36 beds</b><br/><b>NEW Beds Recommended by HTH = 191</b><br/><b>Homeless to Homes Inventory = 456 Transitional Housing beds</b></p> |
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1. A minimum of 191 site-based or scattered-site transitional housing beds are recommended in order to a) allow emergency shelters to serve as short-term facilities; b) enable longer-term support for persons who require longer lengths of stay to achieve their income or housing goals; and c) to reduce the recidivism rate of homeless and/or disabled persons returning to homelessness when they are placed in permanent housing before they are ready or able to succeed. We recommend 140 new beds of site-based transitional housing and 51 new beds of scattered-site transitional housing. In addition, these beds should be designated as follows:
  - a. Approximately 50 beds for single females
  - b. Approximately 40 beds for young adults
  - c. Approximately 30 site-based beds to support a diversion program for non-violent offenders who were homeless upon arrest<sup>7</sup>
  - d. Approximately 16 beds for persons currently residing on the streets or in places unfit for human habitation
  - e. Approximately 40 beds for faith-based programs
  - f. The remaining new beds should be dispersed according to program-design and funding availability.
2. A diversion program in cooperation with Hamilton County and the Hamilton County Pre-Trial Program is recommended to create new housing solutions instead of incarceration for homeless persons.
3. It is recommended that all new transitional housing programs develop a “Good Neighbor Agreement” with adjacent property owners (residents and businesses).<sup>8</sup>
4. Site Recommendations for all new site-based transitional housing programs are as follows: the type (apartment units vs. group living), scale (number of units, number of persons per unit), and the general location of all new site-based transitional housing must fit the needs of the participants. The housing must be readily accessible, either within walking distance or easily accessible by bus and near a bus line, to community amenities such as grocery stores and recreation, medical, training, mental health or substance use disorder treatment, and mainstream benefit/resource facilities. After reviewing the current inventory of TH and PSH<sup>9</sup> the subcommittee recommends that new inventory considered by developers distribute PSH throughout the

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<sup>6</sup> Refer to Appendix 13 for Transitional Housing definition

<sup>7</sup> Refer to Appendix 5 for the complete Statistical Report on Homeless Single Individuals Identified Through HMIS/VESTA Matched with Hamilton County Arrest Record Database

<sup>8</sup> Refer to Appendix 6 for a sample Good Neighbor Agreement.

<sup>9</sup> Refer to Appendix 11 for the HUD map of CoC Funded PSH Units by Census Tract

region.<sup>10</sup> Therefore, no new site-based TH/PSH is recommended currently for Census Tract 9, based on its current level of saturation<sup>11</sup>

5. Outcomes for transitional housing are recommended to be monitored based on the following HMIS data points: number of homeless persons housed (with a minimum occupancy average of 85%), length of stay in relation to the program design, number of persons achieving permanent housing upon exit, number of persons increasing income upon exit or the number of persons obtaining employment upon exit.

### *Permanent Supportive Housing*

The Steering Committee recommends an increase in permanent supportive housing (PSH)<sup>12</sup> units for use by single individuals. Recommendations identify both site-based and scattered-site PSH units and services to be developed in order to facilitate permanent housing for homeless, disabled individuals. Existing requirements by the City and HUD for funding of Transitional Housing mean that no additional processes, including an RFI/RFP, are required. “Good Neighbor Agreements” and site recommendations are included. Additionally, we recommend a new provider, National Church Residences, to assist in developing the new PSH units.

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| <p><b>Permanent Supportive Housing (PSH) for Single Individuals</b></p> <p><b>Current Inventory = 863 units</b></p> <p><b>Inventory Under Development = 53 units</b></p> <p><b>NEW PSH Units Recommended by HTH = 1,020</b></p> <p><b>Homeless to Homes Inventory = 1,936 PSH units</b></p> |
|---|

1. Development of a minimum of 125 site-based PSH units and 79 scattered-site PSH units per year for the next 5 years is recommended. This will a) allow emergency shelters to serve as short-term facilities, b) move those who are seriously disabled to permanent housing, c) support individuals in maintaining their housing and reduce the recidivism rate of homeless disabled persons, and d) provide disabled individuals the stability necessary to access mainstream services and resources for their disabilities.
2. A better use of existing subsidized housing is recommended by creating new entrance supports for homeless single individuals to acquire access to Cincinnati Metropolitan Housing Authority’s (CMHA) existing supply of public housing units.
3. The Creation of a permanent group home or safe-haven (permanent) is recommended for the eight homeless single women who have been long-term shelter residents.
4. The Establishment of a partnership between the CoC and National Church Residences (a highly qualified national developer of PSH units) is recommended to increase the community’s ability to provide PSH and immediate capacity to develop and operate PSH.<sup>13</sup>
5. Encouragement of PSH programs to work with CMHA is recommended to increase the amount of project-based Section 8 housing allocated to PSH.

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<sup>10</sup> Recommendation does not include projects currently funded and under development.

<sup>11</sup> Level of saturation equals the current level of TH and PSH in a tract in relation to other tracts within the jurisdiction.

<sup>12</sup> Refer to Appendix 13 for PSH definition

<sup>13</sup> Refer to Appendix 5 for a description of National Church Residence.

6. It is recommended that all new transitional housing programs develop a “Good Neighbor Agreement” with adjacent property owners (residents and businesses).<sup>14</sup>
7. Site Recommendations for all new PSH are as follows: the type (apartment units vs. group living), scale (number of units, number of persons per unit), and the general location of all new site-based transitional housing must fit the needs of the participants. The housing must be readily accessible, either within walking distance or easily accessible by bus and near a bus line, to community amenities such as grocery stores and recreation, medical, training, mental health or substance use disorder treatment, and mainstream benefit/resource facilities and services. After reviewing the current inventory of TH and PSH<sup>15</sup> the subcommittee recommends that new inventory considered by developers distribute PSH throughout the region.<sup>16</sup> Therefore, no new site-based TH/PSH is recommended currently for Census Tract 9, based on its current level of saturation<sup>17</sup>
8. Outcomes for transitional housing are recommended to be monitored based on the following HMIS data points: number of homeless persons housed (with a minimum occupancy average of 85%), ability to maintain housing (benchmark 6 months), number of persons increasing income upon exit or the number of persons obtaining employment upon exit.

### *Services*

Supportive services are critical in order for homeless individuals to move quickly and appropriately from the streets and emergency shelters into housing. The Steering Committee recommends that the region develop an improved level and quality of service delivery to enable and empower homeless persons to move out of homelessness.

#### *Central Access System*

1. A Central Access System is recommended to coordinate and expedite the flow of all homeless single individuals into and through the shelter system. The Central Access System should include access to shelter information and referrals to homeless housing and supportive services. For homeless single men who present with substance use disorders, the system should also provide basic substance use disorder screening and transportation to Mt. Airy Shelter.
2. Improve capacity to assess mental health and substance use disorders among homeless individuals by providing diagnostic assessment capacity that addresses both mental illness and substance use disorders in order to engage and connect homeless clients into appropriate services is recommended at the Central Access System Center.

#### *Outreach Improvements*

3. Anthony House, a current outreach and engagement center for young adults (age 18 to 25), is recommended for expansion to include: additional street outreach, an increased number of days and hours per day it is open, evening meal services, connections to mainstream services and resources, and connections to services that help individuals become self-sufficient.
4. Four new street outreach workers who specialize in substance use disorder treatment to engage street homeless in services and promote harm reduction and treatment are recommended in

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<sup>14</sup> Refer to Appendix 5 for a sample Good Neighbor Agreement

<sup>15</sup> Refer to Appendix 11 for the HUD map of CoC Funded PSH Units by Census Tract

<sup>16</sup> Recommendation does not include projects currently funded and under development.

<sup>17</sup> Level of saturation equals the current level of TH and PSH in a tract in relation to other tracts within the jurisdiction.

order to address a specific population of street homeless who are currently without outreach services.

5. Formal arrangements between the Cincinnati Police and street outreach programs through the Homeless Outreach Group is recommended so that either the Cincinnati Police specify officers in all districts that are designated to work with the street homeless and outreach workers OR that one specific officer is designated to cross district boundaries.
6. A coordinated community response to people who are sleeping on the streets is recommended so as to not enable a homeless lifestyle. The group developing this response should include the CoC, the Homeless Outreach Group, churches, universities, service providers, and other community stakeholders. This response will be widely shared within the region.

#### *Homeless Case Management*

7. The establishment of a 1:10 homeless case manager to client ratio for all shelters serving homeless individuals is recommended. Service delivery within the housing and homeless services system begins with competent, client-based "homeless case management." Homeless case management is defined as a method of providing services whereby a social worker (or other related professional) assesses the needs of the client and arranges, coordinates, monitors, evaluates, and advocates for a package of housing and multiple services to meet the specific client's complex needs. Though case management is a widely used term within the homeless service delivery system, it is also loosely defined. Applying this clear, specific definition of homeless case management for use across the CoC will enhance a cooperative understanding of what is expected of all homeless case managers.
8. The requirement that all shelters assign everyone entering the shelter to an individual case manager or case management team and expect the person to participate in an assessment and enter into an individualized service plan is recommended.
9. Encouragement of case managers to focus their time and energy on engagement and program enrollment is recommended. Difficulty in providing assistance to homeless individuals often arises from resistance to engagement. Having the case manager's focus on engaging clients, enrolling clients in the emergency shelter system, and fostering stabilization will facilitate movement into housing and needed services.
10. An assessment and screening of all people in all CoC general shelters within 48 hours of admission is recommended. The information acquired during this assessment will serve as the foundation and direction for the individualized service plan. A minimum assessment should include:
  - a. Current situation and reason for homelessness
  - b. Information about personal and family support
  - c. Housing history
  - d. Income and economic situation
  - e. Education and training
  - f. History of social services used
  - g. Health history
  - h. Basic life skills inventory
  - i. Veteran status, service in the Armed Forces, and eligibility for VA housing and services
  - j. Special needs screening for mental health; substance use; physical, cognitive, or sensory disabilities; and other conditions.
11. An individualized service plan (ISP) developed by the case manager with each individual sheltered within the general shelter system is recommended. At the minimum, an ISP should include concrete, measurable steps to obtaining housing, increasing or stabilizing income, and addressing any special needs. ISPs require that staff monitor and make appropriate adjustments to the ISP as the individual engages and discloses more information. ISPs are also fluid

documents which develop over time: the original ISP developed at the beginning of the individual's shelter stay will not be the same as the ISP in place at the end of the stay.

12. The designation of case managers as brokers of services for homeless individuals is recommended. In this role, the case manager would help a homeless individual identify and connect to the resources they need to carry out their ISP. Case managers can also serve as advocates for homeless individuals within the housing, mainstream resource, and service delivery systems so that clients can successfully access other systems and programs.
13. Discharge planning is recommended with homeless individuals as soon as the individuals enter the shelter. Throughout an individual's stay in a shelter, shelter staff should work with the individual on an exit strategy and attempt to remove or lessen any barriers to housing, income, or service access that will stand in the way of the individual's success at independent living. For clients moving from shelter to either transitional housing or PSH, the discharge plan should be forwarded to the next housing placement and should include a summary of the elements of the ISP the person has completed, what is in progress, and what is left to accomplish. The electronic forwarding of ISP's within the HMIS/VESTA system should be considered.
14. A requirement that shelters readmit an individual who was discharged from shelter and later returned to homelessness is recommended. Placement at the same shelter is preferred but depends upon the individual's willingness to engage in a plan different from what precipitated the return to homelessness.

#### *Mental Health and Substance Use Disorder Treatment Services*

15. The Convening of a Service Collaborative Roundtable by the Mental Health and Recovery Services Board (MHRS) and the Continuum of Care for the Homeless (CoC) is recommended. This roundtable will identify and plan interventions that address system gaps; include other stakeholders in the discussions; develop protocols for HCMs to use for accessing and coordinating mental health and substance use disorder treatment services; develop protocols for coordination when a homeless individual is connected to service, and to identify and assess progress toward mutually established benchmarks and outcomes.
16. The development of a system to meet the needs of individuals who have mental health issues but who are not Severely Mentally Disabled (SMD), and are ineligible for most MHRS Board funded services because of current limited resources.
17. Diagnostic Assessments by the MHRS system of care are recommended to be expedited for homeless persons to decrease the chance the person will have moved out of shelter prior to receiving the diagnostic assessment. By establishing new procedures within the Mental Health Access Point (MHAP) system and maintaining the Homeless Housing and Residential Treatment program at Recovery Health Access that reduce wait times for assessments.
18. The development of a data sharing process between the CoC and the MHRS Board is recommended in order to increase collaboration and coordination and decrease duplication of services for clients involved in both systems.
19. The establishment of cross-training programs between the CoC and the MHRS Board provider agencies is recommended to further worker education and communication.
20. Local best practices and evidence-based practices and innovations currently used by MHRS Board provider agencies are recommended to be continued and expanded through the seeking of new financial resources targeted to meet the needs of people who are homeless and have mental health or substance use issues.

### Capital Funding

The recommended beds and housing units in this plan are extensive and will require a substantial amount of capital investment to develop. In light of this several innovative capital funding strategies have been recommended for consideration. This does not mean these are the best or only options that should be considered. Additionally, there are a variety of “one-time” sources of funding through the American Recovery and Reinvestment Act of 2009 (the federal stimulus package) that are also being recommended for consideration.

1. In order to take advantage of current funding opportunities to implement this it is recommended that \$10 million in Neighborhood Stabilization Funds from state and local sources for shelter renovation and/or new construction be considered.
2. The following funding options for the development of transitional and permanent housing, which require multiple, complex funding, are recommended to be explored:
  - a. Set aside \$1.5 million of HUD/HOME dollars annually for the next five years for transitional housing and PSH.
  - b. Create an on-going mechanism to increase dialogue with the Ohio Housing Finance Agency to create and identify funding strategies and opportunities.
  - c. Support the Ohio Supportive Housing for the Homeless Alliance program for “gap subsidies” for PSH.
  - d. Create a Tax Credit Equity Fund whereby a partnership is created with the business community to create a local equity pool where Cincinnati/Hamilton County corporations can invest in their local community through the Low Income Housing Tax Credit program.
3. The local Housing Trust fund is recommended to be renewed and revised to facilitate funding for facilities (capital, leasing or operating) and services contained within this plan. One-time funding sources identified for consideration include: a one-time general fund deposit pursuant to a withdrawal of the property tax rollback, a deposit made from the net proceeds of the sale of the Blue Ash Airport, or general fund allocations. Further, an on-going, dedicated source of revenue is recommended for exploration.
4. In an effort to make operational the Smart Funding recommendation that funds for capital be utilized for capital, thereby freeing up more flexible foundation and grant funds for operations and services, it is recommended that a \$100,000 allocation of Community Development Block Grant funds be established in FY2010 designated for emergency capital repairs of facilities within the CoC system and administered by the CoC, Inc.

### Smart Funding

The implementation of the Homeless to Homes plan will require the cooperation and innovation of the public and private funders in our region. In that spirit, the Smart Funding Subcommittee convened local foundations, the United Way and City of Cincinnati staff to obtain input as the plan was being developed and to create recommendations on funding. As a result of these meetings, **local funders have agreed** to undertake the following activities included in this report for reference.

1. All Local Foundations will be asked to join with *Funders Together to End Homelessness*, a national funders’ movement.<sup>18</sup>
2. Local Funders have agreed to consider making operational the *Funders Together to End Homelessness* principles for local implementation with this plan as follows:

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<sup>18</sup> Information on Funders Together to End Homelessness can be found on the internet at [www.endlongtermhomelessness.org/about-the-partnership/funding-principles-for-ending.aspx](http://www.endlongtermhomelessness.org/about-the-partnership/funding-principles-for-ending.aspx)

- a. Funding that is available for capital should be utilized for capital and funding that is more flexible should be utilized for operations and/or services.
  - b. All local foundations, the United Way, the City of Cincinnati and Hamilton County are being requested to utilize the HUD/CoC outcome measures, as recorded in the Homeless Management Information System (HMIS), for any facility or program resulting from this plan.
  - c. A coordinated request process be developed by the local foundations to support requests expected to be made for facilities, operating, and/or services associated with this plan.
  - d. The Alignment of funding by local grant makers for programs for homeless single individuals within the parameters of their allowable fund usage and consistent with this plan. In order to support these efforts, the CoC will develop a lexicon and handbook of common terms.
3. As a bridge to sustainability for Homeless to Homes, local foundations have agreed to seek a national funding partner to assist with the start-up of additional services and operations required for the success of this plan.
4. On-going sustainability strategies recommended by the funders include:
  - a. Creating an initiative to analyze and recommend approaches to streamline back office and service delivery functions.
  - b. Creating a new diversion initiative with federal, state and local support to divert homeless persons from the jail system into housing/services.
  - c. Working with the Mental Health and Recovery Services Board to engage and collaborate with the plan in order to maximize use of Medicaid funding for services within PSH for homeless people with mental health and substance use issues.
  - d. Maximizing funder giving for operations and services by allocating Community Development Block Grant funds for facility repair and upkeep.
  - e. Creating a Homeless to Homes Trust Fund to support the on-going cost of services and operations.
  - f. Hiring a grant writer, who specializes in writing federal grants to the units within the Department of Health and Human Services, to secure additional federal funding for initiatives associated with this plan.
5. Create a new Fund for Innovation to provide nimble funding to expeditiously test system strategies and improvements.
6. Create a coordinated data system, within federal and state rules, to facilitate future planning by enabling the confidential merger of data from the Mental Health and Recovery Systems Board, the Hamilton County Jail, Hamilton County Department of Job and Family Services and the Homeless Management Information System.
7. Advocate for and leverage national policy and financial support.

# Subcommittee on Single Homeless Men

## *Purpose*

To start from a “blank slate” and develop recommendations for a new plan to ensure access to appropriate shelter facilities, services, and housing for individual men, based on local data and nationally recognized best practices and make clear recommendations on number, size, target population, and expected outcomes of shelter facilities.

## *Chairperson:*

Susan Walsh, Director, Hamilton County Community Development

## *Membership:*

Jim Ashmore, Performance Improvement Section Chief, Hamilton County Job and Family Services

Eric Avner, VP/Sr Program Manager - Community Development, Haile / US Bank Foundation

Ann Barnum, LISW, CCDCIII, Senior Program Officer, The Health Foundation of Greater Cincinnati

Sherman B. Bradley, Vice President, City Gospel Mission

Chris Chatfield, LISW-S, BCD, Grant and Per Diem Liaison, Veterans Administration – Community Psychiatry

Darrick Dansby, M.Ed., Executive Director, City Link Center

Steven R. Howe, Ph.D., Professor and Head of Psychology Department, University of Cincinnati

Steve Knight, MSW, Shelter Program Coordinator, Drop Inn Center

Pamela S. McClain, Vice President, Talbert House

Nan Franks Richardson, Executive Director, Alcoholism Council of the Cincinnati Area, NCADD

Lee Scroggins, Volunteer, City Ministries

## *Consumer Guests:*

Ricky Gore

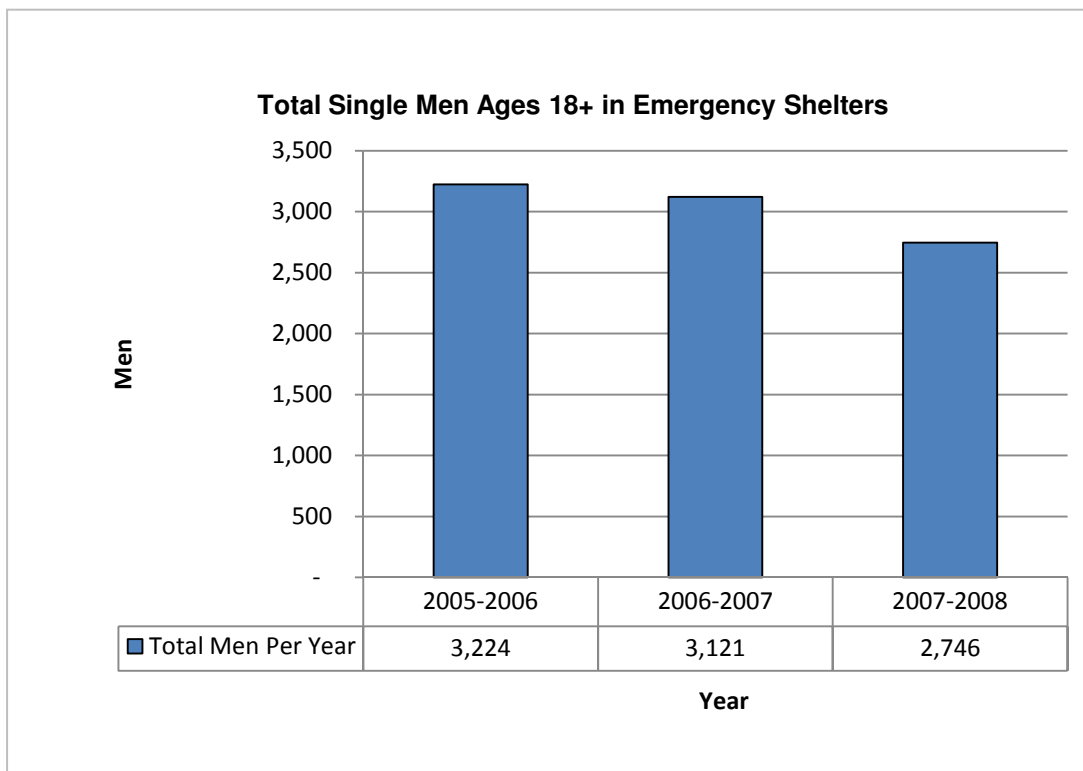
Sam Jackson

## Single Homeless Men

From October 1, 2007, through September 30, 2008, there were 2,746 different homeless single men housed within the Emergency Shelter system and another 267 men served in Street Outreach who never slept within the shelter system. These men were sheltered at City Gospel Mission, Drop Inn Center—Men’s Dorm, and the Mt. Airy Shelter. Currently, there is a combined total of 305 beds per night within these shelters. In addition, there are 16 beds at the St. Francis/St. Joseph Catholic Worker House and 15 beds at the Center for Respite Care. These 15 beds, however, are reserved for homeless people who are released from a hospital but who need some continued medical care.

### **I. Data on Single Homeless Men**

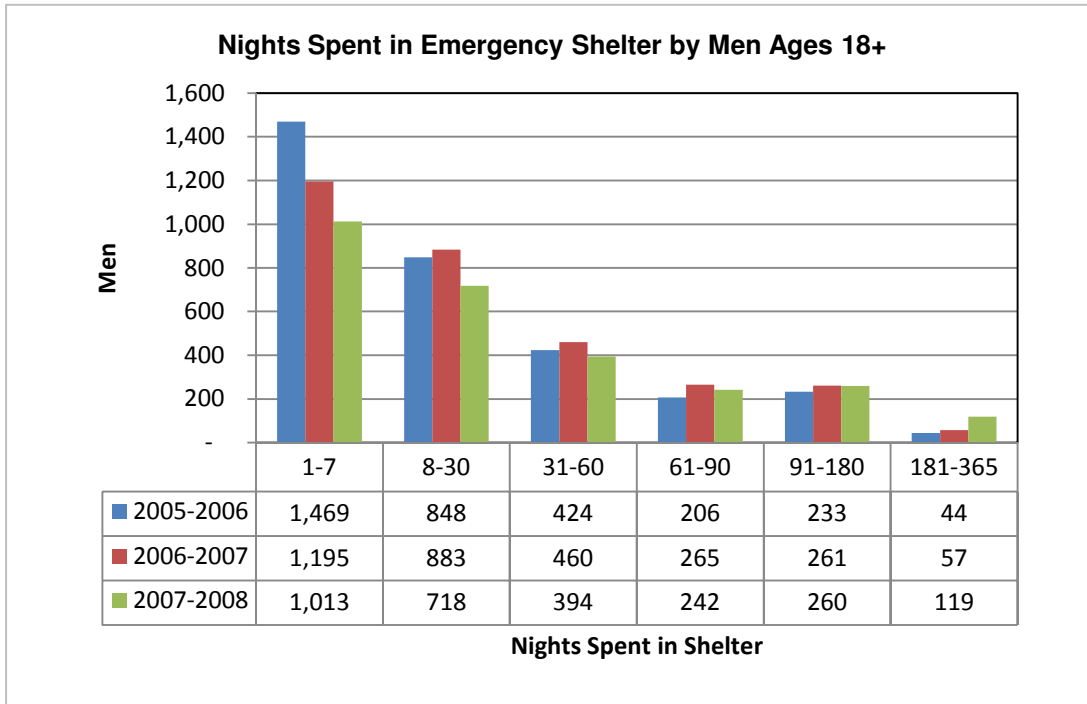
Over a three-year period, HMIS data show a substantial decline in the number of homeless single men sheltered in Cincinnati, from a high of 3,224 men in 2005–2006 to 2,746 in 2007–2008<sup>19</sup>. The subcommittee and other local experts believe this decline in homeless single men is due to two primary reasons: 1) the creation of the Homeless Individuals Partnership, a program with skilled case managers designed to work with chronically homeless persons and move them from shelter to permanent housing, and 2) the enhanced coordination of services and housing moving men from the streets to permanent housing as enhanced by the Continuum of Care’s VESTA Homeless Certification system.



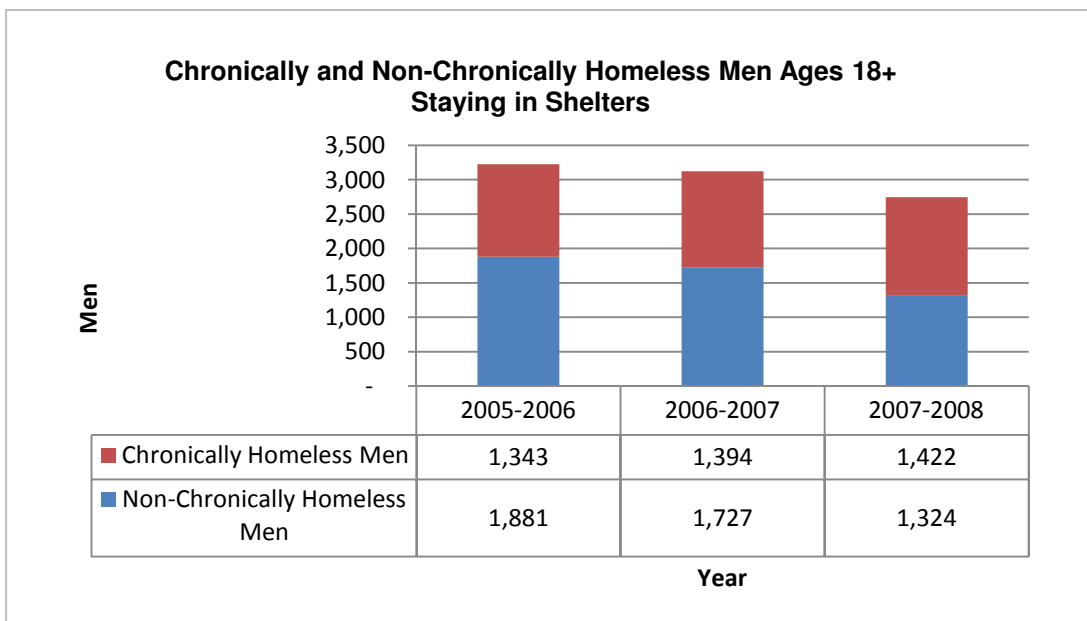
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<sup>19</sup> For this report, a year is defined as the period between October 1 of one year and September 30 of the following year.

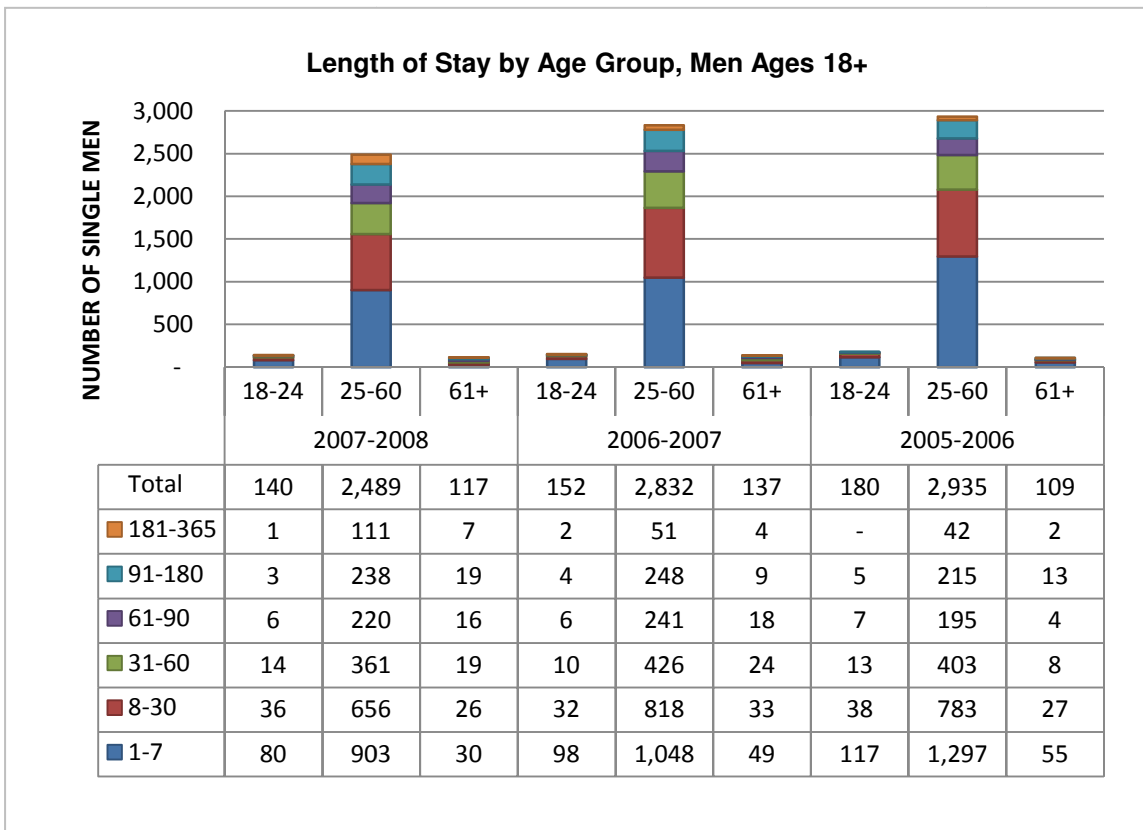
The most substantial decline came from men who stayed from one to seven nights in shelter. Although fewer men have used shelter in 2007–2008 than in the previous two years, more men are staying in shelters longer. Specifically, 44 men stayed in emergency shelters for 181–365 days in 2005–2006, 57 stayed for 181–365 days in 2006–2007, and 119 men stayed for 181–365 days in 2007–2008. Still, the majority of men are staying in shelter for less than 30 days.



Although there has been a decline in the number of homeless men in Cincinnati, there has also been an increase in the number of men who are chronically homeless. People who are chronically homeless are individuals who have been homeless for longer than one year, or individuals who have been homeless more than 4 times in 3 years.



When the data are further broken down by age, we see that men ages 25–60 are more prevalent in shelters than men younger than 25 or older than 60.

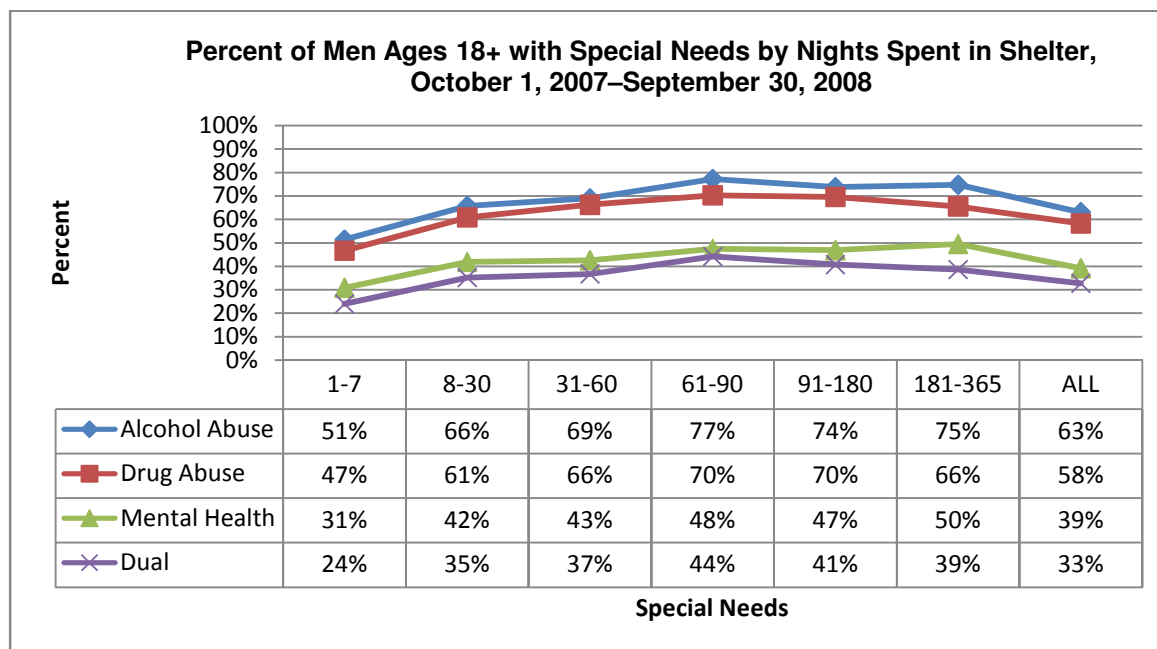


### Men with Special Needs

Within the HMIS/VESTA system, “special needs” are defined as issues that affect the client’s ability to find and maintain housing. They do not necessarily indicate that a person has been diagnosed with a condition. Rather, they are used by providers to indicate the specific supportive services a client needs. A man may have zero, one, or multiple special needs. Special needs of single men in 2007–2008 were:

| Special Needs             | Men with Special Needs | Percentage of Total Men Sheltered |
|---------------------------|------------------------|-----------------------------------|
| Alcohol Abuse             | 1,733                  | 63%                               |
| Drug Abuse                | 1,600                  | 58%                               |
| Mental Illness            | 1,078                  | 39%                               |
| Dual Diagnosis            | 901                    | 33%                               |
| Physical / Sensory        | 835                    | 30%                               |
| Domestic Violence         | 323                    | 12%                               |
| Developmental / Cognitive | 234                    | 9%                                |
| Illiteracy                | 96                     | 3%                                |
| HIV / AIDS                | 77                     | 3%                                |
| Migrant Worker            | 10                     | < 1%                              |
| Non-English Speaking      | 6                      | < 1%                              |

When we looked at the top four special needs (alcohol and drug abuse, mental illness, and dual diagnosis—having a need for alcohol or other drug services **and** mental health services) in relation to the length of stay in a shelter, we found that as the length of stay increased, the percentage of men with substance abuse needs also increased.



## II. Recommendations:

**A) A Central Access System** will coordinate and expedite the flow of all single individuals into and through the shelter system as appropriate, by way of in-person and telephone screenings. This will be the primary point of entry into the shelter system, modeled after or incorporated into the CAP (Central Access Point) system in use for the family shelters. The Central Access will provide at minimum the following services:

- 1) **Access to Shelter** Information will be acquired from each individual in order to identify the correct facility for that individual to be placed in. This information may be taken over the telephone or on a walk-in basis. An electronic referral through VESTA will be made for placement into the appropriate emergency shelter and a reservation for a bed will be made. General Shelters may accept walk-in clients on an emergency basis, but in general, referrals should go through Central Access. This system is intended to create the opportunity for homeless individuals to go directly from where they are to the most appropriate shelter facility to meet their needs, without having to move from shelter-to-shelter. The goal is for all clients to receive a comprehensive assessment either before or once placed into shelter.
- 2) **Basic Substance Abuse Screening.** To facilitate the flow of individuals to the substance abuse shelter, a basic substance abuse screening will be done at Central Access to facilitate placement. All screening will be done at Central Access and no longer at the Hamilton County Department of Job & Family Services.

- 3) **Assessment capacity that addresses both mental illness and substance abuse issues.** For those who want and need additional services, staff will complete diagnostic assessments and place homeless clients into appropriate mental health and substance abuse services. This position would serve as a resource to emergency shelter staff, determine the most appropriate treatment, facilitate placement, and make service provision for homeless clients more efficient.
- 4) **Homeless Information Services.** During regular weekday hours, staff knowledgeable of the CoC housing and services, mental health and substance abuse services, health care for the homeless services, medical services, meal services, and other supportive community services will be available for basic information and help with referrals.
- 5) **Transportation Services** – Bus transportation will be provided daily from Central Access to off- site shelters not within walking distance. Should new homeless transportation systems be developed within the CoC, such programs will also provide pick up and drop off services at Central Access.

**B) Expanded substance abuse treatment shelter (currently Mt. Airy Shelter).** A Request for Information (RFI) will be released by the City of Cincinnati Department of Community Development, in conformance with the Homeless to Homes plan for a Substance Abuse Treatment Shelter for 96 men.

**Description:** Substance abuse recovery-focused shelter designed to serve individuals who are homeless by the McKinney-Vento definition and who are willing to consider or engage in substance abuse treatment as a part of their movement from shelter to permanent housing, and use an intake/exit system. If possible, the renovation/construction of any facility for men should be designed to give men the smallest group sleeping rooms' feasible, rather than large, dormitory-style, sleeping rooms. This shelter would provide:

- a) Basic service: a bed, food, and toiletries will be provided for each individual in residence
- b) A complete assessment of the individual's situation will be provided within 48 hours of admission into the shelter. At a minimum the assessment must include:
  - i) Current situation and reason for homelessness
  - ii) Information about personal/family support
  - iii) A housing history
  - iv) Income/economic situation
  - v) Education/training levels achieved
  - vi) Social service and health history
  - vii) Basic life skills inventory
  - viii) Veterans status, service in the Armed Forces, and eligibility for VA housing and services
  - ix) Special issues review (e.g. mental health, substance abuse, physical/cognitive/sensory disabilities, etc.)
- c) One-one case management (1:10 ratio) will be provided to each individual within the system. The case manager will be responsible for development of the individual case plan that at a minimum must include: an attainable housing plan, an income/benefit plan, and a stabilization and development plan. All individual case plans will be stored in VESTA and a partnership agreement between the shelters will be used to address case planning in

recidivist cases. Information, referral, and support to access housing and services will be expected to be provided by the case manager to meet the individual needs of the client.

- d) On-site substance abuse programming, such as the current Substance Abuse Management System (SAMS), a chemical dependency program provided by the Alcoholism Council. This program is recommended to be continued and considered for funding through the Mental Health and Recovery Services Board as the primary substance abuse service at the substance abuse treatment shelter.
- C) Three **General Shelters for Men** are recommended, each with a 50 bed capacity. It is recommended that one of these three shelters is a faith-based facility, and that the faith community continue to support such a facility, as it currently supports the City Gospel Mission. The other two shelters (Shelter A and Shelter B) will make up the remainder of the men's general emergency shelter system. Recognizing the benefit of focusing services, Shelters A and B may each need to be focused on a particular segment of the homeless male population (such as, employed, chronically homeless, severely mentally ill, newly homeless, or ex-offending individuals). An RFP system will be developed, upon the approval of the system from City Council and the County Commission, to accept applicants to develop Shelters A and B. It is recommended that one of these general shelters be located adjacent to the Safe Shelter so as to provide some flexibility in meeting the needs of the population of single homeless men.

**Description:** General shelters are designed to serve individuals who are homeless who are willing to engage in and work with a case manager on a case plan designed to facilitate the movement from shelter to permanent housing. All general shelters are designed to use an intake/exit system. The targeted length of stay within a general shelter will be 30 to 60 days. If possible, the renovation/construction of any facility for men should be designed to give men the smallest group sleeping rooms feasible, rather than large, dormitory-style, sleeping rooms. This shelter would provide:

- a) Basic service: a bed, food and toiletries will be provided for each individual in residence
- b) Screening and reconnection to Central Access for any and all walk-in clients
- c) A complete assessment of the individual's situation will be provided within 48 hours of admission into the shelter. At a minimum the assessment must include:
  - i) Current situation and reason for homelessness
  - ii) Information about personal/family support
  - iii) A housing history
  - iv) Income/economic situation
  - v) Education/training levels achieved
  - vi) Social service and health history
  - vii) Basic life skills inventory
  - viii) Veterans status, service in the Armed Forces, and eligibility for VA housing and services
  - ix) Special issues review (e.g. mental health, substance abuse, physical/cognitive/sensory disabilities, etc.)
- d) Intensive case management (1:10 ratio) will be provided to each individual within the general shelter system. The case manager will be responsible for development of the individual case plan that at a minimum must include: an obtainable housing plan, an income/benefit plan, and a stabilization and development plan. All individual case plans will be stored in VESTA and a partnership agreement between the shelters will be used

to address case planning in recidivist cases. Information, referral, and support to access housing and services will be expected to be provided by the case manager to meet the individual needs of the client.

- e) On-site substance abuse and mental health engagement and referral services will be available in each facility.

D) Understanding that some homeless individuals will not participate in services, **a city-wide, walk-in, Safe Shelter** would serve people who are unable or unwilling, at the current time, to engage in services but are homeless and in need of emergency shelter. The goal of the Safe Shelter is to provide a “respite” from the individual’s current living environment. This would be the only shelter in the system that is designed on a “drop-in” basis. An RFP system will be developed, upon the approval of the system from City Council and the County Commission, to accept applicants to develop the Safe Shelter.

#### **CITY WIDE SAFE WALK-IN SHELTER**

- o 10 beds for women
- o 30 beds for men

**Description:** The Safe Shelter is designed to serve people who are unable or unwilling currently to engage in services, but are homeless and in need of emergency shelter. The goal of the Safe Shelter is to provide a place to stay that is safe and engaging while at the same time is not enabling of long-term homelessness.

**Services:** As with all shelters, basic services including: a bed, food, and toiletries will be provided for each individual in residence. To facilitate movement from the Safe Shelter to either general shelter or housing, workers within the facility will provide on-going engagement opportunities. Around-the-clock staffing at the facility would be by persons trained in best-practice, harm-reduction strategies and engagement techniques aimed toward encouraging connection to services and movement beyond the Safe Shelter and out of homelessness.

**Length of Stay:** The Safe Shelter will not be intended to serve as a residence for a person for longer than 10 consecutive nights, but length of stay will be considered on an individual basis. No stay for any one individual should be long enough that the homeless individual believes the Safe Shelter to be their “regular place to stay” indefinitely. Persons who are harmful to themselves or others will be referred to University Hospital for assessment and treatment prior to re-admittance.

**Facility:** The Safe Shelter, as all new emergency shelter facilities, should be designed with small sleeping spaces such as individual rooms or small group rooms. Accommodations for special needs individuals must be accounted for in the design (such as persons with severe paranoia, transgendered individuals, or disabled persons). Some flexibility to accommodate couples is expected.

# Subcommittee on Single Homeless Women

## *Purpose*

To start from a “blank slate” and develop a new plan to ensure access to appropriate shelter facilities, services, and housing for individual women, based on local data and nationally recognized best-practices.

## *Chairperson:*

Alice Skirtz, PhD/LISW-S, Casework Supervisor, Family Shelter Partnership Program

## *Membership:*

Lucy Crane, Manager – Community Impact, United Way of Greater Cincinnati

Suzette Fisher, Board Member, YWCA of Greater Cincinnati

Fanni Lloyd Johnson, Shelter Program Coordinator, Drop Inn Center

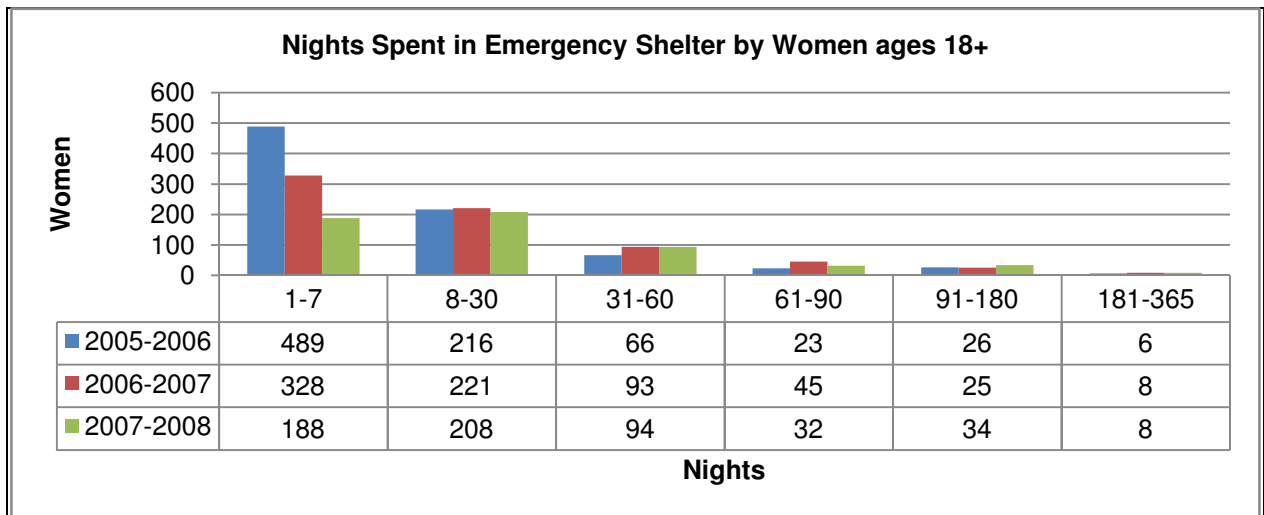
Mary Carol Melton, Executive Vice President, Cincinnati Union Bethel

*Single Homeless Women*

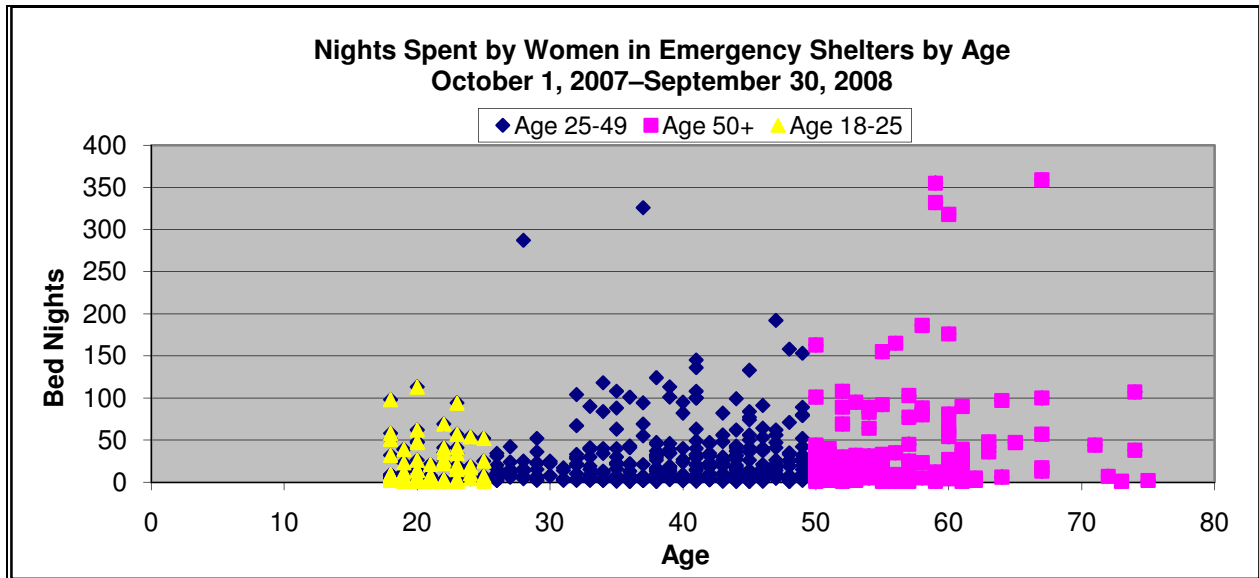
Between October 1, 2007, and September 30, 2008, , there were 564 different single homeless women housed within the Emergency Shelter system. There are a total of 46–50 beds for single women in shelters on any given night in Cincinnati/Hamilton County. Noteworthy is that “shelter hopping” (the movement between shelters) is not the norm for this population. There are two shelters that are not included in this bed-count: the Battered Women’s Shelter, which accepts single women in danger of domestic violence or abuse, and Off the Streets Shelter, a 10-bed emergency shelter run by Cincinnati Union Bethel for women in a prostitution reform program.

**I. Data on Single Homeless Women**

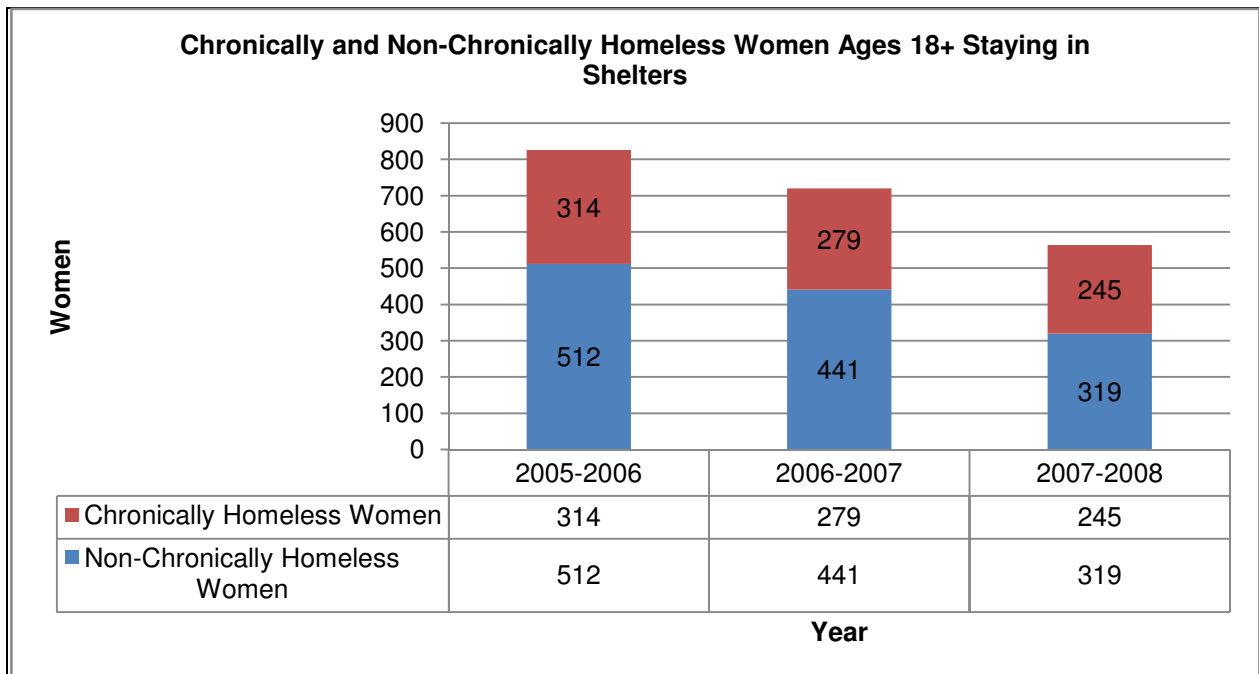
Over a three-year period, the HMIS data show a substantial decline in the number of homeless single women sheltered in Cincinnati, from a high of 826 women in 2005–2006 to 564 in 2007-2008. The most substantial decline was in women who stayed between one and seven bed nights in a shelter. The subcommittee and other local experts believe the decline in homeless women from 2005–2008 is due to three primary reasons: 1) the placement of a dedicated worker within the Women’s Dorm; 2) the creation of the Homeless Individuals Partnership, a program with skilled case managers designed to work with chronically homeless persons and move them from shelter to permanent housing; and 3) the enhanced coordination of services and housing moving women from the streets to permanent housing as enhanced by the Continuum of Care’s VESTA Homeless Certification system.



The data indicate that the older the woman is, the longer she remains sheltered.



There has been a general decline between 2005 and 2008 in the number of chronically and non-chronically homeless women sheltered. People who are chronically homeless are individuals who have been homeless for longer than one year, or individuals who have been homeless more than 4 times in 3 years.

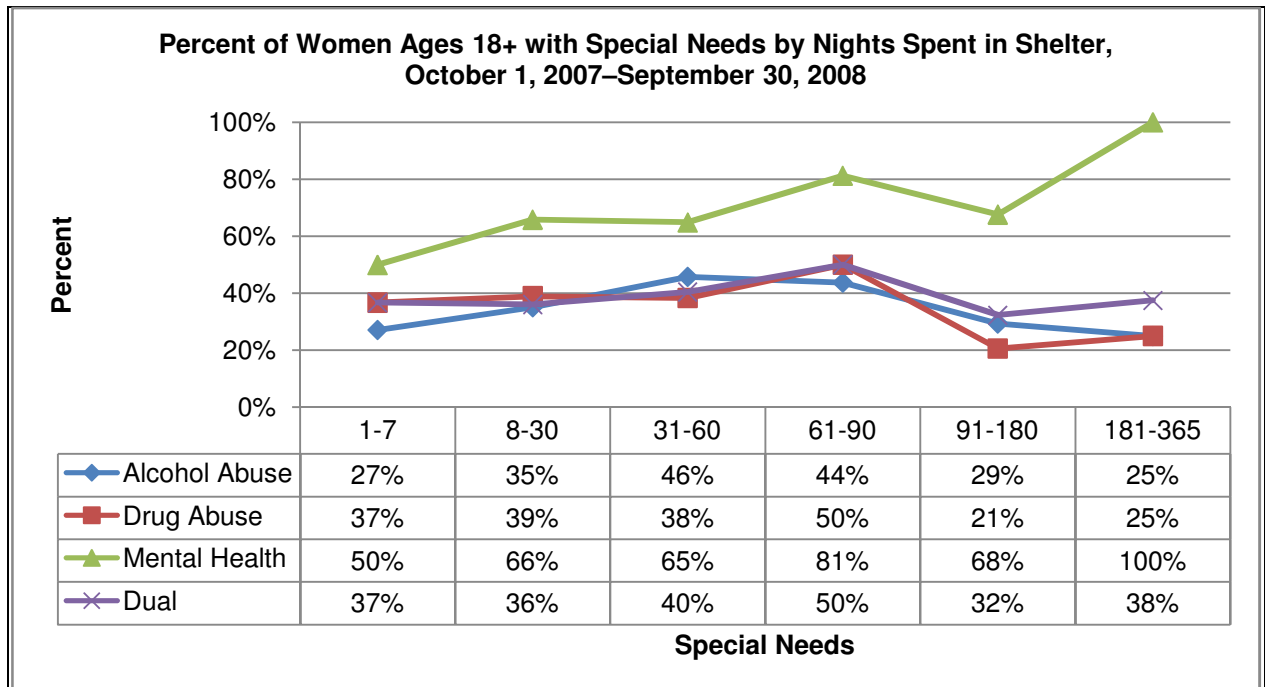


## Women with Special Needs

Within the HMIS/VESTA system, “special needs” are defined as issues that affect the client’s ability to find and maintain housing. They do not necessarily indicate that a person has been diagnosed with a condition. Rather, they are used by providers to indicate the specific supportive services a client needs. A woman may have zero, one, or multiple special needs. Special needs of single women in 2007–2008 were:

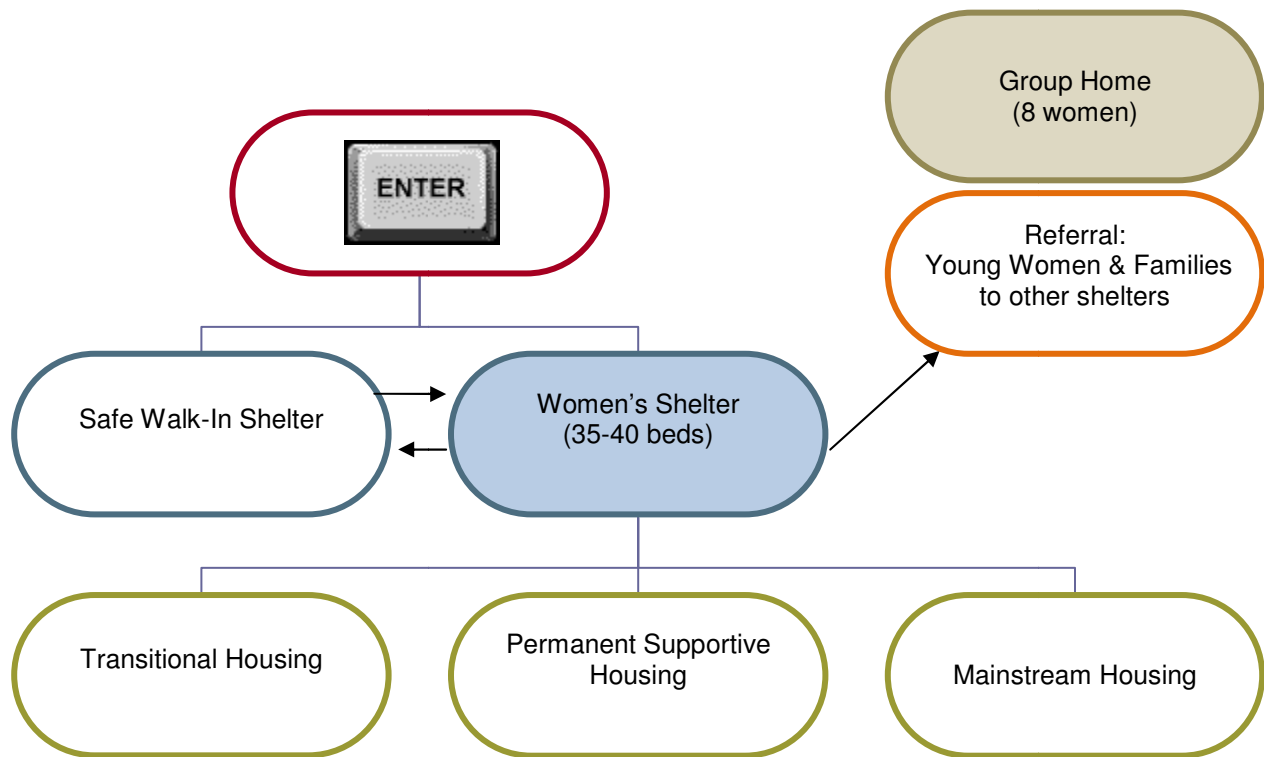
| Special Need                       | Women with Special Needs | Percentage of Total Women Sheltered |
|------------------------------------|--------------------------|-------------------------------------|
| Mental Illness                     | 349                      | 62%                                 |
| Drug Abuse                         | 211                      | 37%                                 |
| Alcohol Abuse                      | 193                      | 34%                                 |
| Domestic Violence                  | 148                      | 26%                                 |
| Physical/Sensory Disability        | 126                      | 22%                                 |
| Developmental/Cognitive Disability | 66                       | 12%                                 |
| Illiteracy                         | 55                       | 10%                                 |
| Non-English Speaking               | 18                       | 3%                                  |
| HIV/AIDS                           | 14                       | 2%                                  |

When we looked at the top three special needs (mental illness and alcohol and drug abuse) in relation to the length of stay in a shelter, we found that as the length of stay increased, the percentage of women with mental illness needs also increased.



## II. Recommendations

Based on the data and best-practice research, combined with the experience of local providers, the Homeless to Homes Subcommittee on Single Women is recommending that the programs and beds for single, homeless women (except for those at the domestic violence shelter) be restructured as follows:



### 1) Shelter Recommendations

- a) A new **Safe Walk-In Shelter** must be created to provide emergency refuge for 10–15 women on a walk-in basis. These women are generally women with serious mental illnesses and are not willing or able to engage with the mental health system for medication or services. The Safe Shelter must be a place of engagement, designed to support a movement from the streets to shelter, but without the restrictions of formal case planning and/or compliance with a program.
- b) A new **General Women's Shelter**, separate from any men's facility, must be created to provide for the needs of single homeless women. The Women's Subcommittee recommends a new facility be designed to house 35–40 women nightly (depending on weather conditions). Access to the Women's Shelter would be through the Central Access Point (CAP), currently in use by the Family Shelter Partnership, but with the same flexibility as other CAP agencies to accept emergency walk-ins. With the opening of the Women's Shelter it would be expected that all beds for single homeless women would be consolidated (except those specifically for victims of domestic violence) into this new facility.
  - i) **Client group:**
    - (1) Open to single homeless women
    - (2) Women with dependent children in custody but not with them at the point of intake will be referred the Family Shelter Partnership for emergency shelter as room becomes available.

The population of (solitary) homeless women... is likely to benefit from intervention programs that are designed to address their specific problems and needs, which are not necessarily the same as those of homeless men.

*North & Smith: A comparison of homeless men and women: Different populations, different needs, 2004*

- (3) All victims of domestic violence that are fleeing a domestic violence situation will be referred to the Domestic Violence Shelter for emergency shelter.
  - (4) Women who are harmful to themselves or others will be referred to University Hospital for an assessment and treatment prior to admittance.
  - (5) Young women ages 18–24 will be referred to the Young Adults Shelter.
  - (6) Prostituted women will be referred to Off-the-Streets.
  - (7) Service-resistant women will be referred to the Safe-Walk In Shelter.
- ii) **Shelter Services:**
- (1) Basic human needs – shelter, food, clothing, toiletries
  - (2) Engagement
  - (3) Assessment within 48 hours of admission (for all new clients)
    - (a) current situation,
    - (b) personal/family support
    - (c) housing history
    - (d) income/employment
    - (e) education/training
    - (f) social service/health history
    - (g) basic life skills
    - (h) special issues
  - (4) One-on-one case management (1:10 client-to-case manager ratio) to develop and support an individual's plan for independence and self-sufficiency. The case management plan will include a housing plan, an income/benefit plan, and personal issues plan.
  - (5) Coordinated diagnostic assessment (DAF) for all women with substance use or mental health issues who are willing to engage in services. Optimally the assessment and DAF should be done on-site at the shelter to maximize participation and engagement.
- iii) **Facility Needs:**
- (1) Shelter for 35 women with the flexibility for 5 overflow beds (cots)
  - (2) Smaller rooms (2–4 women per room) preferred to dormitory style
  - (3) Facility must be handicap accessible with at least one sleeping room accessible for women in wheelchairs or with walkers
  - (4) Facility must accommodate a minimum of five staff offices, common kitchen, community/meeting room, laundry facility
- iv) **Length of Stay:**
- (1) Each woman's length of stay within the Women's Shelter will be recommended based on her individual case plan and contracted for between the woman and the facility.
  - (2) All women will be expected to develop a short-term plan with a case manager. In general the plan should be accomplishable within a 30 day timeframe. The client should exceed a 30-day stay only when the case manager and the client believe significant progress is being made and the client is awaiting a specific housing option.

The Women's Subcommittee further recommended the consideration of the following activities/actions which are within the jurisdiction of other Subcommittees, but are considered critical to enabling single, homeless women to move forward from homelessness to housing:

## 2) Services/Best Practice Recommendations

- a) Based upon the number of single chronically homeless women who have substantial lengths of stay within the shelter system:
  - The inclusion and integration of the Hamilton County Department of Job and Family Service's Adult Protective Services (APS) programs and resources in the mix of programming provided to clients. Specifically, APS services need to be provided for a) those persons who meet the definition of chronically homeless, and b) those age 60+ who at assessment meet the criteria of "abuse, neglect, or exploitation" and those who might be in the situation of "incapacitated person" pursuant to the Ohio Revised Code 5101.60. (Recommendation sent to Mental Health and Substance Abuse Best Practices Subcommittee.)
- b) Based on the overwhelming evidence of mental health issues among the population of homeless women combined with practitioners' knowledge that many women are not being screened and/or served:
  - The addition of "homelessness" to the screening criteria used to determine the need for a mental health assessment. Should homelessness be indicated in the screening - an assessment would be automatic. (Recommendation sent to Mental Health and Substance Abuse Best Practices Subcommittee.)
- c) Based on overwhelming provider feedback that entrance into the mental health and substance abuse assessment systems does not currently work for women with dual issues (both mental health and alcohol or other drug abuse):
  - The creation of a "single point of entry" for all homeless women in need of assessment for mental health, substance abuse, or both. As stated previously, optimally the assessment and DAF should be done on-site at the shelter to maximize participation and engagement. (Recommendation sent to Mental Health and Substance Abuse Best Practices Subcommittee)
- d) Based on the vast majority of single homeless women being identified with mental health and alcohol or other drug abuse as a primary special need:
  - The expansion of mental health services. These services must include assessment, case management, and medication management for single homeless women for those with a diagnosis outside severe mental disorders criteria. (Recommendation sent to Mental Health and Substance Abuse Best Practices Subcommittee)

### 3) **Transitional and Permanent Supportive Housing Recommendations**

- a) From age and disability data and provider reports, it is known that several single homeless women have resided in shelters almost every night for over 10 years, using beds that could be used for other single homeless women:
  - The immediate creation of an 8-bed "group home" facility for these single chronically homeless women, all of whom have mental health issues and several also suffer from chemical dependency. The group home must include: a high level of engagement to encourage continued residence in the facility, harm reduction methods, and a linkage to on-going services as the women agree to but are not required to attend. The group home for this particular population must be sited within the Central City. (Recommendation sent to Transitional/Permanent Housing Subcommittee)
- b) Based on the need to create a movement from shelter to permanent housing, the current length of stay for many homeless women, and the complexity of their individual issues:
  - The creation of 50–60 units of transitional housing for single women. Though transitional housing regulations enable clients to be housed for up to 24 months, this transitional housing must be focused on movement of the client to permanent housing. The length of stay in transitional housing should be tailored to meet the individual woman's needs, and services and policies must be designed to facilitate permanent housing access and placement as soon as possible or many additional units would be required. Individual case management for all

residents of transitional housing is essential. (Recommendation sent to Transitional/Permanent Housing Subcommittee)

- c) Based on the severity of the special needs among single homeless women, especially mental health issues:
  - The capacity to move approximately 40 single women, especially those with mental illnesses, into permanent supportive housing each year. This permanent supportive housing may either be site-based or scattered-site in nature as required. (Recommendation sent to Transitional/Permanent Housing Subcommittee)

The Women's Subcommittee believes that there are several different existing site options, should renovation funding be available. Further, we believe that skilled providers are also available to serve this population as described above.

## Subcommittee on Homeless Young Adults

### *Purpose*

To start from a “blank slate” and develop a new plan to ensure access to appropriate shelter facilities, services, and housing for homeless young adults (ages 18–24), based on local data and nationally recognized best practices.

Steven R. Howe, Ph.D., Professor and Head of Psychology Department, University of Cincinnati

Robert Mecum, President and CEO, Lighthouse Youth Services, Inc.

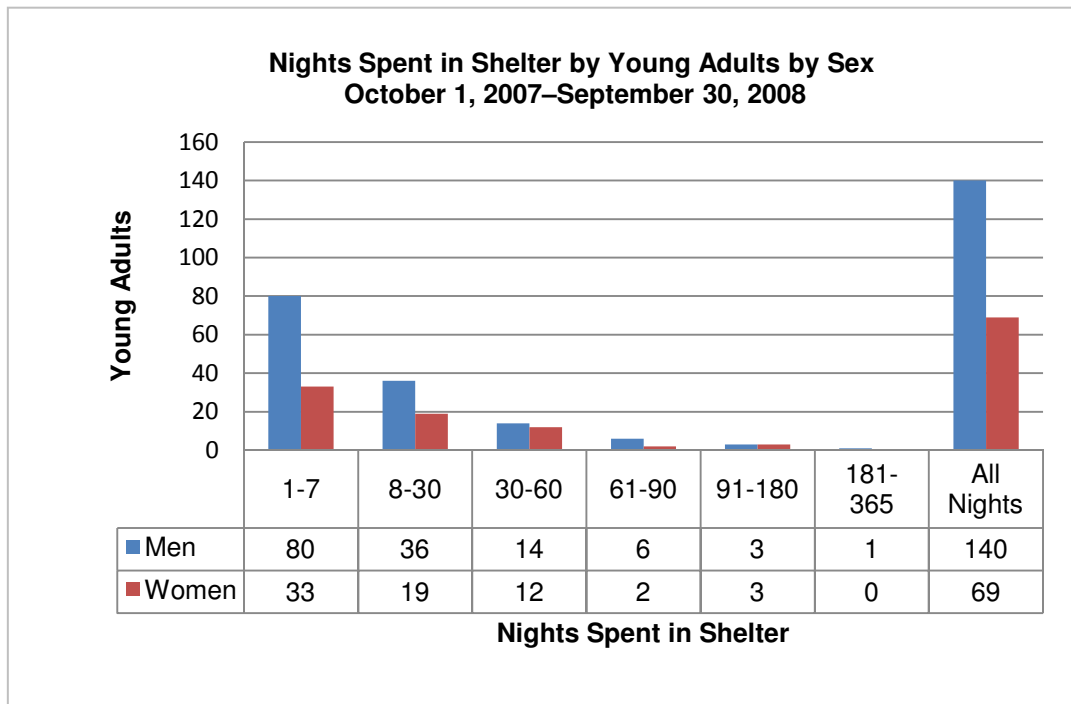
Note: In 2007, The Health Foundation of Greater Cincinnati provided a planning grant to Lighthouse Youth Services (LYS) to “plan integrated services for homeless youth with substance use disorders and mental illnesses in Hamilton County.” This grant specifically enabled LYS to contract with Dr. Howe to conduct focus groups and research in best practice methods and create a new business plan for Anthony House, LYS's Outreach and Engagement Center for Street Youth. Homeless to Homes incorporated the work of Dr. Howe and LYS into this document.

*Single Homeless Young Adults*

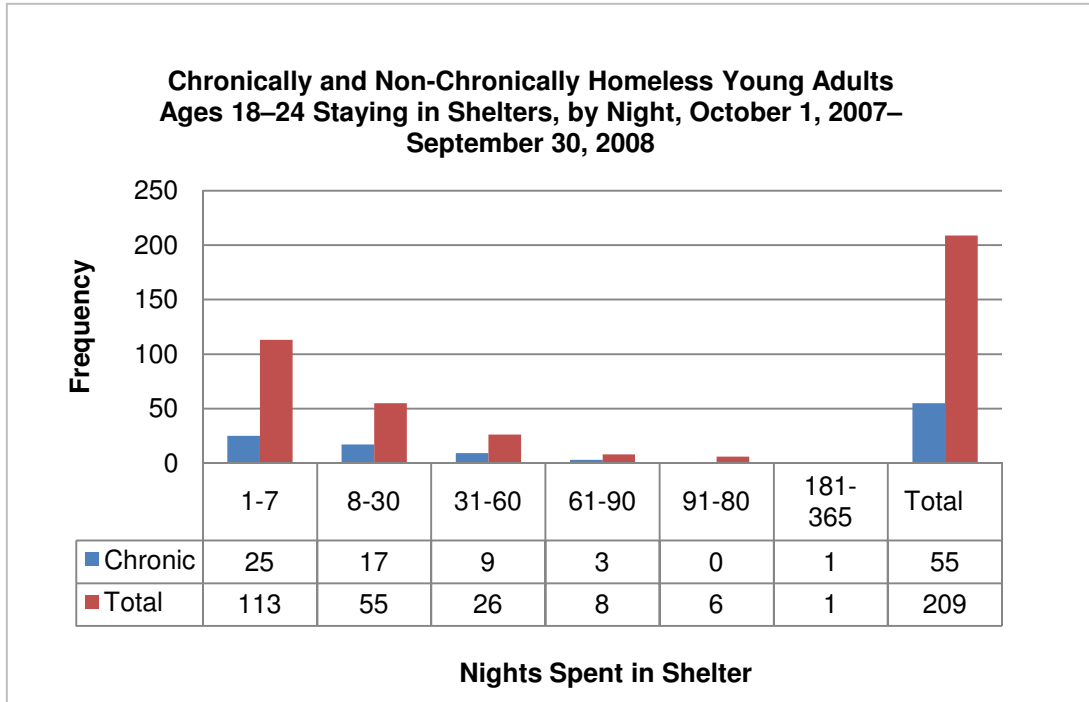
From October 1, 2007–September 30, 2008, there were 209 different single homeless young adults, age 18 through age 24 were housed within the Emergency Shelter system. The vast majority of these young adults were sheltered at the Drop Inn Center’s Women’s and Men’s Dorms. Men who did not stay at the Drop Inn Center’s Men’s Dorm stayed at either Mt. Airy Shelter or City Gospel Mission. Women who did not stay at the Drop Inn Center’s Women’s Dorm stayed at either the Bethany House, or Salvation Army. In addition, there were another 154 young adults who were served though a street outreach program but were not sheltered. Of these, 117 were served through the Anthony House Outreach Program.

**I. Data on Single Homeless Young Adults**

In 2007–2008, HMIS data show that more single young men stayed in emergency shelters than single young women (without children). HMIS data also show that most young adults who stayed in emergency shelter stayed less than 60 days: only 10 of 140 young men and 5 of 69 young women stayed longer than 60 days.



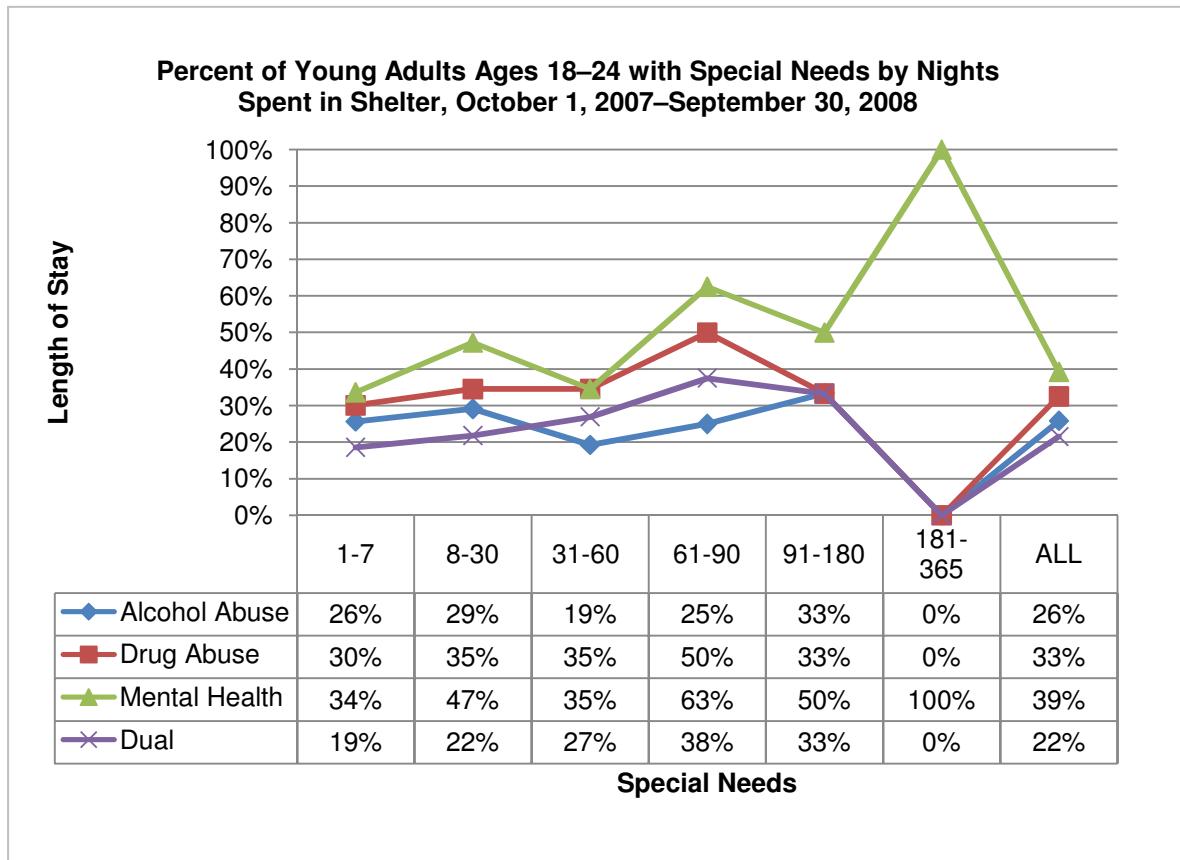
About 26% of single homeless young adults are chronically homeless, compared to 43% for single women and 52% for single men. People who are chronically homeless are individuals who have been homeless for longer than one year, or individuals who have been homeless more than 4 times in 3 years and have a disabling condition. According to HMIS data, single chronically homeless young adults have relatively short stays in emergency shelters, suggesting that young adults either become homeless for short periods of time or do not prefer to stay in shelters when they are homeless.



Within the HMIS/VESTA system, “special needs” are defined as issues that affect the client’s ability to find and maintain housing. They do not necessarily indicate that a person has been diagnosed with a condition. Rather, they are used by providers to indicate the specific supportive services a client needs. A young adult may have zero, one, or multiple special needs. Special needs of single young adults in 2007–2008 were:

| Special Needs                      | Young Adults with Special Needs | Percent of Total Young Adults Sheltered |
|------------------------------------|---------------------------------|---|
| Mental Illness                     | 82                              | 39%                                     |
| Drug Abuse                         | 68                              | 33%                                     |
| Alcohol Abuse                      | 54                              | 26%                                     |
| Dual Diagnosis                     | 45                              | 22%                                     |
| Developmental/Cognitive Disability | 30                              | 14%                                     |
| Physical/Sensory Disability        | 20                              | 10%                                     |
| Illiterate                         | 16                              | 8%                                      |
| Non-English Speaking               | 1                               | < 1%                                    |
| HIV/AIDS                           | 0                               | 0%                                      |

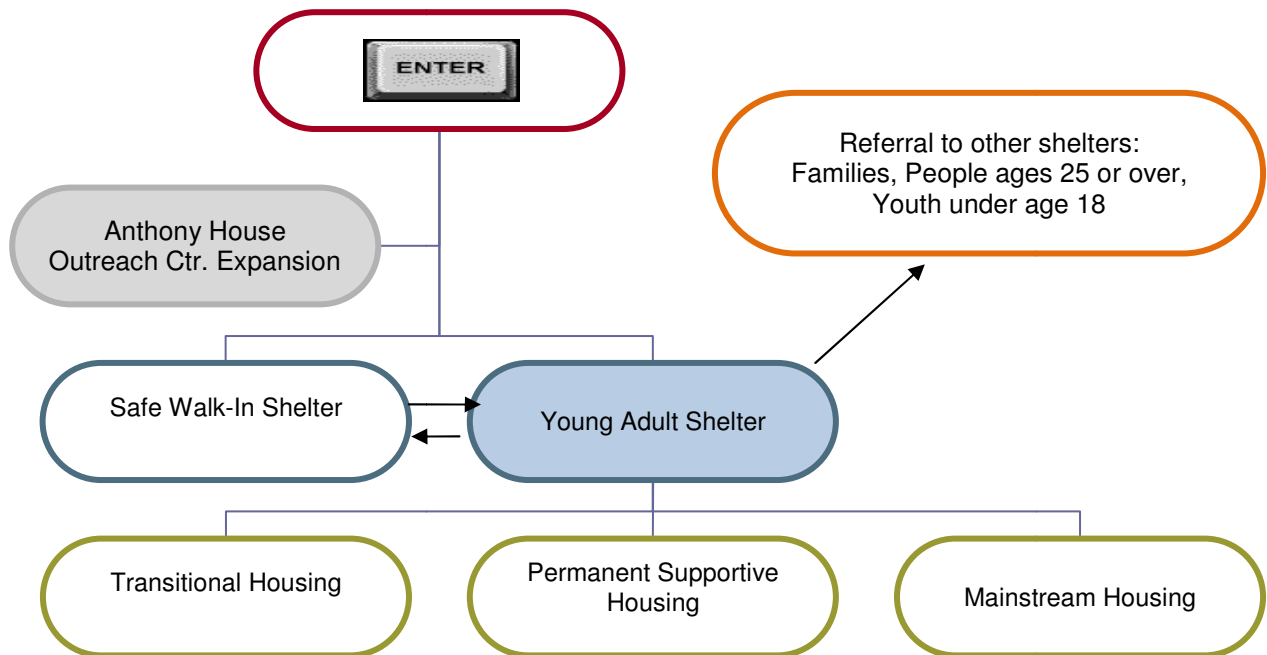
When we looked at the top four special needs (mental illness, alcohol and drug abuse, and dual diagnosis—having a need for alcohol or other drug services **and** mental health services) in relation to the length of stay in a shelter, we found that as the length of stay increased, the percentage of young adults with mental health and substance use needs also increased.



## II. Recommendations

Based on the data and best-practice research combined with the experience of local providers, the Homeless to Homes Subcommittee on Single Young Adults recommends an expansion of the Anthony House, which is an outreach center targeted toward homeless youth and young adults and the creation of a new general shelter specifically for single homeless young adults age 18 through age 24.

***Lighthouse looked at nationally recognized best practice programs in Portland’s Outside In and Seattle’s YouthCare provided the structural framework for the HTH recommendations on young adult services.***



**The goal of services for homeless young adults 18-24 should be nothing less than the expectation that all of them will achieve stability and self-sufficiency by the age of 25.**

**The recommendations for increased engagement are as follows:**

- A)** Anthony House **day center (outreach center)** operated by Lighthouse Youth Services must be expanded in hours opened and in street outreach capacity and include the following services:
- 1) Street outreach
  - 2) An almost zero-barrier center that promotes a long-term commitment between service and consumer (e.g., My Space)
  - 3) Evening meal service that facilitates interaction between outreach workers, volunteers and case managers
  - 4) Immediate connection to specialized alternative and mainstream services whenever possible
  - 5) Links to low-intensity exploration of paths to self-sufficiency and treatment (e.g., exposure to GED programs, help with job search, substance abuse treatment)
  - 6) Harm reduction, especially with respect to sex, substance use, and exposure to elements or violence
  - 7) Housing stabilization through all appropriate means
  - 8) Internet connectivity to encourage communication between the outreach workers and young adults as they move
  - 9) A long-term commitment with young adults, so that even if they leave without having made any commitment to further stabilization, they will come back

**The recommendations for shelter are as follows:**

- A)** A new **General Shelter for Young Adults** ages 18– 24 must be created to meet the special needs of this population. The expectation for this new facility is that it will be integrated with Anthony House to provide a seamless transition and removal of time-delay barriers between the Central Access Point and the shelter for single homeless young adults who make a commitment to engagement and services. The new co-ed general shelter will be designed to house 25 young adults each night.

Individuals who fall outside of the age range for this shelter will be referred to the youth or general adult shelters as appropriate.

**1) Client Group:**

- a) Open to single homeless young adults ages 18– 24.
- b) Men and women ages 25 and older will be referred to the general men’s and women’s shelters.
- c) Young women with dependent children either with them or in custody but not with them at the point of intake will be referred to the family shelter system for emergency shelter.
- d) Unaccompanied minors ages 17 and under will be referred to Lighthouse Youth Crisis Center.
- e) Young adults who are harmful to themselves or others will be referred to University Hospital for an assessment and treatment prior to admittance.
- f) Service-resistant young adults will be referred to the Safe Shelter for housing while continuing engagement through Anthony House.

**2) Shelter Services:**

- a) Basic human needs – shelter, food, clothing, toiletries
- b) Engagement
- c) Assessment within 48 hours of admission (for all new clients)
  - i) current situation,
  - ii) personal/family support/ reunification
  - iii) housing history
  - iv) income/employment
  - v) education/training
  - vi) social service/health history
  - vii) basic life skills
  - viii) criminal justice
  - ix) special issues
- d) One-on-one case management (1:10 ratio) to develop and support an individual’s plan for independence and self-sufficiency. The case management plan will include: a housing plan, an income/benefit plan, and personal issues plan.

**3) Facility Needs:**

- a) The General Shelter must have a capacity for 25 young adults with the flexibility for overflow.
- b) Shelter must be handicap accessible with at least one sleeping room accessible for young adults in wheelchairs or with walkers.

**4) Length of Stay:**

- a) Each individual’s length of stay within the shelter will be recommended based on his or her individual case plan and contracted for between the individual and the facility.
- b) All individuals will be expected to develop a short-term plan with a case manager. In general, the plan should be accomplishable within 30–60 days. The client should exceed a 30-day stay only when the case manager and client believe significant progress is being made and the client is awaiting a specific housing option.

The Young Adults’ Subcommittee further recommends the consideration of the following actions which are within the jurisdiction of other Subcommittees, but are considered critical to enabling single homeless young adults to move forward from homelessness to housing:

**A) The recommendations for Transitional and Permanent Supportive Housing are as follows:**

- d) Based on the need to move young adults from shelter to permanent housing, and the complexity of the individual issues of young adults, the Subcommittee recommends the addition of 40 units of transitional housing for young adults. Though transitional housing regulations enable clients to

be housed for up to 24 months, this transitional housing must be focused on moving the client to permanent housing. The length of stay in transitional housing should be tailored to meet the individual's needs and services and policies must be designed to facilitate permanent housing access and placement as soon as possible, or many additional units would be required. Individual case management for all residents of transitional housing is essential.

- e) The committee recognizes the need for permanent supportive housing for some single homeless young adults.. However, no specialized permanent supportive housing is being recommended, Rather, young adults should be incorporated into current and future permanent supportive housing as needed.

# Subcommittee on Street Outreach

## *Purpose*

To start from a “blank slate” and develop recommendations for a new plan to ensure access to appropriate shelter facilities, services, and housing for individuals living on the streets, based on local data and nationally recognized best-practice and safe-haven models. Housing options considered will include a Safe Haven in Cincinnati including recommendations for its size, scope, and the type to be developed.

## *Chairperson:*

Sergeant Stephen Saunders, Cincinnati Police Department

## *Membership:*

Janice Bogner, LISW, Senior Program Officer, The Health Foundation of Greater Cincinnati

Jeff Kirschner, Chief of Program Operations, Greater Cincinnati Behavioral Health

Anita Paige, Director of Programming and Research, One-City Foundation

Russell L. Wingers, LISW, Executive Director, Tender Mercies

*Street Outreach*

Street Outreach programs for the homeless use trained social workers to work with people who are homeless but who, for a variety of reasons, do not generally go to shelters. Programs for street outreach in our region include Greater Cincinnati Behavioral Health's PATH Program, Lighthouse Youth Services' Street Outreach, Block By Block's Street Outreach and efforts by the Greater Cincinnati Homeless Coalition and the Cincinnati Police Department

**A. Data on Street Outreach**

The U.S. Department of Housing and Urban Development (HUD) requires each continuum of care program to do a "point-in-time" count of its homeless people for reports to HUD and Congress. Cincinnati/Hamilton County's past three counts document the following decrease in the street population.

|  |           |           |           |
|--|-----------|-----------|-----------|
| Point-in-Time Dates                        | 1/24/2005 | 1/25/2007 | 1/28/2008 |
| <i>Count of individuals on the streets</i> | 167       | 59        | 55        |

When compared to continuum of care programs across the country, Cincinnati has an extremely low street count:

| 2007 Homeless Population Data   |                  |             |                   |                   |                |                |
|---|------------------|-------------|-------------------|-------------------|----------------|----------------|
| Ohio Comparables  | PIT Date         | Unsheltered |                   |                   |                |                |
| <b>Cincinnati/Hamilton County, Ohio</b>   | <b>1/25/2007</b> | <b>59</b>   |                   |                   |                |                |
| Columbus/Franklin County  | 1/31/2007        | 114         |                   |                   |                |                |
| Cleveland/Cuyahoga County   | 1/28/2007        | 162         |                   |                   |                |                |
| Dayton/Kettering/Montgomery County  | 1/26/2007        | 66          |                   |                   |                |                |
| All of Ohio   | Jan-07           | 1,443       |                   |                   |                |                |
| City Population Comparables   | PIT Date         | Unsheltered | Population        | City              |                |                |
| St Louis City, MO   | 1/31/2007        | 213         | 350,759           | St. Louis         |                |                |
| Santa Ana/Anaheim/Orange County, CA   | 1/25/2007        | 665         | 339,555           | Anaheim           |                |                |
| Tampa/Hillsborough County, FL   | 1/25/2007        | 4,502       | 336,823           | Tampa             |                |                |
| Santa Ana/Anaheim/Orange County, CA   | 1/25/2007        | 665         | 333,249           | Anaheim           |                |                |
| <b>Cincinnati/Hamilton County, OH</b>   | <b>1/25/2007</b> | <b>59</b>   | <b>332,458</b>    | <b>Cincinnati</b> |                |                |
| Bakersfield/Kern County, CA   | 1/25/2007        | 608         | 315,837           | Bakersfield       |                |                |
| Pittsburgh/McKeesport/Penn Hills/Allegheny County, PA   | 1/27/2007        | 247         | 311,218           | Pittsburgh        |                |                |
| Toledo/Lucas County, OH   | 1/26/2007        | 109         | 295,029           | Toledo            |                |                |
| Riverside City and County, CA   | 1/24/2007        | 2,864       | 294,437           | Riverside         |                |                |
| City Population Comparables   | PIT Date         | Unsheltered | City              | Day's High (°F)   | Day's Low (°F) | Day's Avg (°F) |
| Rochester/Irondequoit/Greece/Monroe County, NY  | 1/25/2007        | 10          | Rochester, NY     | 61                | 34             | 47.5           |
| San Antonio/Bexar County, TX  | 1/25/2007        | 435         | San Antonio       | 57                | 39             | 48             |
| Columbus/Franklin County, OH  | 1/31/2007        | 114         | Columbus, OH      | 63                | 34             | 48.5           |
| <b>Cincinnati/Hamilton County, OH</b>   | <b>1/25/2007</b> | <b>59</b>   | <b>Cincinnati</b> | <b>66</b>         | <b>32</b>      | <b>49</b>      |
| Louisville/Jefferson County, KY   | 1/25/2007        | 180         | Louisville, KY    | 66                | 34             | 50             |
| Pittsburgh/McKeesport/Penn Hills/Allegheny County, PA   | 1/27/2007        | 247         | Pittsburgh        | 65                | 35             | 50             |
| San Francisco, CA   | 1/31/2007        | 2,743       | San Francisco     | 56                | 46             | 51             |
| Report is based on point-in-time information provided by Continuum's of Care to HUD in the 2007 grant applications. CoC's are required to provide an unduplicated count of homeless persons to according to HUD standards. HUD has not independently verified the information and cautions that since compliance with the standards may vary the reliability and consistency of the data may also vary. |                  |             |                   |                   |                |                |

### *Special Needs of People Using Street Outreach Programs*

Between October 1, 2007, and September 30, 2008, HMIS data show that there were a total of 484 single homeless people (217 women and 267 men) who were engaged in street outreach but who were not in emergency shelters. Of these, 42% had special needs related to mental illness and 34% had special needs related to chronic homelessness.

| Special Needs             | Single Adults with Special Needs in Outreach Programs but not in Emergency Shelters | Percentage of Total Single Adults in Outreach Programs but not in Emergency Shelters |
|---------------------------|---|--|
| Mental Illness            | 201   | 42%  |
| Chronically Homeless      | 166   | 34%  |
| Drug Abuse                | 123   | 25%  |
| Alcohol Abuse             | 71  | 15%  |
| Domestic Violence         | 34  | 7%   |
| Developmental / Cognitive | 34  | 7%   |
| Physical / Sensory        | 26  | 5%   |
| Illiterate                | 6   | 1%   |
| HIV / AIDS                | 5   | 1%   |
| Non-English Speaking      | 0   | 0%   |

An informal focus group with the PATH Street Outreach Team identified homeless people with chronic mental illnesses—especially those who are paranoid or delusional—and homeless people with substance abuse problems as the most difficult to serve populations. These were also the groups identified as making up the largest component of the “street homeless,” or people who do not go to shelters. The PATH Street Outreach Team also identified other street populations: sex offenders; couples without children; people who have both a substance use problem and a mental illness (“dually diagnosed”); people with repeat criminal offenses; people who have a substance use problem, a mental illness, and a developmental disability (“triple diagnosed”); Hispanic people; travelers; and people who don’t want to be sheltered.

### **B. Recommendations**

Based on the data and best-practice research, combined with the experience of local providers, the Homeless to Homes Subcommittee on Street Outreach is recommending the following:

**1) Add street outreach workers specializing in substance abuse to the PATH Street Outreach Team.**

The current street outreach programs are limited to serving: 1) people with severe mental illness, 2) people who are panhandling downtown, and 3) adults below the age of 25. This current configuration, based on funding mandates, excludes one of the most numerous groups of street homeless individuals: those who are currently abusing alcohol or other drugs. By adding four additional street outreach workers who specialize in substance abuse engagement, harm reduction, and treatment to the PATH Team, the street homeless with substance use problems will have access to services from a dedicated outreach worker. Since the four existing PATH outreach workers are specialists in mental health, placing four specialists in substance use with them allows for coordination of both best practice services between the two systems as well as interdisciplinary approaches and supervision.

**2) Create a new Street Outreach Transitional Housing program for individuals who have been sleeping on the streets and in places not meant for human habitation.**

The Street Outreach Transitional Housing program<sup>20</sup> is designed to serve 16 individuals at a time who are unable or resistant to enter an emergency shelter facility or engage in services other than those offered to them by street outreach workers. Such individuals frequently have chronic substance use problems, chronic mental illnesses, or both, and the symptoms of their illnesses make it impossible for them to live in a congregate shelter facility.

**3) Create a new Safe Shelter for individuals who are unwilling or unable to engage in services but are willing to enter an emergency shelter.**

(See Men's and Women's subcommittee recommendations).

**4) Create a Homeless Information Service Program within the Safe Shelter site.**

(See Men's and Women's subcommittee recommendations).

**5) Formalize arrangements between street outreach programs and Cincinnati Police so that officers in all districts are designated to work with the street homeless and outreach workers.**

The Cincinnati/Hamilton County count of individuals sleeping outside has declined in recent years in part due to the fact that Police District 1 has procedures for interacting with street homeless and an officer who has dedicated himself to understanding and working with the street homeless population. All districts should have such procedures and a designated officer AND/OR one "homeless officer" should be able to move between districts as homeless individuals and camps change and move.

**6) Develop a coordinated community response to those who are sleeping on the street so as to not enable a homeless lifestyle.** Coordinate the efforts of street outreach programs with those of churches, universities, mental health services, service providers, and the criminal justice system.

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<sup>20</sup> Refer to Appendix 8 – Street Outreach Transitional Housing

# Subcommittee on Mental Health and Substance Abuse Best Practices

## *Purpose*

To identify and develop recommendations for a plan to implement nationally recognized best-practices in serving homeless individuals with mental illnesses, substance use disorders, or both (the “dual diagnosed”) and address service delivery models and on-going funding support especially for people with dual diagnoses within the shelter system and in permanent supportive housing.

## *Chairperson:*

Diana McIntosh, PhD, APRN, BC, Vice President of Clinical Services, Hamilton County Mental Health and Recovery Services Board

## *Membership:*

Dave Bagent, MSW, LISW-S, Director, Mental Health Access Point (MHAP)

Amy Harpenau, LISW, Homeless Individual Partnership Program Coordinator, Drop Inn Center

Kevin Holt, Section Chief – Workforce Development, Hamilton County Job and Family Services

Jeff Kirschner, Chief of Program Operations, Greater Cincinnati Behavioral Health

Janie Mynatt, LISW-S, Social Worker Manager – Mobile Crisis Team, The University Hospital

Elizabeth Osinbowale, MSW, LISW, LICDC, Vice President of Clinical Operations, The Crossroads Center

Margo Spence, MS, LSW, CCDCIII-E, President and CEO, First Step Home, Inc.

John Young, M.Ed., President and CEO, FreestoreFoodbank, Inc.

## **I. Background**

According to the U.S. Department of Health and Human Services' Substance Abuse & Mental Health Services Administration (SAMHSA)<sup>21</sup>, essential service system components in working with the homeless and identified as "Evidence-based and Promising Practices" include:

- 1) Outreach and engagement
  - Meets immediate and basic needs for food, clothing, and shelter
  - A non-threatening, flexible approach to engage and connect people to needed services
- 2) Housing with appropriate services
  - Includes a range of housing options from safe havens to permanent supportive housing
  - Combines affordable, independent housing with flexible, supportive services
- 3) Multidisciplinary treatment teams with intensive case management
  - Provides or arranges for an individual's clinical, housing, and other rehabilitation needs
  - Features low caseloads (1:10 to 1:15) and 24-hour service availability
- 4) Integrated treatment for co-occurring disorders
  - Features coordinated clinical treatment of both psychiatric and substance abuse disorders
  - Reduces alcohol and drug use, homelessness, and the severity of mental health problems
- 5) Motivational interviewing/stages of change
  - Helps prepare individuals for active treatment
  - Incorporates relapse prevention strategies
  - Must be matched to an individual's stage of recovery
- 6) Modified therapeutic communities
  - View the community as the therapeutic method for recovery from substance abuse
  - Have been successfully adapted for people who are homeless and people without co-occurring mental disorders
- 7) Self-help programs
  - Often include a 12-step method with a focus on personal responsibility
  - May provide an important source of support for people who are homeless
- 8) Involvement of consumers and recovering persons
  - Can serve as positive role models, help reduce stigma, and make good team members
  - Should be actively involved in the planning and delivery of services
- 9) Prevention services
  - Reduce risk factors and enhance protective factors
  - Include supportive services in housing, discharge planning, and additional support during transition periods

Examples of evidence-based and best practice methodology can be found within multiple venues of the mental health and substance use disorder treatment delivery systems within Hamilton County. For example:

- Multidisciplinary treatment teams are the framework of an Assertive Community Treatment (ACT) model which is used by Greater Cincinnati Behavioral Health as one of its service approaches to housing homeless people with mental illnesses.

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<sup>21</sup> *An Overview of Mental Health and Substance Abuse Services and Systems Coordination Strategies* (SAMHSA 2003)

- Motivational Interviewing is a client-centered, non-judgmental, non-confrontational approach to influencing a client to consider making change. This approach is widely used with homeless people within the substance use disorder treatment system as seen at the Crossroads Center and First Step Home.
- The Alcoholism Council provides high-level engagement and substance use disorder counseling, support, and education on-site at Mt. Airy Shelter, designed to build and enhance healthy lifestyles through education and awareness.
- Multiple mental health and substance use disorder treatment providers within Hamilton County use “Integrated Dual Diagnosis Treatment” (IDDT) as a treatment approach for dually diagnosed people to help recovery by offering both mental health and substance use disorder treatment services at the same time and in one setting.

Best practice substance use disorder and mental health treatment are delivered to Cincinnati’s homeless populations in a variety of settings:

- Through the PATH Outreach Team, people who are mentally ill and who are on the streets have a proactive team of outreach workers who specialize in engagement, coordinated service delivery, and access to housing.
- Through a joint project between the CoC and the Hamilton County Mental Health and Recovery Services Board, the Recovery Health Access Center (RHAC) at the Alcoholism Council has become the centralized access point for all homeless persons seeking substance abuse services to receive an assessment, placement in the correct level of treatment to meet their needs, coordinated housing placement, and out-patient services as a model of blended best practice methods.
- Through the CoC’s Shelter Plus Care housing program, housing subsidy vouchers are assigned to homeless persons with disabilities and then appropriate mental health and substance use disorder treatment services are wrapped around the person through Caracole, Lighthouse Youth Services, Talbert House, and other providers.
- Through the substance use disorder treatment system identifying levels of care and matching clients to the most appropriate service.

In 2000, a combined effort by the U.S. Departments of Health and Human Services, Housing and Urban Development, Veterans Affairs, Labor, and Education and the U.S. Interagency Council on Homelessness created the Homeless Policy Academy Initiative. This initiative, which is still operational, provides technical assistance and policy planning states to address homeless issues. The nature of the problem, as defined by the initiative has four prongs:

1. The needs of people who are homeless cross administrative boundaries.
2. Housing and service needs can be adequately addressed through collaboration.
3. No single funding source or program can address the complexity of homelessness.
4. Mainstream resources are underutilized.

Through an intensive technical assistance initiative, many states including Ohio joined the Policy Academy to better understand promising practices to serving the homeless and ultimately created State Interagency Councils on Homelessness. Ohio, for example, created the Interagency Council on

Homelessness and Housing. Many best and promising practices were identified through the Policy Academy's work including the following Best Practices/ Principles of Care<sup>22</sup>:

- 1) **Integrated Treatment:** Where traditional models of treatment for dual disorders result in poor outcomes (i.e. high utilization of Emergency Rooms, jails, hospitals; ping-pong treatment and/or parallel treatment) integrated treatment is associated with better outcomes especially when it is supported by an integrated system of care.
- 2) **Individualized Treatment Planning:** Individualized Treatment Planning is derived from a comprehensive assessment. Use of several approaches and longitudinal nature of assessments is critical to success.
- 3) **Assertiveness:** The system must include outreach and engagement services. Successful interventions “go where the client is” and work with family, landlords, employers, etc. as necessary.
- 4) **Close Monitoring:** Intensive supervision is needed until the homeless individual is stable. Persuasive techniques may need to be utilized (e.g. representative payeeship, mandatory substance abuse treatment, urine testing, court sanctions, etc.)
- 5) **Longitudinal Perspective:** Treatment continues for years, and progress is measured over time. Mental illnesses and substance use disorders are diseases which are chronic and often result in relapsing conditions.
- 6) **Harm Reduction Strategies:** Provides for clients basic needs while reducing consequences of clients' negative behaviors. It provides an alternative to an “abstinence only” philosophy and is often more likely to engage those who don't yet have abstinence as a goal.
- 7) **Stages of Change:** Includes engagement, persuasion, active treatment, and relapse prevention.
- 8) **Stable Living Situation:** A range of safe, affordable housing options are necessary from safe haven/low demand residents for engagement to alcohol/drug free housing during active treatment and prevention focus. Assessments should not be tied to housing, though recognition that not having housing often makes assessments difficult and protracted. Flexible, tolerant and tailored support is required to efficiently and effectively retain long-time homeless persons in housing.
- 9) **Cultural Competency and Consumer Centeredness:** Programs have interdisciplinary teams of SUD, MH, homeless specialties, varying degrees and lengths of service to the homeless community.
- 10) **Optimism:** Have good staff retention despite intensity of position.

Through the Policy Academy, Social Security experts<sup>23</sup> also identified “helping people with disabilities who are homeless gain access to [Social Security Administration (SSA)] benefits programs...is a financially sound investment in people, programs and communities”. The Cincinnati CoC's Supplemental Security Income (SSI) program out of the FreestoreFoodbank has been recognized by the Ohio Interagency Council on Homelessness and Housing and Social Security experts as the best in the state and one of the best in the country. Promising practices identified within this program include:

- 1) Focus on the initial application.
- 2) Become the applicant's representative.
- 3) Avoid the need for Disability Determination Services (DDS) required Clinical Evaluations or collaborate with DDS to make Clinical Evaluations more effective.
- 4) Work closely with health care providers.

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<sup>22</sup> Fred. C. Osher, M.D, .*Addressing Chronic Homelessness – What Works: Evidence-Based Practices and Best Practice Models.*

<sup>23</sup> Dennis, Deborah, Yvonne Perret, Aaron Seaman, Susan Milstrey Wells: *Expediting Access to SSA Disability benefits: Promising Practices for People Who Are Homeless*

- 5) Reach out to medical records departments.
- 6) Establish on-going communication with SSA/DDA.
- 7) Create a summary report.

In addition to reviewing the literature and principles, best and evidence-based practices around the country and in Hamilton County, the Subcommittee met with a small group of homeless shelter workers and trainers to ask questions ranging from “How do you decide a person who is homeless may need mental health and/or substance abuse services and is not already connected to services?” to “What recommendations do you have for the system in helping persons be identified, assessed and connected to appropriate services?” Although some answers varied from individual to individual, there were some patterns related to training, access, and need for transportation.

## **II. Recommendations**

The Homeless to Homes Mental Health and Substance Abuse Best Practices Subcommittee makes the following recommendations:

1. **The Hamilton County Mental Health and Recovery Services Board (MHRSB) and the Continuum of Care for the Homeless (CoC) will convene the Service Collaborative Roundtable.** The Roundtable will include membership from MHRSB, MHAP, RHAC, mental health and substance use disorder treatment provider agencies, the CoC, and CoC agency executive directors as well as front-line homeless workers. The first meeting will be convened within one month of the publishing of the Homelessness to Homes comprehensive plan, and on an at least quarterly basis afterward to mutually problem solve and:
  - a. Identify and plan interventions to address system gaps and barriers that people who are homeless experience in getting the mental health and/or substance use disorder treatment services they need. Initial gaps to be addressed would include:
    - Access and related standards
    - Reconnection of homeless clients to mental health and substance use disorder services
    - Services for dually diagnosed homeless clients
    - Implementation of additional street outreach services for chronic substance abusers
    - Services for non- severely mentally disabled homeless clients
    - Appropriate Adult Protective Services involvement with homeless clients
    - Availability of detoxification beds
    - Data sharing and identification of longitudinal data to be tracked between systems
  - b. Include other stakeholders, when appropriate, such as the criminal justice system, Hamilton County Department of Job and Family Services, FreestoreFoodbank, etc., which have an impact on the ability of a person who is homeless to receive mental health and alcohol and other drug treatment services.
  - c. Develop protocols for shelter case managers to use in helping clients access mental health, community support psychiatric treatment (CPST) services, and substance use disorder treatment services;
  - d. Develop protocols for coordinating services when persons connected to mental health, CPST, or substance use disorder treatment services become homeless and access CoC services.

- e. Identify and assess progress toward mutually established targeted benchmarks and outcomes the roundtable membership would like to accomplish through its work.
2. **Locate diagnostic assessment capacity that addresses both mental illness and substance abuse issues at the Homeless Information Service Center to complete DAFs and place homeless clients into appropriate services.** This staff person would serve as a resource to emergency shelter staff, would determine the most appropriate treatment, facilitate placement, and make service provision for homeless clients more efficient.
  3. **Develop a system to meet the needs of individuals who have mental health issues, but who are not severely mentally disabled (SMD).** In Hamilton County, major funding entities for public mental health programs, such as the MHR SB, United Way, and The Health Foundation of Greater Cincinnati, have established missions and priorities that do not include adults who have a non-severe mental illness. Demand for the resources currently available for non-SMD clients far exceeds capacity. Therefore, there is a gap in obtaining treatment services for persons who are homeless and have a non-severe mental illness, such as anxiety. It is recommended that alternative models and funding be sought to provide services to this non-SMD homeless population.
  4. **Expedite diagnostic assessments for homeless persons to decrease the chance a person will have moved out of shelter or otherwise become unavailable prior to receiving a diagnostic assessment by:**
    - a. Continuing the collaboration between the CoC and RHAC's Homeless Housing Residential Treatment Program (HHRT), as appropriate through CoC processes;
    - b. Having MHAP put in place procedures that reduce wait times for assessments for persons who are homeless such as:
      - i. Prioritizing the initial call from a shelter worker or person who is homeless so that they can always get a live voice for an appointment time and never need to leave a message on voice mail;
      - ii. Using VESTA data to determine homeless status;
      - iii. Prioritizing vacant assessment times (due to cancellations, etc.) for homeless individuals who have been referred for assessment.
  5. The CoC and the MHR SB will work together to develop a data sharing process to increase collaboration and decrease duplication of services due to the awareness of clients being provided services in both systems by:
    - i. Exploring a data sharing process with MHAP and RHAC to appropriately identify individuals as homeless who are in need of mental health and alcohol or drug services, in collaboration with the CoC's HMIS Advisory Committee.
    - ii. Establishing a release protocol whereby homeless services staff are given information by MHAP or RHAC that a person is receiving services in the mental health or substance use disorder treatment systems;

- iii. Collecting aggregate data among systems for quality improvement and strategic planning.

**6.** The CoC and MHRSB collaboratively establish training that:

- a. Provides an overview of systems and orients line workers to each other's systems, including standardized services and definitions common to each other's systems;
- b. Informs homeless line workers of the protocols and procedures necessary for persons who are homeless to access mental health and/or substance use disorder treatment services; and
- c. Informs mental health and substance use disorder treatment line workers of expectations of their role with persons who are homeless and housing opportunities for their clients.

This training would be offered three times a year and consistently evaluated for its relevance, current information and helpfulness to the systems.

**7.** In relation to best and evidence based practices, the MHRSB and its contract agencies will provide services to persons served within CoC system to:

- a. Maintain local best and evidence based practices and innovations currently available to persons who are homeless and in need of mental health or substance use disorder treatment services, such as:
  - i. Assertive Case Management (ACT)
  - ii. Integrated Dual Disorder Treatment (IDDT)
  - iii. Motivational Interviewing
  - iv. Cognitive Behavioral Therapy (CBT)
  - v. Supported Employment
  - vi. Wellness Management and Recovery Services
  - vii. Project for Assistance to Transition from Homelessness (PATH)
  - viii. Motivational Enhancement Therapy (MET)
  - ix. Corrective Thinking
  - x. Seeking Safety
- b. Support the maintenance and use of self-help support groups such as:
  - i. Alcoholics Anonymous
  - ii. Narcotics Anonymous
  - iii. Al-Anon
- c. Adapt best practices as needed to meet local needs.
- d. The CoC and MHRSB collaborate to seek funding to bring additional best and evidence based practices to meet the needs of persons who are homeless and have mental health or AOD issues.

**8.** The CoC and MHRSB collaborate to seek funding to meet the needs of persons who are homeless and have mental health or AOD issues.

# Subcommittee on Transitional and Permanent Supportive Housing

## *Purpose*

To develop recommendations for a plan to increase transitional housing and permanent supportive housing (PSH) capacity within Cincinnati and Hamilton County based on local data and nationally recognized best-practices, identify a targeted number of PSH units to be developed within a five-year period, review the capacity needs of current development entities, make recommendations appropriate to meet the targets, and define the local PSH approach.

## *Chairperson:*

Stephen C. Smith, President, The Model Group

## *Membership:*

Blaine P. Brockman, Assistant Executive Director, Ohio Housing Finance Agency

Christine Buchholtz, One-City Foundation

Michael Cervay, Director – Department of Community Development, City of Cincinnati

James A. Cunningham, Director – Cincinnati Field Office, U.S. Department of Housing and Urban Development

Mary Burke Rivers, Executive Director, Over-the-Rhine Community Housing

**I. Background**

The problem is homelessness and the answer in the simplest terms is housing. But for many homeless persons in Cincinnati being able to access affordable housing and then being able to maintain housing has been a goal beyond their reach. To that end the range of housing opportunities for the homeless needs to be expanded in order to move persons from the streets and emergency shelters into permanent housing. To contextualize the housing issues it is important to understand several key principles of affordable housing:

**INCOME COMPARISON FOR SINGLE INDIVIDUALS**

|                                     |          |                                   |
|-------------------------------------|----------|-----------------------------------|
| <b>INCOME OF SINGLE INDIVIDUALS</b> | \$46,300 | Cincinnati - Median Income        |
|                                     | \$23,150 | 50% Median - Very Low Income*     |
|                                     | \$14,500 | Minimum Wage                      |
|                                     | \$13,890 | 30% Median - Extremely Low Income |
|                                     | \$10,404 | Poverty Level                     |
|                                     | \$7,644  | SSI                               |
|                                     | \$0      |                                   |

- Federal guidelines stipulate that no more than 30% of a household's income should go towards housing cost.
- In Cincinnati, the Fair Market Rent (FMR) for a one-bedroom unit is \$566.00.
- The federal poverty level for a one person household is \$10,404.
- The average annual income of someone on Supplemental Security Income (SSI) is \$7,608. At 30% of income for housing, he or she would pay \$190 per month for housing, requiring a \$376 monthly subsidy on the rent.
- If the individual was able to work a full-time, minimum wage job, he or she would gross \$14,500. At 30% of income for housing, he or she would pay \$362 per month for housing, requiring a \$204 monthly subsidy on the rent.

\* Maximum eligibility level for most federal housing programs

Complicating factors in the creation of permanent supportive housing (PSH) can be summarized as follows:

- ✓ PSH requires not only a developer with skills and capital necessary to develop affordable housing for extremely low- or no-income people, but also requires the partnership of a service provider who is able to acquire scarce resources to provide case management and key supportive services. Critical supportive service components are not covered in the developers' operating or capital budgets.
- ✓ In order to lower rents, developers or owners must receive a development subsidy (i.e. tax credits, free land or building) to reduce the debt service amount or an operating subsidy to fill the gap between the FMR and what the resident can afford to pay.
- ✓ PSH and affordable housing which supports individuals at very-low rent levels also tend to have operating expenses well above what market rate properties experience, therefore subsidizing the gap between FMR and 30% affordability does not necessarily put the project at a break-even or better point.
- ✓ PSH requires not only deep capital subsidies but on-going operating subsidies and critical front-desk and service funding. The number of income sources for each project easily reaches 8–10 sources, all with different accounting and reporting requirements.
- ✓ Financing is often leveraged and layered, with conflicting timetable and usage requirements. One source may not commit to funding without the commitment of other sources, all of which operate on different time tables.
- ✓ Capital, operating, and services dollars are most often highly competitive. Putting all the pieces together in a timely manner is difficult at best.
- ✓ Local planning, zoning, and historical issues are often critical components that are difficult to work through.
- ✓ Local “not in my backyard” (NIMBY) issues often cause projects to cascade into lengthy community review and approval processes and/or legal challenges.

The development and operating of permanent supportive housing requires a mix of capital and income sources. The following chart identifies the most active funding streams used locally for capital and operating support for PSH. It identifies how each source of funding is accessed (i.e., competitive grant application to a specific entity); if that funding stream can be used to pay for construction or renovation activities; ongoing operating support through operating subsidies in the building or lease subsidies directly to the tenants; the number of unit limitations, if any; and if the funding stream will pay for supportive services.

| BRIEF DESCRIPTION   | ACCESS                                | Construction   | Unit Based Subsidy | Tenant Based Subsidy | Number of Units | Supportive Services                                 |
|---|---------------------------------------|----------------|--------------------|----------------------|-----------------|---|
| <b>HUD - 202 Program - Supportive Housing for the Elderly</b>   |                                       |                |                    |                      |                 |   |
| The Section 202 program helps expand the supply of affordable housing with supportive services for the elderly. It provides very low-income elderly with options that allow them to live independently but in an environment that provides support activities such as cleaning, cooking, transportation, etc. The program is similar to Supportive Housing for Persons with Disabilities (Section 811). | Federal Competitive Grant Application | Yes            | Yes                | No                   | 42 annually     | Yes   |
| <b>HUD - 811 Program - Supportive Housing for Persons with Disabilities</b>   |                                       |                |                    |                      |                 |   |
| The Section 811 program helps expand the supply of affordable housing with supportive services for the elderly. It provides very low-income elderly with options that allow them to live independently but in an environment that provides support activities such as cleaning, cooking, transportation, etc. The program is similar to Supportive Housing for Persons with Disabilities (Section 202). | Federal Competitive Grant Application | Yes            | Yes                | No                   | 10 annually     | Yes   |
| <b>HUD - HOME Program</b>   |                                       |                |                    |                      |                 |   |
| HOME is the largest Federal block grant to State and local governments designed exclusively to create affordable housing for low-income households. Participating jurisdictions (PJs) match 25 cents of every dollar in program funds mobilizes community resources in support of affordable housing.   | City, County, State Applications      | Yes            | No                 | Yes (TBRA)           | TBD             | No  |
| <b>HUD - Community Development Block Grant (CDBG)</b>   |                                       |                |                    |                      |                 |   |
| The CDBG entitlement program allocates annual grants to larger cities and urban counties to develop viable communities by providing decent housing, a suitable living environment, and opportunities to expand economic opportunities, principally for low- and moderate-income persons. Note: Limit on public service cap.   | City, County, State Applications      | Yes rehab only | No                 | No                   | TBD             | Yes (within the public service cap of 15% of funds) |
| <b>HUD - Neighborhood Stabilization Program (NSP)</b>   |                                       |                |                    |                      |                 |   |
| HUD's new Neighborhood Stabilization Program will provide emergency assistance to state and local governments to acquire and redevelop foreclosed properties that might otherwise become sources of abandonment and blight within their communities.  | City, County, State Applications      | Yes            | No                 | No                   | TBD             | No  |

| BRIEF DESCRIPTION   | ACCESS  | Construction | Unit Based Subsidy        | Tenant Based Subsidy | Number of Units | Supportive Services |
|---|---|--------------|---------------------------|----------------------|-----------------|---------------------|
| <b>HUD/Veteran's Affairs - Supportive Housing (HUD/VASH)</b>  |   |              |                           |                      |                 |                     |
| Provides rental assistance vouchers to homeless veterans in public housing.   | CMHA  | No           | No                        | Yes                  | TBD             | Yes through the VA  |
| <b>HUD- FHA Insured Loans</b>   |   |              |                           |                      |                 |                     |
| Provides loans for construction.  | Bank Application  | Yes          | No                        | No                   | TBD             | No                  |
| <b>HUD - Project Based Section 8</b>  |   |              |                           |                      |                 |                     |
| Provides rental assistance on a project basis (subsidy is attached to specific units). Note: Service Coordinator  | CMHA  | No new units | Yes                       | No                   | TBD             | Yes                 |
| <b>HUD - Housing Choice Vouchers</b>  |   |              |                           |                      |                 |                     |
| Provides rental assistance directly to the tenant. Vouchers are portable and may be used wherever landlords will accept them.   | CMHA  | No           | Yes Project Based by CMHA | Yes                  | 20%             | No                  |
| <b>HUD - Shelter Plus Care (SPC)</b>  |   |              |                           |                      |                 |                     |
| Provides project based or tenant based rental subsidies for homeless disabled persons. Requires a 1:1 match in local services on aggregate for each grant funded.                   | Continuum of Care Process Competitive Federal Grant Application | No           | Yes                       | Yes                  | TBD             | Match               |
| <b>HUD - Supportive Housing Program (SHP)</b>   |   |              |                           |                      |                 |                     |
| Provides funding for transitional and permanent supportive housing, services only programs, safe havens, and HMIS. Funds have match requirements and specific program restrictions. | Continuum of Care Process Competitive Federal Grant Application | Yes          | Yes                       | Yes                  | TBD             | Yes                 |
| <b>Low Income Housing Tax Credits</b>   |   |              |                           |                      |                 |                     |
| Provides incentives for the utilization of private equity in the development of affordable housing.   | Ohio Housing Finance Agency - Competitive Application           | Yes          | No                        | No                   | TBD             | No                  |

| BRIEF DESCRIPTION   | ACCESS           | Construction | Unit Based Subsidy | Tenant Based Subsidy | Number of Units | Supportive Services |
|---|------------------|--------------|--------------------|----------------------|-----------------|---------------------|
| <b>Federal Home Loan Bank Grants</b>  |                  |              |                    |                      |                 |                     |
| The affordable housing and economic development programs of the twelve FHL Banks consist of grants and low-interest loans to member financial institutions to use to provide financing for economic development and housing activities. | FHLB Application | Yes          | No                 | No                   | TBD             | No                  |
| <b>Private Capital</b>  |                  |              |                    |                      |                 |                     |
| Investment from Private Sources (individuals, business, foundations)  | Open             | Yes          | Possible           | Possible             | TBD             | Yes                 |

### **Approach to PSH**

The Subcommittee on Transitional and Permanent Supportive Housing recommends that the strategy for PSH within the CoC be based on individual need, not a one-size-fits-all housing approach. Many methods should be deployed under this strategy. For example, a chronically homeless, mentally ill individual who has been on the streets for years may benefit from “housing first” methods (i.e., placing the homeless person directly in housing rather than in shelter and then in housing). Individuals who have been long time substance abusers or are dual diagnosed may benefit from more secure, site-based supportive housing programs with intensive engagement and harm reduction services. Other homeless individuals may prefer a site-based housing option to overcome some of their barriers to housing (criminal records, drug histories, etc.) while some prefer scattered-site units so that they can live in proximity to their special needs services or family and community support networks. No one approach will meet all individual needs, thus the continuation of a multiplicity of options needs to be supported, while filling in the unit gap with thoughtful approaches to development based on population data and current need.

Deploying multiple approaches to PSH can also be a cost-effective solution to the housing issue. “Housing first” service methods tend to be the most expensive way to provide the supportive housing services to people with severe mental illnesses, as Assertive Community Treatment (ACT) Teams are the best practice methodology for serving these clients. ACT requires a team of clinical professionals to provide on-site services to each client in residence. While this method is in use in Cincinnati with marked success, primarily with long-term street homeless individuals who have chronic mental illnesses, it is not cost-effective to replicate for another 750 units of PSH. And, not all clients need the high-level, high-intensity services of an ACT team. Multiple service plan options need to be created to support the clients at all levels in the housing units recommended in this plan.

### **Approach to Transitional Housing:**

The Subcommittee on Transitional and Permanent Supportive Housing recommends that a shift occur in the placement of persons within transitional housing. Currently, many people who require PSH are placed in transitional housing without a comprehensive assessment of individual housing needs, or they are placed in transitional housing while waiting on a PSH unit or subsidy to become available. Neither of these placements makes the most effective use of transitional housing. The Subcommittee recommends a shift in placement methods consistent with the findings within the shelter committees. An individual placed in transitional housing should be there because the individual service plan or case plan begun in the shelter system indicates that the individual requires supportive services in order to transition to mainstream housing (market rate, public housing, or Section 8). If individuals are housed within transitional housing due to a wait for PSH, they should be immediately placed on waiting lists and moved at the first possible opportunity. This shift in emphasis will enable stronger program development within transitional housing around life-skills development, good tenant training, obtaining and maintaining housing skills, and accessing site-based and mainstream services for on-going attention to their special needs.

**“Permanent supportive housing** increases housing stability and decreases use of costly institutional services such as shelters, hospitals, emergency departments, and jails and prisons.”

*Toward Understanding Homelessness: The 2007 National Symposium on Homeless Research as prepared for HUD and HHS*

**Overall numbers:**

Through the utilization of data generated on homeless persons within documented throughout this report combined with a statistical flow analysis provided by Steven Howe, Ph.D. the committee is recommending the following increase in transitional and permanent housing:

| Shelter-using consumers | 18-24 | Women 25+ | Men 25+ |
|-------------------------|-------|-----------|---------|
| Total Persons           | 209   | 495       | 2,606   |
| mental illness          | 82    | 320       | 1,025   |
| substance use           | 80    | 261       | 1,906   |
| dually diagnosed        | 45    | 208       | 868     |
| Neither                 | 92    | 122       | 543     |

| Outcomes   | 18-24     | Women 25+  | Men 25+    |
|--|-----------|------------|------------|
| Lost or institutionalized  | 73        | 173        | 912        |
| Mainstream housing, current  | 25        | 59         | 313        |
| Mainstream housing projected increase with case management service | 25        | 59         | 313        |
| Family and friends   | 42        | 99         | 521        |
| TOTAL HOUSED Without SUPPORT                                       | 165       | 390        | 2,059      |
| <b>Persons Needing TH or PH</b>                                    | <b>44</b> | <b>105</b> | <b>547</b> |

| Destinations Needed | 18-24 | Women 25+ | Men 25+ |
|---------------------|-------|-----------|---------|
| Transitional        | 29    | 69        | 358     |
| Permanent           | 15    | 36        | 189     |

| Total transitional beds needed (not per year) | 18-24 | Women 25+ | Men 25+    |
|---|-------|-----------|------------|
| Average length of stay                        | 12    | 12        | 12         |
| Total bed months                              | 348   | 828       | 4,296      |
| Minimum # beds needed                         | 29    | 69        | 358        |
| <b>TOTAL TH BEDS NEEDED:</b>                  |       |           | <b>456</b> |

| New permanent units needed/year | 18-24 | Women 25+ | Men 25+    |
|---------------------------------|-------|-----------|------------|
| Turnover rate                   | 15%   | 15%       | 15%        |
| New beds needed/year            | 13    | 31        | 161        |
| <b>TOTAL ANNUAL PSH GOAL</b>    |       |           | <b>204</b> |

**Subcommittee Recommendations:**

**1. Expand the supply of transitional housing**

In order to enable the emergency shelter system to function as a short-term provider of emergency housing, an ample supply of transitional housing must be established for persons who require longer-lengths of stay. The motivation for communities to develop transitional housing comes from the desire to reduce the rate of homeless or disabled people returning to homelessness (or recidivism rate) when they are placed in permanent housing before they are ready and/or able to succeed. Transitional housing programs are designed to increase the likelihood that people will be able to reestablish an independent lifestyle within a permanent housing unit by supporting them to develop independent living life-skills, increase or stabilize their income and benefits, obtain good tenant skills, and make appropriate and strong connections with on-going mainstream service systems to address their special needs.

The following specific recommendations are being made to increase the supply of transitional housing to meet the needs of the population as described in the demographic section(s) of this report:

| <b>TRANSITIONAL HOUSING TYPE</b>  | <b>NEW units &amp; subsidy requirements</b> | <b>Population Emphasis</b>   | <b>Acquisition</b> | <b>Renovation</b> | <b>Operations</b> | <b>Leasing</b> | <b>Services</b> |
|---|---|--|--------------------|-------------------|-------------------|----------------|-----------------|
| Site-based transitional housing for single women  | 50 units                                    | mental health connections for non-SMD  | x                  | x                 | x                 |                | x               |
| Site-based transitional housing for homeless jailed persons   | 30 units                                    | Identified at the front door of the jail system as homeless                                      |                    | x                 | x                 |                | x               |
| Site-based transitional housing for single men  | 40 faith-based, 20 general                  | substance abuse recovery and employment or reemployment  | x                  | x                 | x                 |                | x               |
| Scattered-site transitional housing for men and women (increase in the Transitional Housing Leasing Pool) | 51 subsidies                                | independent living skills and life-skills (short term and moderate transition: 6-months average) |                    |                   |                   | x              | x               |

| <b>TRANSITIONAL HOUSING FUNDED: Increase through 2008 CoC</b> | <b>Number of Beds</b> | <b>Funded</b> | <b>Population Emphasis</b> | <b>Acquisition</b> | <b>Renovation</b> | <b>Operations</b> | <b>Leasing</b> | <b>Services</b> |
|---|-----------------------|---------------|----------------------------|--------------------|-------------------|-------------------|----------------|-----------------|
| Existing Inventory  | 229                   | 1996-2007 CoC | Diverse                    |                    |                   | x                 | x              | x               |
| Tapp House  | 20 scattered          | 2008 CoC      | Women – homeless from jail |                    |                   |                   | X              | X               |
| Goodwill – Veteran Specific Leasing Pool                      | 16 scattered          | 2008 CoC      | Men/Women – veterans       |                    |                   |                   | X              | X               |
| Total TH Inventory  | 265                   |               |                            |                    |                   |                   |                |                 |
| <b>New Beds Required</b>                                      | <b>191</b>            |               |                            |                    |                   |                   |                |                 |

**2. Expand the supply of permanent supportive housing**

A person who requires PSH is defined by statute as: “a homeless person with a disability who has at least one of the following characteristics: Considered disabled under Section 223 of the Social Security Act; determined to have a physical, mental, or emotional impairment of long-continued duration, impeding the ability to live independently, and of a nature that could be improved by more suitable housing; having a developmental disability; having AIDS or conditions arising for its etiological effects.”

A person may be placed directly into a PSH unit from the streets using a “housing first” approach or may enter through the emergency shelter system following an assessment of their needs and previous housing situation(s). No matter what the entry method is, or the approach used, PSH assumes the following:

- The intent of the resident and housing provider is that a long-term PSH housing situation is required by the resident.
- Supportive services are provided to all residents; however, the level of support and participation in the services are optional and are based on an agreement between the service provider and the resident.
- Landlord-tenant and appropriate fair housing law prevail.

The following specific recommendations are being made to increase the supply of PSH to meet the needs of the population as described in the demographic section(s) of this report:

| <b>PERMANENT SUPPORTIVE HOUSING</b> |                                  |   |             |            |            |         |          |  |
|-------------------------------------|----------------------------------|---|-------------|------------|------------|---------|----------|--|
| TYPE                                | NEW units & subsidy requirements | Population Emphasis                               | Acquisition | Renovation | Operations | Leasing | Services |  |
| Site-based PSH                      | 125 units annually for 5 years   | Chronic homeless and/or disabled homeless persons | x           | x          | x          |         | x        |  |
| Scattered-site                      | 79 new certificates annually     | Varied  |             |            |            | x       | x        |  |

The Committee recognizes a need for minimum of 625 site-based units of PSH in the pipeline for development within the next 5 years. They also recognize that site-basing units may take up to three years lead time. Therefore, accomplishment of this goal in full may not be reached for up to eight years.

| <b>PSH FUNDED: Increase through 2008 CoC</b> | <b>Number of Beds</b>   | <b>Funded</b> | <b>Population Emphasis</b> | <b>Acquisition</b> | <b>Renovation</b> | <b>Operations</b> | <b>Leasing</b> | <b>Services</b> |
|--|-------------------------|---------------|----------------------------|--------------------|-------------------|-------------------|----------------|-----------------|
| Existing Inventory                           | 863                     | 1996-2007 CoC | Diverse                    |                    |                   | x                 | x              | x               |
| Jimmy Health House – 2008 application        | 25 site-based scattered | 2007-2008 CoC | Chronically homeless       | x                  | x                 | x                 | X              | match           |
| New Shelter Plus Care                        | 28                      | 2008 CoC      | Men/Women                  |                    |                   |                   | X              | match           |
| <b>Total PSH Inventory</b>                   | <b>916</b>              |               |                            |                    |                   |                   |                |                 |

**3. Expand the placement rate of people into Cincinnati Metropolitan Housing Authority's (CMHA) existing supply of vacant public housing units**

Homeless people applying to CMHA often find that the policies and procedures of CMHA are unaccepting of their life histories. For example, people applying to CMHA cannot owe back rent, previous eviction histories are taken into account, and jail records are considered. These are all factors that inhibit renting to homeless individuals. In discussions between the Executive Director of CMHA and the Transitional and Permanent Supportive Housing Subcommittee, it was clear that at times vacancies exist within CMHA's public housing, especially in the area of efficiency units. The director also recognized the issues that often times ban an eligible person from accessing this housing and made it clear that CMHA was open to considering applications if a new innovative approach made it easier to overcome barriers wherever legally possible.

The following specific recommendation is being made to enable access to CMHA housing for single individuals: CMHA and the CoC or its designee will apply for a HUD ROSS Elderly Program grant under the 2009 NOFA. The purpose of the ROSS program is for the delivery and coordination of supportive services and other activities designed to help improve the living conditions of public and Indian housing residents who are elderly and/or disabled. In 2008, the limitation of the ROSS funding was \$125,000 for a three-year period to non-profit applicants or approximately \$350,000 for PSH applicants. CMHA and the CoC will develop a program and process to streamline access to public housing for homeless elderly or disabled residents. The program will provide information and referral connections to area mainstream services which may be necessary for the individual to maintain permanent housing.

**4. Create one group home or safe-haven (permanent) for the single chronically homeless women who have been long-term shelter residents.**

There are 8 to 10 women who have been chronically homeless for more than 10 years. Moving these women to a group home, where they could stay together and still be in the central city area would immediately free up 8 to 10 shelter beds each night and is consistent with the Women's Subcommittee's recommendation. Key informants note that the past attempts at housing some of these women within the existing group home system has failed because they could not comply with group home requirements. The creation of a group home with the safe-haven like components of engagement, support, and harm-reduction features designed for mentally ill women is necessary for them be able to access and maintain permanent housing.

**5. Support a partnership between a qualified, experienced developer with a proven track record and the CoC for the purposes of developing immediate capacity to develop and operate PSH.**

There is currently only one non-profit housing developer who has expressed interest in developing and operating PSH: Over-the-Rhine Community Housing. In consideration of the extensive need for PSH and the ability to diversify locations, a new PSH provider needs to be brought into Cincinnati/Hamilton County. The role of this new provider is envisioned by the Subcommittee to be the following: 1) lead the development efforts in partnership with the CoC to develop, manage, service, and sustain new units of PSH in the next five years; and 2) provide training and support for existing non-profit development corporations within Cincinnati and Hamilton County who might also be interested in expanding their housing portfolios to include PSH for the homeless.

The Subcommittee has identified National Church Residences (NCR) as a potential PSH partner. NCR is a non-profit corporation certified as a 501(C)(3) charitable organization with assets of more than \$700 million. In 1961, the Reverend John R. Glenn and four Ohio Presbyterian churches formed NCR out of a Christian commitment to serve older adults' housing, social, and human needs. NCR has a rich history of affordable housing development (including PSH), property management, and service coordination as well as a primary interest area in Ohio. NCR is well suited to partner with the CoC in order to support the development of a cadre of PSH as is required in this plan.

**6. Improve Access and Community Competitiveness for funding for Transitional and Permanent Supportive Housing.**

- a) Create an annual set-aside within the HUD/HOME federal funding allocated to the City for PSH for the next 5 years of \$1.5 million each year.
- b) Increase the dialogue between the private and public stakeholders and the Ohio Housing Finance Agency for the purpose of developing a better understanding of what will increase the competitiveness and success of PSH funding applications (including tax credit financing).
- c) Support the Ohio Supportive Housing for the Homeless Alliance's program for PSH Gap Subsidies currently under consideration at the Ohio Housing Finance Agency (OHFA) and later to be introduced as legislation in the Ohio General Assembly.

**7. Increase project-based Section 8**

Periodically, CMHA releases a notice of the availability of Section 8 voucher transfers to site-based contracts. Every effort should be made by the CoC to work with CMHA on this process and to encourage housing provider application for the subsidies.

**8. Work with Hamilton County to create housing solutions instead of incarceration for homeless persons.**

- a) Create a screening procedure within Hamilton County Pre-Trial Services to place repeat homeless persons arrested for minor crimes in transitional housing or PSH instead of in jail or prison.
- b) Create a method of recapturing a portion of the savings from jailing a homeless individual into services and operations for the transitional housing or PSH placement.

**9. Create a Tax Credit Equity Fund for PSH/Transitional/Affordable Housing Investment:**

Low Income Housing Tax Credits (LIHTC) can generate funding for over 70% of the capital costs of an affordable housing project. In recent years, the primary LIHTC investors have been large banks, particularly banks with Community Reinvestment Act (CRA) compliance needs; however, large corporations may also invest in LIHTC and take full advantage of the tax credits and depreciation. Due to the recent financial crisis, most banks have either suspended or significantly curtailed LIHTC investment creating a significant shortage of LIHTC equity.

We are recommending the formation of a local equity pool where Cincinnati/Hamilton County corporations can invest in their local community through the LIHTC program. Additionally, we recommend that this equity pool be managed by a LIHTC syndicator with a strong track record of underwriting, administering, and monitoring such a fund in order to alleviate the need for each investor to develop the skill set "in-house".

**10. Recommend all new transitional housing and PSH programs develop a "Good Neighbor Agreement" with adjacent property owners (residents and businesses).**

Good Neighbor Agreements are a tool designed to enable the transitional housing and PSH programs and neighborhood residents and businesses to overcome issues of concern. The agreement is intended to promote dialogue among the interested parties. It does not, however, provide the right of a neighborhood or group to stop the project by opposing the agreement.

The agreement is produced in draft form once the pre-development work is complete (i.e. site plans, architectural drawings, building permitting, and financing commitments). The agreement and process of connection with neighbors enables the housing provider to accurately share what they intend to do with the housing; it enables both parties to brainstorm ideas and to mitigate issues that are of concern. The agreement outlines both the intended housing program and the responsibilities of all parties to maintain the housing and neighborhood as places where all can live harmoniously. Through dialogue and good faith between the parties, an agreement is crafted that takes into account the issues on both sides and comes to a resolution that is agreed to on paper. The housing provider should not only ensure that their end of the agreement is managed through the appropriate design, management, and services but should also convene on-going discussions with neighbors once the

property is occupied to address any new concerns that were overlooked or misunderstood in the original agreement.<sup>24</sup>

**11. Site recommendations for transitional housing and PSH.**

The type (apartment units vs. group living), scale (number of units, number of persons per unit), and the general location of all new housing must fit the needs of the participants. The housing must be readily accessible, either within walking distance or easily accessible by bus and near a bus line, to community amenities such as grocery stores and recreation, medical, training, mental health or substance use disorder treatment, and mainstream benefit/resource facilities. After reviewing the current inventory of TH and PSH<sup>25</sup> the subcommittee recommends that new inventory considered by developers distribute PSH throughout the region.<sup>26</sup> Therefore, no new site-based TH/PSH is recommended currently for Census Tract 9, based on its current level of saturation<sup>27</sup>

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<sup>24</sup> Refer to Appendix 7 for a Sample Good Neighbor Agreement

<sup>25</sup> Refer to Appendix 11 for the HUD map of CoC Funded PSH Units by Census Tract

<sup>26</sup> Recommendation does not include projects currently funded and under development including the Jimmy Heath House on Odeon Street.

<sup>27</sup> Level of saturation equals the current level of TH and PSH in a tract in relation to other tracts within the jurisdiction.

# Smart Funding

## *Purpose*

To develop recommendations for a smart funding plan with community and private foundations and funders designed to coordinate funding and resource allocations in a purposeful and strategic way, to assist in the implementation and ongoing funding of the “Homeless to Homes” comprehensive plan and other aspects of the CoC system.

## *Chairperson:*

Penny Friedman, Vice-President and COO, Interact for Change

## *Membership:*

Eric Avner, VP/Sr Program Manager - Community Development, Haile / US Bank Foundation  
Ann Barnum, LISW CCDCIII, Senior Program Officer, The Health Foundation of Greater Cincinnati  
Edward Burdell, Consultant, William Cooper Procter Fund  
Dwendolyn I. Chester, Deputy Director – Community Development Department, City of Cincinnati  
Ed Hubert, Board Member, Hubert Foundation  
Heidi Jark, Vice President – Foundation Officer, Fifth Third Bank Foundation Office  
Mary Alice Koch, Foundation Administrator, PNC Advisors, Institutional Investment Group  
Mary Beth Martin, Executive Director, Summer Hill, Inc.  
Helen Mattheis, Senior Program Officer, The Greater Cincinnati Foundation  
Judy M. Rose, Senior Community Investment Representative, Federal Home Loan Bank of Cincinnati  
Jeff Seibert, Grant Officer, Manuel D. and Rhoda Mayerson Foundation  
Barbara Terry, VP – Community Impact, United Way of Greater Cincinnati  
Ray Watson, Community Investment Program Officer, The Greater Cincinnati Foundation  
Megan Wolfer, Schmidlapp Program Associate, Fifth Third Bank Foundation Office  
William K. Woods, Consultant, William Cooper Procter Fund  
Craig Young, Trustee, Craig Young Family Foundation

The Smart Funding Committee grew out of work begun at the *Philanthropy and the Challenge of Homelessness Forum*, convened August 18, 2008 by Interact for Change. The Forum brought together charitable foundations and other key funders from across the region to discuss the state of homelessness and the importance of the continuum of care funding methodology. HUD Deputy Assistant Secretary of Special Needs, Mark Johnston joined the funders for the event.

## COLLABORATIVE SMART FUNDING

The Collaborative Smart Funding Committee is a group of community and private foundations and funders. This Committee is coordinating funding and resource allocations in a purposeful and strategic way to help in starting and continuously supporting the “Homeless to Homes” comprehensive plan and other aspects of the Continuum of Care (CoC) system.

The Smart Funding Committee recognizes that funding the Homeless to Homes initiative must be transformational in nature. Funders, both private and public, must come together in new ways to make the changes that are called for in the plan. Therefore, the members of the Committee recommend the following actions:

- I. Observe Shared Principles to End Homelessness
  - A) All local foundations should observe the principles of Funders Together to End Homelessness<sup>28</sup> which are to:
    - 1) Promote housing-based solutions with access to appropriate services that are integrated into our communities, as the primary investment for ending homelessness.
    - 2) Initiate and collaborate through strategic partnerships among funders, local policymakers, business leaders, and government, as well as advocacy, housing, and service providers.
    - 3) Support effective prevention programs and strategies, such as discharge planning, employment training, substance abuse and mental health counseling, and family reunification efforts.
    - 4) Raise awareness of homelessness and help implement existing local ten year plans to end homelessness, while building public will for long-term strategies locally and nationally.
    - 5) Encourage and support research, demonstration projects, and data collection to identify and confirm evidence-based approaches for serving the homeless population.
    - 6) Promote needed systems change, including increased coordination across government departments and agencies and efforts to transition providers from shelter-based to housing first models.
    - 7) Work actively to leverage national policy and financial support for these efforts.
  
- II. Implement Local Action Steps for Collaborative Smart Funding (§ indicate funders have already begun the implementation)
  - A) **Operationalize the Funders Together principles** locally in support of the Homeless to Homes initiative and across all funding for the homeless by:
    - 1) Prioritizing the capital needs for Homeless to Homes by restricting funds for capital use.
    - 2) Providing flexible funding for operations and services.
    - 3) Requesting that all funders use the HUD/CoC outcome measures (income, housing, and self-determination) for all grants associated with Homeless to Homes.
    - 4) Requiring that all grantees use the Homeless Management Information System (HMIS) for reporting to ensure consistency and continuous improvement of data quality.
    - 5) Creating a single, coordinated grant application and process that will be used for all funding requests (capital, operating, and services) associated with the Homeless to Homes plan regardless of the grant maker.

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<sup>28</sup> Refer to Appendix 9 for a listing of the Funders Together to End Homelessness

- 6) Encouraging local grant makers to align any funding that addresses homelessness with the Homeless to Homes plan.
  - 7) Create a process that prioritizes all approved CoC recommendations for funding through the next five years of funding cycles for all local funders involved in ending homelessness.
- B) Create a **bridge to sustainability** by seeking national funding partners to assist with the start-up of additional services and operations recommended under the Homeless to Homes plan. §
- C) Implement the following **sustainability strategy** for Homeless to Homes:
- 1) Analyze operations of homeless agencies and recommend steps to streamline back office and service delivery functions.
  - 2) Work with Hamilton County to redirect current jail costs for the homeless into a planned housing diversion program for homeless individuals arrested for minor crimes. §
  - 3) Though the Hamilton County Board of Commissioners engage and collaborate with the Hamilton County Mental Health and Recovery Services Board on the Homeless to Homes plan, with the Board serving as a partner to allocate Medicaid funding for services within Permanent Supportive Housing for people who are homeless and who have a mental illness or substance use disorder.
  - 4) Recommend the allocation of \$100,000 of Community Development Block Grant (CDBG) funds annually to the CoC designated for emergency capital repairs for facilities within the CoC system. Transition the application, allocation, and contracting processes for these funds from the City of Cincinnati to the Continuum of Care for the Homeless, Inc.

“Housing trust funds are the single most impressive advance in the affordable housing field in the United States over the last several decades.”

*Center for Community Change*

- 5) Establish a Cincinnati/Hamilton County Homeless to Homes Trust Fund. Based on the best practices and learning’s from the Housing Trust Fund Project of the Center for Community Change. Currently the Housing Trust Fund project reports that there are 55 city housing trust funds in twenty four states and 83 county housing trust funds in 11 states. Collectively these housing trust funds generate over \$411,000,000 annually. The most common ongoing source of dedicated revenue for these trusts is through developer’s fees. On average these trust funds leverage between \$6.50 to \$10.00 of outside funding for every dollar allocated through the trusts.

Steps to implementation include:

- a) Developing a public/private Trust Fund Development Committee
  - b) Securing technical assistance from the Mary Brooks, of the Housing Trust Fund Project.
  - c) Creating the necessary legislation for the trust fund.
  - d) Identify the source of dedicated revenue.
- e) Create a “starter” in the trust fund through a deposit of revenue from one/all of the following sources:

- (i) A deposit equal to 1% of the City of Cincinnati general fund pursuant to a withdrawal of the property tax rollback as a one-time only deposit.
  - (i) An annual deposit of .5% of the City of Cincinnati and County general funds
  - (ii) A deposit of 10% of the net portion of the sale of Blue Ash Airport as a one-time only deposit.
- D) Create a collaboratively governed **Fund for Innovation for the Homeless** focused on flexible, nimble funding that allows for testing system strategies and improvements and making changes quickly and efficiently. §
- E) Support advocacy efforts to **leverage national policy and financial support** for our initiatives and systems
- F) Hire a Federal proposal writer to solely focus on obtaining federal funds for Homeless to Homes. Examples of funds currently available include: §

| Program/Grant Name   | Applicants:   | Closing Date | Funding:         |
|--|---|--------------|------------------|
| Knowledge Dissemination Conference Grants Program Announcement (Substance Abuse and Mental Health Services Projects of Regional and National Significance) | Substance Abuse & Mental Health Services Administration | 3/31/2009    | Ceiling: \$50,00 |
| Service Expansion for Enabling Services for Special Populations  | Health Resources & Services Administration              | 3/2/2009     | Available: \$5M  |
| Section 202 Demonstration Pre-Development Grant Program  | U.S. Department of Housing and Urban Development        | 2/18/2009    | Open             |
| VA Grant Per Diem, 2009 Capital Grant  | Veterans Administration                                 | 3/26/2009    | Available \$15M  |

- G) Develop a **coordinated data warehouse** that includes data from HMIS, MHARS, the criminal justice system, Hamilton County Job and Family Services, and other sources to allow for strategic, cost effective planning for services leading to ending homelessness.
- H) Develop a **dictionary of common terms** and initiatives to guide funders who want to work to address homelessness.

## Appendix 1 – Emergency Ordinance No. 0347-2008

**DIRECTING** the Cincinnati/Hamilton County Continuum of Care for the Homeless to immediately address the inadequacies of the current provision of services for single homeless individuals in the City of Cincinnati, and to put into place a comprehensive plan to implement such services. The plan must ensure that as a critical segment of the homeless community, single homeless men and women, will have access to safe, appropriate shelter facilities and that such facilities will provide comprehensive services necessary for homeless individuals to obtain and maintain housing.

Furthermore, Council directs that the comprehensive plan guarantee the highest standards of care for the homeless so they can successfully move from “Homeless to Homes.” In addition, all plan recommendations must insure that any facilities are “Good Neighbors” and do not result in any behavior or actions that are disruptive to businesses and residents. Recommendations for shelter facilities and service models must be based on nationally recognized best-practice methods within the context of the Continuum of Care for the Homeless and shall include case management services, medical services, mental health services, and recovery services.

Furthermore, it is the intent of the Mayor and the Cincinnati City Council that the recommended best practices model will guide City of Cincinnati resource allocations for services to single homeless men and women in the future. Any and all providers of these services will be selected through an objective, competitive process consistent with HUD guidelines that homeless services planning and implementation are coordinated, inclusive and outcome-oriented. The Continuum of Care is urged to submit its recommendations to the Mayor and Cincinnati City Council no later than March 31, 2009.

Furthermore, it is the intention of the Mayor and City Council to empower the Continuum of Care to respond to this mandate by creating a process that is inclusive of all of the key stakeholders in the community, including but not limited to homeless providers, the business community, government representatives, funding entities and regional/national experts. Failure to present a comprehensive completed plan to Council by the deadline will lead to direct intervention by Council to address the homeless system in a different manner.

WHEREAS, since 1996, the City of Cincinnati and Hamilton County have partnered around the Continuum of Care for the Homeless (“CoC”) efforts to plan and implement a comprehensive, effective service and housing delivery system for the homeless, including street outreach, individual and family emergency shelters, transitional and permanent housing, and services-only programs; and

WHEREAS, the Cincinnati/Hamilton County Continuum of Care for the Homeless is one of the nation’s top-scoring CoC programs and maximizes federal resources attracted to Greater Cincinnati, with a reputation for effective planning, implementation, and innovation, with overall outcomes that exceed national expectations; and

WHEREAS, the homeless sections of the Consolidated Plans of both the City and the County match and identify the housing needs and current inventory of facilities as is critical to the success of the CoC and of both jurisdictions ability to continue to generate and utilize federal Housing and Urban Development resources; and

WHEREAS, in 2007 there were a total of 7,298 unduplicated persons served through street outreach, emergency shelters and/or transitional housing within the City of Cincinnati and Hamilton County, of which 3,604 were single males and 1,139 were single females without children in their homeless household composition; and

WHEREAS, a total of 413 emergency shelter beds are available nightly for single individuals. Of this total number, 312 emergency shelter beds are reserved for single homeless men at the City Gospel

Mission, the Drop Inn Center, the Mt. Airy Shelter, and at the St. Francis/St. Joseph Catholic Worker House; and

WHEREAS, the Mayor and City Council recognize the experience of the local shelter providers and commend the existing individual men and women's shelter facilities for the resources and energy currently expended to provide emergency shelter and services for this population, while recognizing that innovations and service enhancements to meet the needs of the hardest-to-serve may exceed existing capacity; and

WHEREAS, the Hamilton County Department of Job and Family Services believes that the direct provision of shelter at Mt. Airy Center is not within their core competencies and have requested a process be developed to privatize Mt. Airy and in consideration of the considerable community debate about the Drop Inn Center; now, therefore,

BE IT ORDAINED by the Council of the City of Cincinnati, State of Ohio:

Section 1. That the Cincinnati/Hamilton County Continuum of Care ("Continuum of Care") immediately address the inadequacy of the current provision of services for single homeless individuals in the City of Cincinnati, and to put in place a comprehensive plan to implement such services.

The plan must ensure that as a critical segment of the homeless community, single homeless men and women will have access to safe, appropriate shelter facilities and that such facilities will provide comprehensive services necessary for homeless individuals to obtain and maintain housing. Furthermore, the comprehensive plan must guarantee the highest standards of care for the homeless so they can successfully move from "Homeless to Homes." In addition, all plan recommendations must insure that any facilities are "Good Neighbors" and do not result in any behavior or actions that are disruptive to businesses and residents. Recommendations for shelter facilities and service models must be based on nationally recognized best-practice methods within the context of the Continuum of Care for the Homeless and shall include case management services, medical services, mental health services, and recovery services.

Section 2. That the recommended best practices model serve as a guide for City of Cincinnati resource allocations for services to single homeless men and women in the future; and that the provider of these services will be selected through an objective, competitive process, consistent with HUD scoring guidelines that homeless services planning and implementation are coordinated, inclusive and outcomes-oriented, that may include national service providers.

Section 3. That Continuum of Care submit its recommendations to the Mayor and Council no later than March 31, 2009.

Section 4. That the City Manager is hereby directed to provide all necessary staff and financial support necessary to assist Continuum of Care in this process.

Section 5. That Continuum of Care shall include and/or consult with the following key stakeholders in the process:

- Current providers of service for homeless single, individuals.
- Mental Health and Substance Abuse Service system represented through the HCMHRS Board.
- The medical and dental community, including but not limited to doctors involved in Health Care for the Homeless.
- Community Foundations and Funders, including but not limited to the Health Foundation of Greater Cincinnati, Greater Cincinnati Foundation and SC Ministries.
- The religious community through various judicatories.
- The business community through 3CDC and the CBC.

Section 6. That this ordinance shall be an emergency measure necessary for the preservation of the public peace, health, safety and general welfare and shall, subject to the terms of Article II, Section 6 of the Charter, be effective immediately. The reason for the emergency is to ensure that those people in need of comprehensive services will have access to such services as soon as possible.

## Appendix 2 – Continuum of Care for the Homeless Background

Since 1994, the U.S. Department of Housing and Urban Development (HUD) has encouraged local communities to address issues related to housing and services for homeless persons and families through a single, comprehensive, coordinated system. Following research and discussion, HUD created the “continuum of care for the homeless” concept, designed to help communities develop the capacity to plan and implement long-term solutions to homelessness for their jurisdictions.

The City of Cincinnati partnered with Hamilton County in 1996 and created the first planning session around homelessness for both the City and the County. Jointly, the two Community Development Departments funded a consultant (The Partnership Center, Ltd.) to develop and facilitate the process, to oversee the work of the Continuum, and to produce the “Continuum of Care Grant” for HUD annually. The Greater Cincinnati Coalition for the Homeless also participated as key lead organization from the onset of the process. The jurisdictions were combined and are identified as the Cincinnati/Hamilton County Continuum of Care for the Homeless (CoC) recognized as CoC number OH-500 with HUD.

Continuum grants require that the applicant perform the following activities: annually count all persons that are homeless within the jurisdiction on a point-in-time day; maintain an inventory of all emergency, transitional and permanent supportive housing; coordinate and improve access to mainstream services and resources; and monitor, improve and report on outcomes of all housing and service programs within the jurisdiction. Through this annual competitive grant application process, our CoC has secured \$101,056,064 in funding for homeless housing and services in Cincinnati and Hamilton County since 1996. Funds are currently dispersed among 39 different programs and 24 different non-profit organizations.

| <b>Current Inventory by Housing Type</b> | <b>Beds for Individuals</b> | <b>Beds for Families</b> |
|--|-----------------------------|--------------------------|
| Emergency Shelter                        | 422 (+ 20 DV* beds)         | 185 (+45 DV)             |
| Transitional Housing                     | 229 (+9 DV beds)            | 82 (+60 DV beds)         |
| Permanent Supportive Housing             | 863                         | 456                      |

\* DV = Domestic Violence

Additionally, the City and County, together with The Partnership Center, produced for HUD the joint “Homeless and Special Needs” section of both jurisdictions’ Consolidated Plans in 2000 and 2005. These plans document the work of the communities, the results of the Continuum processes, and expectations and plans for the future. Goals, objectives and action steps are annually reported to HUD by both the City and the County, and through the Continuum Grant Process.

The local process and its outcomes and results have been recognized locally and nationally as best-practice models in collaborative efforts. HUD has twice awarded the local CoC with outstanding accomplishment awards. Our Homeless Management Information System (HMIS) remains the only one in the country with 100% participation of all homeless housing and services providers from street outreach to permanent housing (funded through governments and/or HUD and unfunded).

The CoC has, since 1996, operated a *single, coordinated and inclusive process* for planning and management of the local homeless housing and services, as required by the U.S. Department of Housing and Urban Development. This process has repeatedly received an extremely high score in the HUD competitive process, resulting in a high level of funding.

The coordinating body of our local CoC’s inclusive process is the *Homeless Clearinghouse*. This group’s purpose is to:

1. Plan and coordinate community influence on systemic issues affecting the homeless.
2. Uphold the elements of the Consolidated Plans that affect the homelessness.
3. Identify and support the utilization of all sources of funds and other resources used to improve the quality of life for homeless persons and/or to end homelessness.

The Homeless Clearinghouse is composed of representatives of: The City of Cincinnati, Department of Community Development; Hamilton County, Community Development Department; The Greater Cincinnati Coalition for the Homeless, and elected representatives of each of the CoC Working Groups.

The CoC Working Groups provide direct input in planning and implementation of local initiatives, coordinate day-to-day activities of providers, reduce/eliminate duplicative efforts, and actively promote best-practice methodologies. These working groups provide the framework to ensure the ongoing, active participation of the entire community, including local government agencies.

The CoC Working Groups and their focus areas are as follows:

- Benefit Access Group- focused on access to mainstream benefits for the homeless
- Family Shelter Partnership Program- focused on families in shelter
- Homeless Individuals Task Force- focused on homeless single individuals & the chronically homeless
- Homeless Outreach Group- focused on street homeless & chronically homeless
- HMIS Advisory Committee- focused on HMIS quality, integrity, and policies/procedures
- Permanent Housing Group- focused on permanent housing for the disabled funded by the Supportive Housing Program (SHP)
- Shelter Plus Care Work Group- focused on Shelter Plus Care (SPC) permanent housing
- Transitional Housing Group- focused on SHP Transitional Housing for the homeless

In addition to managing the CoC, HUD has encouraged communities to integrate the administration and management of the Emergency Shelter Grant (ESG) and Housing Opportunities for Persons with AIDS (HOPWA) funding into the Continuum's local process, which has been successfully done in Cincinnati.

In response to pending Congressional legislation designed to codify and consolidate the Continuum strategy, The Cincinnati/Hamilton County Continuum of Care for the Homeless, Inc. (CoC, Inc.) was incorporated as a non-profit, 501 (c) 3 organization in 2007 and designed to continue to serve in this capacity for the local jurisdictions and community providers. It is expected with passage of the legislation that the CoC, Inc. will receive direct funding from HUD and will serve as the fiscal agent for all of HUD's continuum funds coming into the community.

### Appendix 3 - Homeless to Homes Process and Participant Information

A planning and research team was identified by the Continuum of Care, Inc. Board. The Procter and Gamble Company identified a retired employee, Jay Price, to facilitate the process on a volunteer basis. Kevin Finn, Executive Director of the CoC, Inc., was to take the lead in the planning effort overseen by Margaret Moertl, the CoC Board Chairperson. The U.S. Department of Housing and Urban Development authorized Michelle Budzek, President of The Partnership Center, Ltd., to provide technical assistance, including data analysis, research, program development, and support to the process and the report.

A Steering Committee was identified using the following process:

- All the Executive Directors of the Continuum of Care were convened to elect three Directors as representatives of the Continuum.
  - Pat Clifford, General Coordinator, Drop Inn Center
  - Linda Seiter, Executive Director, Caracole, Inc.
  - Sr. Mary Stanton, Executive Director, Bethany House Services (elected/illness prohibited attendance)
- The Cincinnati Business Committee was invited to send up to four representatives.
  - Gary Lindgren, Executive Director, Cincinnati Business Committee
  - Lynn Marmer, Group Vice President, Kroger Co.
- The Continuum of Care, Inc. Board of Directors identified two community funders.
  - Barbara Terry, Vice President – Community Impact, United Way of Greater Cincinnati
  - Robert L. Obermeyer, Senior Vice President, Hamilton County Mental Health and Recovery Services Bd
- The Continuum of Care, Inc. Board, soliciting input from church leaders, selected three groups of faith-based coalitions to represent the churches.
  - H.F. (Pat) Coyle, Jr., Vice President – Executive Board, Metropolitan Area Religious Coalition
  - Rev. Aaron Greenlea, Co-chairperson, Greater Cincinnati Faith Alliance
  - Roger Howell, President, City Ministries, representing Evangelical Church Community
- Finally, both the City and County were asked to seat two representatives. The County elected to seat two people. The City declined and instead identified a person to “staff” the process.
  - Michael Cervay, Director – City of Cincinnati Department of Community Development, (staff)
  - Susan Walsh, Director – Hamilton County Community Development Department, Hamilton
  - Moirra Weir, Director – Hamilton County Department of Job and Family Services

Subcommittees were identified and purposes established to begin the process. Each subcommittee chairperson and the executive director of the Continuum of Care were to identify subcommittee members that included three to five persons with subject matter expertise along with relevant community leaders. Subcommittees were as follows:

#### Homeless Women

Purpose: To start from a “blank slate” and develop a new plan to ensure access to appropriate shelter facilities, services, and housing for individual women, based on local data and nationally recognized best-practices.

Chairperson: Alice Skirtz, Ph.D., Family Shelter Partnership Supervisor, Metropolitan Area Religious Coalition Member

#### Homeless Men

Purpose: To start from a “blank slate” and develop recommendations for a new plan to ensure access to appropriate shelter facilities, services, and housing for individual men, based on local data and nationally recognized best-practices; make clear recommendations on number, size, target population, and expected outcomes of shelter facilities recommended.

Chairperson: Susan Walsh, Director, Hamilton County Community Development

Homeless Young Men and Women (age 18 through age 24)

Purpose: To start from a “blank slate” and develop recommendations for a new plan to ensure access to appropriate shelter facilities, services and housing for young homeless persons, based on local data and nationally recognized best practices.

Chairperson: Robert Mecum, Executive Director Lighthouse Youth Services, Inc.

Street Outreach

Purpose: To start from a “blank slate” and develop recommendations for a new plan to ensure access to appropriate shelter facilities, services, and housing for individuals living on the streets, based on local data and nationally recognized best-practice and safe-haven models. Housing options considered will include a Safe Haven in Cincinnati including recommendations for its size, scope, and the type to be developed.

Chairperson: Sergeant Stephen Saunders, Cincinnati Police Department

Mental Health and Substance Abuse – Best Practices

Purpose: To identify and develop recommendations for a plan to implement in Cincinnati nationally recognized best-practices in serving mentally ill, substance abusing, and dually diagnosed homeless individuals; address service delivery models and on-going funding support especially for the dual diagnosed targeted populations within the shelter system and in Permanent Supportive Housing.

Chairperson: Diana McIntosh, Vice-President, Clinical Services, Hamilton County Mental Health & Recovery Services Board

Transitional and Permanent Supportive Housing

Purpose: To develop recommendations for a plan to increase permanent supportive housing and transitional housing capacity within Cincinnati and Hamilton County based on local data and nationally recognized best-practices, identify a targeted number of PSH units to be developed within a five year period, review the capacity needs of current development entities, make recommendations appropriate to meet the targets, and define the local PSH approach.

Chairperson: Stephen C. Smith, President, The Model Group

Smart Funding

Purpose: To develop recommendations for a smart funding plan with community and private foundations and funders designed to coordinate funding and resource allocations in a purposeful and strategic way, to assist in the implementation and ongoing funding of the “Homeless to Homes” comprehensive plan and other aspects of the CoC system.

Chairperson: Penny Friedman, Vice-President and COO, Interact for Change

Subcommittees met on a regular basis (some weekly) over a five month period. Each committee was provided with specific HMIS data relating to their specific subpopulation. Subcommittees were also provided with an electronic bibliography on best practices and current research via a web connection built on the Continuum of Care for the Homeless website. Each subcommittee developed initial recommendations and a draft of those recommendations was prepared by The Partnership Center, Ltd. for their review, comment and edit. The Steering Committee reviewed the work of each Subcommittee at least twice, providing suggestions to the Subcommittees for changes and clarification. The final version of each of the subcommittee's work, as accepted by the Steering Committee, is included in the final report. Acceptance of the report means the Steering Committee agreed the Subcommittee covered the relevant topics and used an appropriate process. It does not mean that members of the Steering Committee agree with or approve every recommendation in a Subcommittee report.

The Steering Committee is responsible for the final recommendations within the report. Recommendations were based on: 1) the recommendations of the subcommittees that the Steering Committee choose to move forward as recommendations to City Council; and 2) the incorporation of those points into a plan that also included issues the City Council's ordinance mandated to be included.

## Appendix 4 – Outcome Reporting

### Current HUD benchmarks for outcomes

| Objective  | Local 2008 Achievement Level | 2009 Proposed Goal |
|--|------------------------------|--------------------|
| Increase the percentage of homeless persons staying in (supportive) permanent housing over 6 months to at least 71.5%                          | 82%                          | 85%                |
| Increase the percentage of homeless persons moving from transitional housing to permanent housing (supportive or mainstream) to at least 63.5% | 71%                          | 73%                |
| Increase the percentage of homeless persons employed at exit to at least 19%   | 28%                          | 30%                |

### 2007 Outcome Measures across the Continuum are as follows:

| Housing Exit by Type: exit destinations for 3,674 clients who exited Street Outreach, Emergency Shelter, Transitional Housing with exit data recorded<br>(excludes drop-in facilities which do not record exit data; clients with multiple exits during the year are counted only as of their last exit): | Overall | Percent |
|---|---------|---------|
| Exited to a Permanent Housing Destination   | 1,918   | 52%     |
| Exited to Transitional Housing  | 835     | 23%     |
| Exited to an Institution (hospital, jail, treatment program, etc.)  | 105     | 3%      |
| Exited to another place, includes persons with unknown exit destinations.   | 816     | 22%     |

| Length of stay for all persons housed in Permanent Supportive Housing during 2007<br>(those staying and exiting) | 1,577 Persons Total |
|--|---------------------|
| Less than 6 months (including new intakes)   | 246 people - 16%    |
| Six months to one year (including new intakes)   | 367 people - 23%    |
| One to two years   | 361 people - 23%    |
| Two to four years  | 348 people - 22%    |
| Four to six years  | 189 people - 12%    |

|                     |                |
|---------------------|----------------|
| Six to ten years    | 45 people - 3% |
| More than ten years | 21 people - 1% |

| <b>Income sources for primary clients/households that exited Outreach, Shelter* or Transitional Housing during 2007 and did not return:</b> | <b>Source at First Intake</b> | <b>Source at Last Program Exit</b> |
|---|-------------------------------|------------------------------------|
| Earned Income   | 288                           | 460                                |
| Social Security (elderly or death benefits)   | 8                             | 8                                  |
| Social Security Disability Benefit: SSI or SSDI   | 232                           | 259                                |
| Temporary Assistance to Needy Families (TANF/OWF)   | 151                           | 222                                |
| Veterans Administration (Disability or Pension)   | 47                            | 50                                 |
| Other Income  | 115                           | 129                                |
| No cash income reported   | 1,198                         | 938                                |

| <b>Sources for primary clients/households that exited Outreach, Shelter* or Transitional Housing during 2007 and did not return:</b> | <b>Source at First Intake</b> | <b>Source at Last Program Exit</b> |
|--|-------------------------------|------------------------------------|
| Food Stamps  | 652                           | 848                                |
| WIC—Special Supplemental Nutrition Program for Women, Infants and Children   | 63                            | 82                                 |
| Medicaid (including Children's Health Insurance Program)   | 532                           | 651                                |
| Medicare Health Insurance  | 81                            | 81                                 |
| Other Insurance Public and/or Private  | 15                            | 58                                 |
| VA Medical Services  | 208                           | 212                                |

# FINDING A PERMANENT SOLUTION



## PERMANENT, SUPPORTIVE HOUSING

### WHO IS NATIONAL CHURCH RESIDENCES?



National Church Residences (NCR) is a not-for-profit corporation certified as a 501(C)(3) charitable organization with assets of more than \$1 billion. In 1981, the Reverend John R. Glenn and four Ohio Presbyterian churches formed NCR out of a Christian commitment to serve older adults' housing, social, and human needs.

As of 2008, NCR is comprised of over 300 affordable communities (23,000 units), and includes permanent independent senior housing, supportive housing for the formerly homeless; home health care; assisted living and skilled nursing communities; and numerous charitable foundations that support the needs of our residents.

### What is Supportive Housing?

The objective of NCR Supportive Services Housing Operations is:

- to provide services that allow tenants the opportunity to achieve residential stability, while increasing personal and economic independence;
- to link residents to internal programs and external community resources to provide an extensive and sustained support system that will both empower and enable residents to participate in the workforce at the highest possible level, based on individual circumstances.

Supportive services incorporate both traditional property management and social services delivery under a blended management structure, and may include:

- case management
- counseling
- life-skills training
- education enrichment
- social service referrals
- health care education
- career services
- job training
- financial management assistance
- individualized supportive services

## Permanent Supportive Housing

In spring 2003, National Church Residences (NCR), the nation's leading not-for-profit developer and manager of affordable senior and family housing, ushered in a new era of service with the opening of The Commons at Grant in downtown Columbus, Ohio. A 100-unit, service-enriched, permanent supportive housing community serving the workforce population, as well as individual, formerly homeless candidates of Columbus' Rebuilding Lives program, The Commons at Grant represented both a departure and an extension of NCR's mission to serve the under-accommodated by coupling supportive services with quality, affordable housing.

As a service-enriched facility, The Commons at Grant is more than an apartment building. Quite simply, the purpose of The Commons at Grant is to provide quality, affordable housing, while providing residents with access to those supportive services that they may need in order to achieve the highest possible standard of living. The Commons at Grant employs full-time professional case workers, a 24-hour staffed front security desk, job training, employment resources, and a blended management structure that allows residents to peacefully co-exist, while benefitting from the experiences and issues resolution of fellow residents.

Spurred by the overwhelming success of The Commons at Grant, The Commons at Chantry opened its doors in 2008. Comprised of 100 apartment homes for individuals and families, The Commons at Chantry is made up of two- and three-bedroom townhomes. Chantry Place, located within the core of The Commons at

Chantry campus, offers one-bedroom units in a building designed to provide social services for the formerly homeless, while promoting independence, all within a comprehensive, multi-building supportive housing community.



Opening in 2010, The Commons at Buckingham will serve the northern end of downtown Columbus, Ohio. Mirroring The Commons at Grant, The Commons at Buckingham will offer 100 units of permanent supportive housing for low-income wage earners and the formerly homeless.

Over the last 7 years, NCR has reached out to develop permanent supportive housing for the homeless. In conjunction with the NCR board's annual strategic planning process, NCR is now actively seeking opportunities to develop, own and manage quality supportive housing in other markets beyond Columbus. NCR strongly supports the concept that service-enriched housing continues to be the most effective avenue to ending homelessness, and we are honored to be part of these efforts.

### For Inquiries

Michelle Norris  
PH: 614-273-3575  
mnorris@ncr.org



**Appendix 6 –Report on HMIS/VESTA Matched with Hamilton County Arrest Records  
Homeless Single Individuals (Men and Women)  
Identified Through HMIS/VESTA Matched with Hamilton County Arrest Record Database**

Methodology: Data was provided to The Partnership Center, Ltd. (PCL) by the Hamilton County Justice System which included all persons arrested and incarcerated from October 1, 2005 through September 30, 2008. PCL unduplicated the jail data and then matched it to VESTA (the Homeless Management Information System of the Cincinnati / Hamilton County Continuum of Care for the Homeless) records for each of the three years. PCL identified the total number of people who spent time in an emergency shelter, jail, and both emergency shelters and jail during the same year as seen in the chart below. It's important to note that that the reported number of nights individuals spent in shelter are not necessarily sequential.

*Findings: The findings in this report represent the data as it was pulled. No attempt has been made to interpret the data or make recommendations for future plans of action.*

**FINDING #1: Total number of individuals in Emergency Shelter (ES) and Jail in the same year:  
Time Period: Three Years - October 1, 2005 through September 30, 2008**

|   | ES*<br>& Jail | 05-06<br>Jailed | 05-06<br>Homeless | ES*<br>& Jail | 06-07<br>Jailed | 06-07<br>Homeless | ES*<br>& Jail | 07-08<br>Jailed | 07-08<br>Homeless |
|---|---------------|-----------------|-------------------|---------------|-----------------|-------------------|---------------|-----------------|-------------------|
| <b>Women</b>  | 171           | 4,120           | 826               | 152           | 3,913           | 720               | 137           | 4,333           | 566               |
| <b>Men</b>  | 1,081         | 18,553          | 3,224             | 1,085         | 20,055          | 3,121             | 910           | 17,808          | 2,746             |
| <b>% of ES &amp; Jail to All women Jailed or Homeless</b> |               | 4%              | 21%               |               | 4%              | 21%               |               | 3%              | 24%               |
| <b>% of ES &amp; Jail to All men Jailed or Homeless</b>   |               | 6%              | 33%               |               | 5%              | 35%               |               | 5%              | 33%               |

\* ES = Emergency Shelter

Special needs are based on HMIS data only and are defined as an identified issue that an individual must overcome in order to exit homelessness. Special needs do not constitute a diagnosis. It is important to note that one individual can be identified as having multiple special needs including drug abuse, mental illness, dual diagnoses, alcohol abuse, and chronic homelessness. Therefore some individuals have been counted under more than one need category as having multiple special needs in the chart below. Individuals without mental health or substance abuse special needs have been recorded in HMIS and are also indicated in the chart below.

**FINDING #2: Number of individuals both jailed and homeless with identified special needs:  
Time Period: 1 Year - October 1, 2007 through September 30, 2008**

| Number of Nights Sheltered       | 1-7 | 8-30 | 31-60 | 61-90 | 91-180 | 181-366 | TOTAL | % of Total Jailed |
|----------------------------------|-----|------|-------|-------|--------|---------|-------|-------------------|
| <b>Unduplicated WOMEN jailed</b> | 14  | 24   | 18    | 6     | 6      | 69      | 137   |                   |
| <b>Dual (MH &amp; SA)</b>        | 3   | 8    | 13    | 5     | 5      | 46      | 80    | 58%               |
| <b>Mental health</b>             | 4   | 15   | 16    | 5     | 5      | 52      | 97    | 71%               |
| <b>Drug abuse</b>                | 3   | 9    | 13    | 5     | 5      | 49      | 84    | 61%               |
| <b>Alcohol abuse</b>             | 2   | 11   | 12    | 5     | 5      | 35      | 70    | 51%               |
| <b>Chronically Homeless</b>      | 1   | 12   | 12    | 5     | 5      | 42      | 77    | 56%               |
| <b>NO - MH, SA in HMIS</b>       | 10  | 5    | 0     | 1     | 0      | 9       | 25    | 18%               |

| Number of Nights Sheltered     | 1-7       | 8-30      | 31-60     | 61-90     | 91-180    | 181-366    | TOTAL      | % of Total Jailed |
|--------------------------------|-----------|-----------|-----------|-----------|-----------|------------|------------|-------------------|
| <b>Unduplicated MEN jailed</b> | <b>38</b> | <b>87</b> | <b>69</b> | <b>36</b> | <b>42</b> | <b>638</b> | <b>910</b> |                   |
| Dual (MH & SA)                 | 17        | 35        | 35        | 16        | 24        | 247        | 374        | 41%               |
| Mental health                  | 19        | 41        | 38        | 16        | 25        | 284        | 423        | 46%               |
| Drug abuse                     | 27        | 69        | 58        | 32        | 39        | 400        | 625        | 69%               |
| Alcohol abuse                  | 20        | 63        | 51        | 30        | 38        | 425        | 627        | 69%               |
| Chronically Homeless           | 15        | 48        | 43        | 28        | 34        | 346        | 514        | 56%               |
| <b>NO - MH, SA in HMIS</b>     | <b>7</b>  | <b>6</b>  | <b>4</b>  | <b>2</b>  | <b>0</b>  | <b>123</b> | <b>142</b> | <b>16%</b>        |

\*MH = Mental Health, SA = Substance Abuse

**FINDING #3: Most frequent charges for jailed homeless individuals:**

| <b>Most frequent charges for jailed homeless individuals (men and women)</b> |     |                                |    |
|--|-----|--------------------------------|----|
| <b>Time Period: October 1, 2007 through September 30, 2008</b>               |     |                                |    |
| <b>Male</b>  |     | <b>Female</b>                  |    |
| THEFT  | 342 | POSS ILLEG DRUG PARAPHENALIA   | 78 |
| POSS ILLEG DRUG PARAPHENALIA   | 308 | SOLICITING                     | 65 |
| POSSESSION OF OPEN FLASK   | 283 | THEFT                          | 30 |
| CRIMINAL TRESPASS  | 209 | POSSESSION OF OPEN FLASK       | 30 |
| DISORDERLY CONDUCT   | 145 | CRIMINAL TRESPASS              | 24 |
| DC-INTOX,ANNOY OR ALARM  | 112 | DISORDERLY CONDUCT             | 23 |
| ASSAULT  | 106 | OBSTRUCT OFFICIAL BUSINESS     | 22 |
| POSSESSION OF MARIJUANA  | 93  | POSSESSION OF DRUGS            | 18 |
| POSSESSION OF DRUGS  | 88  | ASSAULT                        | 16 |
| TRESPASS-KNOWINGLY   | 84  | RESISTING ARREST               | 12 |
| OBSTRUCT OFFICIAL BUSINESS   | 79  | FALSIFICATION                  | 12 |
| POSS COCAINE   | 72  | DC-INTOX,ANNOY OR ALARM        | 10 |
| PEDESTRIAN VIOLATION   | 62  | DRIVING UNDER FR SUSPENSION    | 10 |
| AGGRAVATED MENACING  | 60  | POSS COCAINE                   | 9  |
| RESISTING ARREST   | 59  | PEDESTRIAN VIOLATION           | 8  |
| THEFT-WITHOUT CONSENT  | 56  | DRIVING W/O VALID LICENSE      | 8  |
| DOMESTIC VIOLENCE  | 56  | DOMESTIC VIOLENCE              | 8  |
| ASSLT-KNOWINGLY,VICTIM HRMD  | 51  | TRESPASS-KNOWINGLY             | 7  |
| ALCOHOLIC BEVERAGS IN PARK-R11   | 45  | ASSLT-KNOWINGLY,VICTIM HRMD    | 7  |
| DRIVING UNDER FR SUSPENSION  | 45  | RECEIVING STOLEN PROPERTY      | 6  |
| RECEIVING STOLEN PROPERTY  | 43  | UNAUTHORIZED USE OF VEHCL      | 6  |
| MENACING   | 41  | CRIM DAMAGING OR ENDANGRNG     | 6  |
| ATTEMPT  | 40  | ALCOHOLIC BEVERAGS IN PARK-R11 | 5  |
| SOLICITING   | 34  | BURGLARY                       | 5  |
| SAFETY RESTRAINT VIOL-DRIV   | 34  | DC-FIGHTING OR THREATENING     | 4  |

**FINDING #4: The length of stay is greater in jail than in shelters:**

Between October 1, 2007 and September 30, 2008, a total of 1,042 homeless individuals entered jail 1,954 times. These 1,042 homeless individuals spent 42,903 nights in jail and 37,236 nights in emergency shelters from October 2007 through September 2008.

- Jailed homeless individuals spent an average of 41 nights in jail and 35 nights in shelter during the same year.
- Homeless individuals who were in jail over the same year entered jail an average of 1.9 times. Details about the number of times these individuals spent in jail can be seen in the table below.
- The total count of charges related to these jail stays was 4,326 or an average of 2.2 charges per person per jail stay.
- Of the 1,042 homeless people with jail stays during the same year, 524 or 50.3% are identified as mentally ill in HMIS.
- Among homeless individuals with more than one jail stay in the same year, 53.9% were identified as mentally ill. For those with more than 3 jail stays, 61% were identified as mentally ill.
- There were 145 homeless individuals who have been in contact with outreach workers but have not spent any time in emergency shelters who were jailed 245 times during the same year. These individuals entered jail an average of 1.7 times.
- The same 145 homeless individuals in outreach but not shelter spent a total of 6,104 nights in jail during the same year. Their average length of stay in jail was 42 nights. They received 593 charges with an average of 2.4 charges per person per jail stay.

| 10/1/2007 - 9/30/2008 | All Homeless | Mentally Ill | % Mentally Ill |
|-----------------------|--------------|--------------|----------------|
| Jail Stays            |              |              |                |
| 1                     | 608          | 290          | 47.7%          |
| 2                     | 238          | 120          | 50.4%          |
| 3                     | 96           | 53           | 55.2%          |
| 4                     | 42           | 26           | 61.9%          |
| 5                     | 23           | 14           | 60.9%          |
| 6                     | 11           | 6            | 54.5%          |
| 7                     | 8            | 6            | 75.0%          |
| 8                     | 4            | 2            | 50.0%          |
| 9                     | 3            | 1            | 33.3%          |
| 10                    | 3            | 3            | 100.0%         |
| 11                    | 2            | 1            | 50.0%          |
| 12                    | 1            | 1            | 100.0%         |
| 15                    | 2            | 1            | 50.0%          |
| 18                    | 1            | 0            | 0.0%           |
| Total                 | 1042         | 524          | 50.3%          |
| Recidivists           | 434          | 234          | 53.9%          |
| > 3 jail stays        | 100          | 61           | 61.0%          |

**FINDING #5: Cost of jailing and sheltering:**

Between October 1, 2007 and September 30, 2008, a total of 1,042 homeless individuals entered jail 1,954 times for a total of 42,903 nights in jail. The cost to house an individual within the Hamilton County Justice System is \$65.00 per night. The total cost of jailing those who were homeless equals \$2,788,695.00

These same 1,042 homeless individuals spent 37,236 nights in emergency shelters during the same year. The cost to provide the very basic emergency shelter (bed, limited services, food) is approximately \$25.00 per night. The total cost of sheltering those persons who were also jailed equals \$930,900.00

## Appendix 7 – Sample Good Neighbor Agreement

### GOOD NEIGHBOR AGREEMENT BETWEEN (FILL IN BLANK) AND Its Neighbors

The (FILL IN BLANK) which owns the property at (FILL IN BLANK) is a non-profit organization that provides comprehensive housing and supportive services for homeless and formerly homeless people.

The neighbors of (FILL IN BLANK) include residents of (FILL IN BLANK), businesses of (FILL IN BLANK), and other community members who live near (FILL IN BLANK).

All parties in this agreement share common goals including:

1. Maintaining a peaceful, safe, and clean neighborhood.
2. Sharing open and honest communication.
3. Helping each other address concerns and solve problems.
4. Offering public service for the benefit of the neighborhood and community.

In order to accomplish these goals, all parties are united in support of the commitments described below:

#### 1. Property

Property owners have a responsibility to keep their properties well-maintained and attractive. It is desirable for property owners and residents to show pride in the community by caring for public spaces, and by assisting the neighborhood's service organizations, such as schools, charitable organizations, etc., with improving the landscape. In order to maintain property at the highest possible values,

(FILL IN BLANK) will:

- A. (EXPLAIN HOW/WHEN GROUNDS WILL BE MAINTAINED / REPAIRED)
- B. (HOW / WHEN TO KEEP GROUNDS CLEAN / NEAT).
- C. (ADDRESS TRASH & LITTER).
- D. (EXPLAIN PLANS FOR LANDSCAPING / HOW PROPERTY OWNERS WILL CONTRIBUTE TO THE BEAUTIFICATION OF THE PROPERTY.)
- E. (HOW RESIDENTS CAN IMPROVE THE PUBLIC SPACE, VOLUNTEER EFFORTS ETC.)
- F. EXPLAIN PLANS FOR DEALING WITH EXCESS CAPACITY (IF THIS IS AN ISSUE).

Neighbors will:

- A. AS DEFINED BY NEIGHBORS

#### 2. Safety

Safety and security are essential for citizens to live peacefully and free from harm, and for neighborhoods to remain desirable and attractive. Property owners and residents share the responsibility of creating and maintaining a safe and secure neighborhood. In order to promote safety and security for all residents of the neighborhood,

(FILL IN BLANK) will:

- A. (ADDRESS SECURITY LIGHTING).
- B. (EXPLAIN LAW ENFORCEMENT / SAFETY PRECAUTIONS / CRIME PREVENTION STRATEGIES SUCH AS BLOCK WATCH / RELATIONSHIP WITH POLICE / ETC.)
- B. (EXPLAIN LOITERING POLICY)

C. (EXPLAIN HOW / WHEN EMERGENCIES WILL BE HANDLED).

Neighbors will:

- A. AS DEFINED BY NEIGHBORS

**3. Neighborhood Codes of Conduct**

Conduct and behavior that is respectful of others contributes to the peaceful enjoyment of life in the community. Individuals have the freedom to act as they please, so long as those actions are lawful, and do not harm others or infringe upon their rights. Cooperation and respect between citizens are desirable qualities, and will be actively promoted in the neighborhood. In order to promote good conduct and behavior,

(FILL IN BLANK) is responsible for informing all residents of neighborhood codes of conduct. All neighbors and residents are responsible for adhering to mutually appropriate behavior expectations.

- A. (EXPLAIN HOUSE RULES)
- B. (EXPLAIN ISSUES RELATED TO LOUD MUSIC, OFFENSIVE LANGUAGE, AND FIREARMS ETC.)
- C. (EXPLAIN HOW / WHEN AGENCY WILL RESPOND TO CONCERNS ABOUT RESIDENT BEHAVIOR).

Neighbors will:

- A. AS DEFINED BY NEIGHBORS

**4. Communication**

Communication between (FILL IN BLANK) and the neighboring community is important to develop and maintain positive relationships. Awareness of upcoming events offers the community ways to interact with residents and staff, and helps both parties become more integrated. Methods will be established to ensure routine communication, feedback, and monitoring of this agreement's commitments. In order to promote communication between the program and the neighborhood,

(FILL IN BLANK) will:

- A. (ADDRESS MARKETING).
- B. (INFORMATION ABOUT PROVIDER'S OTHER FACILITIES / INFORMATION ABOUT PROPERTY CONCERNS).
- C. PROCESS FOR CONTINUED COMMUNICATION.
- D. PARTICIPATION IN FACILITY & NEIGHBORHOOD COMMITTEES / BOARDS.
- E. MECHANISM FOR SHARING RESOURCES
- F. RESPONSIBILITY FOR MANAGING MEDIA RELATIONS.

Neighbors will:

- A. AS DEFINED BY NEIGHBORS

**5. Changes to Agreement**

This agreement may be changed or modified from time to time upon mutual agreement of (FILL IN BLANK) and a public process with its neighbors.

## Appendix: 8 - Street Outreach Transitional Housing

### Street Outreach Transitional Housing 16 single-room-occupancy units

**Description:** The Street Outreach Transitional Housing program is designed to serve persons who are unable or resistant to entering an emergency shelter facility or engage in services other than those offered to them by street outreach workers. Such individuals are frequently chronic substance abusers, mentally ill, or both, and the symptoms of their illnesses make it impossible for them to live in a congregate shelter facility. Therefore, they sleep outdoors or in places not meant for human habitation. The goal of the Street Outreach Transitional Housing program is to provide a “respite” from such living conditions, giving them a private, low-intensity, safe, and engaging place to live on a transitional basis. To facilitate movement from the street to the Street Outreach Transitional Housing program, Street Outreach workers will be co-located within the facility to provide on-going engagement opportunities and services (including new street outreach services; see Street Outreach Subcommittee recommendations). Placement into the program would be overseen by the CoC’s street outreach workers exclusively.

**Capacity:** 16 single-room-occupancy units

The street outreach workers currently working with the street homeless in Cincinnati/Hamilton County, upon reviewing their caseloads of clients, established that approximately 8-10 clients at a point in time would be good candidates for the Street Outreach Transitional Housing program. With the additional street outreach capacity for substance abusers on the street (see Street Outreach subcommittee recommendation #1), approximately 6 more individuals not currently being offered intensive outreach services could also be placed into the program.

**Services:** Each unit will contain a bed and basic toiletries. Information & referral services and case management will be available to all residents to encourage them to progress toward permanent housing. Around-the-clock security staff at the facility would be provided.

**Length of Stay:** The goal of the Street Outreach Transitional Housing program would be to house individuals for 3-6 months, but individuals could stay for up to 24 months if necessary. Length of stay will be considered on an individual basis as determined by CoC street outreach workers. Persons who are considered a potential danger to themselves or others will be referred to University Hospital for assessment and treatment prior to admittance.

**Facility:** The Street Outreach Transitions Housing program should consist of 6 single-room-occupancy units. Accommodations for special needs individuals must be accounted for in the design (e.g. persons with severe paranoia, transgendered individuals or disabled persons). The facility could be separate from other homeless services facilities, or collocated with another facility.

## Appendix 9 - Funders Together to End Homelessness

Funders Together to End Homelessness is a national network of foundations and corporations supporting strategic and effective grant making to end homelessness. The goals of Funders Together to End Homelessness are to build a national network of funders to support evidence based practices to end homelessness, support research to improve practices and policies, and to advocate for the increase in resources specifically dedicated to ending homelessness. Funders Together is governed by a National Steering Committee of foundations serving in leadership roles in efforts to end homelessness. The National Steering Committee is made up of:

- Bob Hohler, Executive Director, Melville Charitable Trust (*chairman*)
- Nancy Barrand, Senior Program Officer, The Robert Wood Johnson Foundation
- Sonya Campion, Co-Founder, Campion Foundation
- Terri Donlin Huesman, Director of Programs, Osteopathic Heritage Foundations
- Melinda Marble, Executive Director, Paul and Phyllis Fireman Foundation
- Tom Nurmi, Trustee, The William S. Abell Foundation
- Bill Pitkin, Senior Program Officer, Conrad N. Hilton Foundation
- Leslie Strnisha, Program Officer, Sisters of Charity Foundation of Cleveland
- Martha Toll, Executive Director, Butler Family Fund
- Darren Walker, Director Working Communities, Rockefeller Foundation
- Joseph Weisbord, Director of Homelessness Initiatives, Fannie Mae
- David Wertheimer, Senior Program Officer, Bill and Melinda Gates Foundation
- Deborah DeSantis, Corporation for Supportive Housing
- Nan Roman, National Alliance to End Homelessness

Strategic Partners include funders who have collectively given millions of dollars to fight homelessness. The Strategic Partners include:

- William S. Abell Foundation
- California Endowment
- Deutsche Bank
- Fannie Mae
- Frey Foundation of Minnesota
- Conrad N. Hilton Foundation
- Robert Wood Johnson Foundation
- Melville Charitable Trust
- The Rockefeller Foundation
- Osteopathic Heritage Foundations

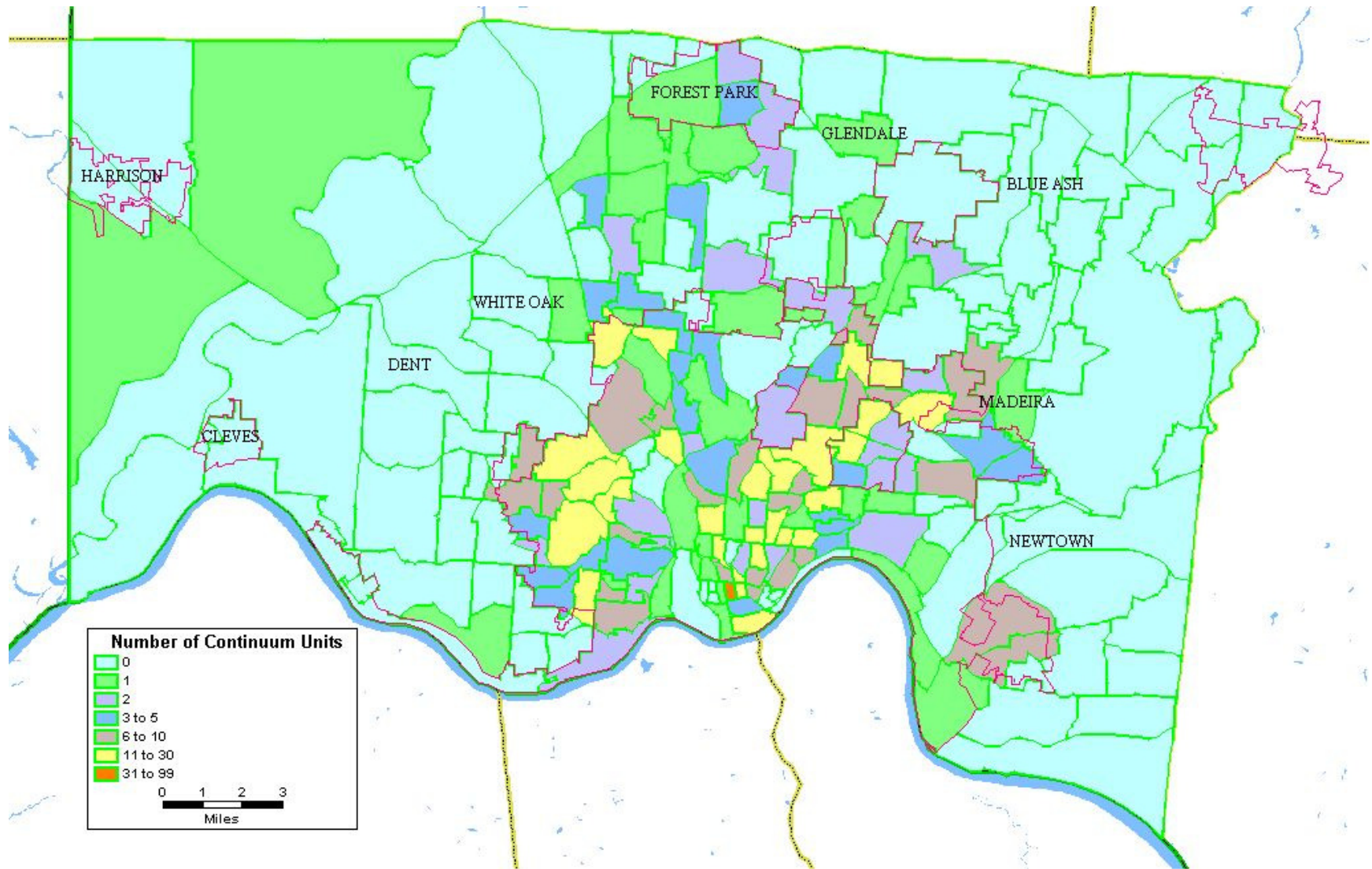
For more information go to: <http://www.endlongtermhomelessness.org/>

| Appendix 10 Continuum of Care – 2008 Housing Inventory of EMERGENCY SHELTERS |                                | Target Population |    | HUD Funding             | All Year-Round Beds/Units |              |                 |                       |
|--|--------------------------------|-------------------|----|-------------------------|---------------------------|--------------|-----------------|-----------------------|
| Provider   | Facility Name                  | A                 | B  | McKinney-Vento funding? | Family Beds               | Family Units | Individual Beds | Total Year-Round Beds |
| Bethany House  | Bethany House                  | SFHC              |    | Yes                     | 26                        | 0            | 4               | 30                    |
| City Gospel Mission  | City Gospel Mission            | SM                |    | No                      | 0                         | 0            | 36              | 36                    |
| Ctr. For Respite Care  | Respite Center                 | SMF               |    | Yes                     | 0                         | 0            | 15              | 15                    |
| Drop Inn Center  | Men's Dorm                     | SM                |    | Yes                     | 0                         | 0            | 204             | 204                   |
| Drop Inn Center  | Women's Dorm                   | SF                |    | Yes                     | 0                         | 0            | 38              | 38                    |
| HCCMHB   | Quick Access                   | SMF               |    | No                      | 0                         | 0            | 10              | 10                    |
| HCJFS  | Child Services./Sycamore Arms  | HC                |    | No                      | 30                        | 0            | 0               | 30                    |
| Interfaith Hospitality Network   | Interfaith Hospitality Network | HC                |    | Yes                     | 32                        | 0            | 0               | 32                    |
| Lighthouse Youth Services  | Youth Crisis Center            | YMF               |    | Yes                     | 0                         | 0            | 20              | 20                    |
| Mercy Franciscan at St. John's   | St. John Temp                  | HC                |    | Yes                     | 32                        | 10           | 0               | 32                    |
| Mercy Franciscan at St. John's   | Anna Louise Inn                | HC                |    | Yes                     | 45                        | 0            | 0               | 45                    |
| Mt. Airy Shelter   | Mt. Airy Shelter               | SM                |    | Yes                     | 0                         | 0            | 65              | 65                    |
| Salvation Army   | Salvation Army                 | HC                |    | Yes                     | 20                        | 0            | 4               | 24                    |
| St. Francis/St. Joseph Catholic Worker Hs.                                   | Catholic Worker                | SM                |    | No                      | 0                         | 0            | 16              | 16                    |
| YWCA   | Battered Women's Shelter       | SFHC              | DV | Yes                     | 45                        | 0            | 20              | 65                    |
| Cincinnati Union Bethel  | Off the Streets                | SF                |    | No                      | 0                         | 0            | 10              | 10                    |

KEY: SM= single male SF= single female SMF= single males and females  
 SFHC= single females and households HC = households with children  
 YMF = youth males and females DV = domestic violence

Shelters/beds for Individuals - included in this report  
 Shelters/beds for Individuals - not changed in this report

Appendix 11 - HUD map of CoC Funded Permanent Supportive Housing Units by Census Tract



**Appendix 12 – Continuum of Care Survey – 2007 Agency Income by Source Type**

| <b>Income sources</b>                                     | <b>Street outreach</b> | <b>Emergency shelter</b> | <b>Transitional Housing</b> | <b>Permanent Supportive Housing</b> | <b>Services Only</b> | <b>Total</b> |
|---|------------------------|--------------------------|-----------------------------|-------------------------------------|----------------------|--------------|
| City General Fund   | 12,000                 | 330,752                  | 53,530                      | 46,000                              |                      | 442,282      |
| County General Fund                                       |                        | -                        |                             |                                     |                      | -            |
| Fees for Service  |                        | 530,145                  | 68,259                      | 58,190                              | 6,211                | 662,805      |
| Fundraising   |                        | 185,329                  | 14,788                      | 204,244                             | 10,000               | 414,361      |
| Greater Cincinnati Foundation                             |                        | 16,000                   |                             |                                     |                      | 16,000       |
| Hamilton County Dept. of Job and Family Services          |                        | 315,408                  |                             |                                     | 121,000              | 436,408      |
| Hamilton County Mental Health & Recovery Services Board   | 111,136                | 340,933                  | 242,497                     | 2,935,754                           |                      | 3,630,320    |
| Health Foundation of Greater Cincinnati                   | 14,000                 | 125,658                  |                             | 116,192                             |                      | 255,850      |
| HHS: Health Care for the Homeless (passed through CHN)    |                        | -                        | 67,175                      |                                     | 141,400              | 208,575      |
| HHS: Homeless Children & Youth                            | 100,000                | 200,000                  | 200,000                     |                                     |                      | 500,000      |
| HHS: PATH (passed through ODMH)                           | 213,089                | -                        |                             |                                     |                      | 213,089      |
| HHS: SAMSA  |                        | -                        |                             |                                     |                      | -            |
| HUD: CDBG (passed through the City or the County)         |                        | -                        |                             |                                     | 79,548               | 79,548       |
| HUD: HOPWA (passed through City)                          |                        | -                        | 96,683                      | 105,317                             |                      | 202,000      |
| HUD: Continuum of Care (SHP or SPC)                       | 134,058                | 371,535                  | 1,704,638                   | 4,690,294                           | 1,021,237            | 7,921,762    |
| HUD: Emergency Shelter Grant (through the City or County) |                        | 694,723                  | 63,745                      |                                     |                      | 758,468      |

|  |                |                  |                  |                   |                  |                   |
|--|----------------|------------------|------------------|-------------------|------------------|-------------------|
| Investment Income  |                | 62,105           | 21,728           | 58,635            |                  | 142,468           |
| Ohio Department of Alcohol & Drug Addiction Services         |                | -                | 95,023           | 264,191           |                  | 359,214           |
| Ohio Department of Development (Trust Funds, Homeless Grant, |                | 699,048          | 107,700          | 335,782           | 169,400          | 1,311,930         |
| Ohio Department of Health                                    |                | -                |                  |                   |                  | -                 |
| Ohio Department of Mental Health                             |                | -                |                  |                   |                  | -                 |
| Other City Grant(s)  |                | -                |                  |                   |                  | -                 |
| Other County Grant(s)  |                | 506,869          | 5,000            |                   |                  | 511,869           |
| Other Federal Grant(s)/Funds                                 |                | 340,980          | 2,773            | 26,827            | 775,350          | 1,145,930         |
| Other Foundation(s) and Trusts                               |                | 374,745          | 88,561           | 190,000           |                  | 653,306           |
| Other Local Grants/Funds                                     |                | 426,538          | 5,726            | 160,239           |                  | 592,503           |
| Other Ohio Grant(s)  |                | 46,378           |                  |                   |                  | 46,378            |
| Private Donations  | 51,447         | 949,797          | 130,875          | 452,579           | 94,594           | 1,679,292         |
| Program Service Fees   |                | 62,871           | 101,587          | 209,787           |                  | 374,245           |
| SC Ministries  |                | 66,000           |                  |                   |                  | 66,000            |
| United Way   |                | 385,933          | 52,898           | 152,142           | 27,000           | 617,973           |
| Veterans Administration (Per Diem, HUD VASH, etc.)           |                | 62,125           | 557,840          |                   | 298,201          | 918,166           |
|  | <b>635,730</b> | <b>7,093,873</b> | <b>3,681,025</b> | <b>10,006,174</b> | <b>2,743,940</b> | <b>24,160,742</b> |

The income survey was generated by the Continuum of Care for the Homeless agencies listed below. None of the data transmitted by the agencies was audited. Data was summarized as submitted with minor obvious corrections. It should be noted that in many cases the person completing the survey was a program director and/or development director and not the financial officer of the agency.

| RESPONDING AGENCIES                            |
|--|
| Bethany House Services                         |
| Caracole                                       |
| Center for Independent Living Options          |
| City Gospel Mission, Inc.                      |
| Dental - McMicken Dental Clinic                |
| Drop Inn Center (Shelterhouse Volunteer Group) |
| Excel Development Corporation                  |
| FreeStore/FoodBank                             |
| Greater Cincinnati Behavioral Health           |
| Grace Place                                    |
| Interfaith Hospitality Network                 |
| Joseph House                                   |
| Justice Watch                                  |
| Lighthouse Youth Services                      |
| Mental Health & Recovery Services Board        |
| Mercy Franciscan at St. John                   |
| Mount Airy Center                              |
| Over-the-Rhine Community Housing               |
| Ohio Valley Goodwill Industries                |
| Respite Center                                 |
| Salvation Army                                 |
| Talbert House                                  |
| Tender Mercies                                 |
| Tom Geiger Guest House                         |
| YWCA of Greater Cincinnati                     |
| MISSING DATA                                   |
| St Francis/St. Joseph Catholic Worker          |

## Appendix 13 - Definitions and Commonly Used Terms

**Homeless:** (McKinney/Vento Definition): “Homeless persons are generally defined as those living in homeless facilities or in places not meant for human habitation. This definition has governed HUD’s implementation of the federal government’s largest emergency shelter, transitional housing, and permanent supportive housing programs since the McKinney Act became law in 1987. It reflects a longstanding policy to target scarce resources to the neediest or in this case to those who are ‘literally homeless’”<sup>29</sup>

**Chronically homeless** – “A chronically homeless person is defined as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four episodes of homelessness in the past three years. To be considered chronically homeless, a person must have been on the streets or in emergency shelters (i.e. not in transitional or permanent housing) during these episodes.”<sup>30</sup>

**Continuum of Care for the Homeless (CoC):** According to HUD the CoC is “an approach that helps communities plan for and provide a full range of emergency, transitional and permanent housing and services to address the various needs of homeless persons.” The CoC is both a process and a product. The process is the inclusive planning, implementation, and year-round management process utilized in collaboration by both the City and the County. The product is an annual grant application to HUD for funding for homeless housing and services for the homeless.

**Consolidated Plan:** The Consolidated Plan (often called Con Plan for short) is a five-year housing and community development plan that is required of local governments by HUD in accordance with 24CFR Part 91. This is considered a strategic planning document and is an application for all of a jurisdiction’s entitlement funding (Community Development Block Grant (CDBG), HOME, Emergency Shelter Grant (ESG), Housing for Persons with AIDS (HOPWA)); it is also a tool for reporting goals and action plans that later are accounted for annually. There is an entire section within the Consolidated Plan dedicated to Special Needs housing that includes housing for the homeless. Both Cincinnati and Hamilton County have a Consolidated Plan or “Con Plan” for short. The Cincinnati and Hamilton County Consolidated Plans’ sections on homelessness (both narrative and goals) have been developed through the CoC special Consolidated Planning process; they are identical and function as our local plan to address chronic homelessness. All tables and charts of the Consolidated Plan are updated annually with the Continuum of Care application exhibits.

### **Types of Housing**

**Emergency Shelter** – “Emergency Shelter is defined as a temporary place for homeless persons to reside. A stay is normally less than 90 days and averages 30 to 45 days. Emergency shelter provides a safe, decent alternative to the streets. Emergency Shelters may be designed on a drop-in basis, where no intake is required and the goal is simply to provide an alternative to the streets for homeless persons, or it may be designed with intake and assessment requirements to assure the appropriate target population is

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<sup>29</sup> U.S. Department of Housing and Urban Development, Office of Community Planning and Development. *Third Annual Homeless Assessment Report to Congress*, July 2008

<sup>30</sup> Ibid.

in the right facility. All Emergency Shelters in Cincinnati must meet the *Minimum Shelter Standards* and are annually inspected for compliance.”<sup>31</sup>

**Transitional Housing (TH)** – “Transitional housing is defined as housing for homeless persons (individuals or families), that is necessary to facilitate the movement of homeless persons from the streets or emergency shelters to permanent housing. Appropriate on-site supportive services necessary to facilitate that movement must be included to be considered transitional housing. Persons in residence must, at a minimum, receive services designed to support future self-sufficiency and housing search/acquisition. In addition, some transitional housing facilities are specific-population based (e.g. substance abusers, veterans, families), and in such cases should also provide for the special needs of their resident populations (e.g. substance abuse services, veterans support groups, family education). Transitional housing is time-limited for up to 24 months. Transitional housing may be provided in one structure or in multiple scattered sites. Cincinnati and Hamilton County do not consider facilities that provide general detox or half-way houses for substance abuse, juvenile detention facilities, or half-way houses for parolees as homeless transitional housing facilities. These facilities do not appear in the CoC inventory nor are their residents counted in regular homeless counts. To receive ESG assistance, any Transitional Housing facility must also meet the *Minimum Shelter Standards* and are annually inspected for compliance.”<sup>32</sup>

**Permanent Supported Housing (PSH)** – “For the purposes of the CoC and Consolidated Planning, Permanent Supported Housing is defined as service-enriched housing where the population of the dwellings must be certified as homeless prior to residing in the units, and where such housing is required by the homeless individual to maintain permanent residency. All Permanent Supported Housing has some level of service designed to support the homeless individual/family’s ability to live independently and gain the appropriate self-sufficiency supports necessary to maintain independent living. Permanent Supported Housing is not time limited. Permanent Supported Housing may be in one building or in multiple scattered sites. It may also be limited to a portion of the complex or development project. For persons using SHP funding for permanent supported housing, access is also limited to persons with disabilities as defined by HUD and articulated by the provider within the SHP grant application. Thus some Permanent Supported Housing is limited to persons with specific disabilities as in the case of Shelter Plus Care and other SHP programs.”<sup>33</sup>

#### **HUD: Homeless Funds**

**Continuum of Care for the Homeless - Supportive Housing Program (SHP):** The Supportive Housing Program provides funding for development (acquisition and/or renovation), operation and services for transitional housing, permanent housing for persons with disabilities, service only programs, and the Homeless Management Information System. Funding is applied for through the CoC and is contracted by HUD directly to the applicant agency. It is expected funding will come through the Cincinnati/Hamilton County Continuum of Care for the Homeless, Inc. in future years, pending Congressional legislation.

**Continuum of Care for the Homeless - Shelter Plus Care (SPC or S+C):** The Shelter Plus Care Program is a rental subsidy program to provide housing for homeless persons with disabilities. Rental subsidies operate under similar rules to Section 8 (i.e. 30% rent limits, housing quality indicators, etc.) but must be matched by an equal (and auditable) level of services for every dollar of housing provided. Funds

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<sup>31</sup> Sourced in the following documents: *City of Cincinnati Consolidated Plan 2005-2009, Hamilton County Consolidated Plan 2005-2009, Cincinnati/Hamilton County Continuum of Care for the Homeless Application.*

<sup>32</sup> Ibid.

<sup>33</sup> Ibid.

may be used for site-based operating support or scattered-site housing rental. A unit of local government or Public Housing Authority must be the applicant for SPC and funds pass through the applicant to project sponsors (i.e. agencies that provide the housing and services). In the CoC's case, the unit of local government is the City of Cincinnati.

***Continuum of Care for the Homeless - Single Room Occupancy for the Homeless (SRO):*** The SRO program provides for the acquisition, renovation and operating support of single room occupancy units for the homeless. The program must be administered through the Public Housing Authority (PHA) which in the CoC's case is Cincinnati Metropolitan Housing Authority (CMHA).

***Emergency Shelter Grant (ESG):*** ESG funds are formula grants provided to both government jurisdictions (City of Cincinnati and Hamilton County). The ESG program provides funding for the renovation and operational costs of shelter facilities and for the administration of the grant. ESG may also provide short-term homeless prevention assistance to persons at imminent risk of losing their housing.

### **Continuum of Care Grant Language**

***Exhibit 1:*** The first section of the annual Continuum of Care grant application to HUD. Exhibit 1 is the portion of the grant application that is scored by HUD on a nationally competitive basis. The narrative documents the annual CoC grant process, year-round process, accomplishments for the prior year, and goals for the upcoming year. Special sections of Exhibit 1 include: the annual Housing Inventory Chart, which includes all emergency shelter, transitional housing and permanent supportive housing beds/units; documentation of unmet need; and the annual Point In Time Homeless Count.

***Homeless Management Information System (HMIS):*** A Homeless Management Information System is a congressionally-mandated, community-wide database system which collects shelter and service use data on the homeless. The CoC's HMIS uses the VESTA<sup>®</sup> system as the local software.

***Notice of Fund Availability (NOFA):*** A Notice of Funding Availability is released in the *Federal Register* announcing all grant submission deadlines and requirements. The SuperNOFA is the *Federal Register* notice created by HUD to release multiple housing funding notices at the same time. The CoC grant funds are released through the SuperNOFA annually.

***Special Needs:*** Within the HIS system Special Needs are defined as "issues affecting the clients ability to find and maintain housing." Special needs does not indicate a formal diagnosis has been given to an individual but is an insight into the needs of the client to be used in determining which supportive services are most appropriate. Special Needs in VESTA include: alcohol abuse; drug abuse; mental illness; physical/sensory disability; developmental/cognitive disability; HIV/AIDS; domestic violence; non-English speaking; illiteracy, migrant worker and pregnancy (for women only). Once entered into the data base for the individual, special needs information is never shared between agencies.

***VESTA<sup>®</sup>:*** VESTA (Virtual Electronic Service Tracking Assistant) is the HMIS software utilized by the CoC. It is a locally developed product owned by The Partnership Center, Ltd.. It serves the CoC as a product in compliance with Federal Data Standards for an HMIS, but also as a community-based software product designed to facilitate partnership and innovation.