

Holes in the Safety Net: Mainstream Systems and Homelessness

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TO THE READER:

Previous research has made it clear that government-funded programs for low-income persons (“mainstream systems”) can play a key role in the effort to prevent and end homelessness nationwide. This report, developed by the Charles and Helen Schwab Foundation, analyzes how homeless persons currently use mainstream systems and how mainstream systems now serve — and don’t serve — their homeless clients.

The interviews and research reveal that, in fact, homeless persons fail to access many services to which they are entitled, and that mainstream systems are not well-organized to meet the needs of homeless persons. This report documents a multitude of reasons for the failure of homeless persons and mainstream service providers to connect. Some of these reasons have to do with the condition of homelessness itself, which may make it difficult, for instance, to store medications provided by a health services program, to travel to widely dispersed treatment or service agencies and organizations, or even to determine what relief may be available. Other reasons for the failure to connect have to do with the mainstream systems, such as fragmentation of services, different standards for access to various programs and, perhaps most importantly, failure of the systems to view stability of housing as a measure of their own success.

Our goal in issuing this report is to provide additional data and insights that can guide our own foundation and the philanthropic community in identifying strategies and initiatives that successfully address the problems in this area and target our efforts and funding accordingly. We believe the report helps to clarify ways in which philanthropic support can help the homeless population and mainstream systems connect. It presents a vision in which philanthropy can leverage its contributions by using them to improve the impact of mainstream systems on the homeless population. We hope it will assist you, as it will us, in developing effective programs in our collaborative efforts to end homelessness.



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EXECUTIVE SUMMARY

The Charles and Helen Schwab Foundation’s previous research, and that of other groups such as the National Alliance to End Homelessness, show that any successful effort to end homelessness must include a combination of services, income supports and housing. The same research tells us that the most important but under-utilized source of income, housing and services to people who are homeless or at risk for homelessness is government-funded programs designed to meet the needs of low-income people (“mainstream systems”).

Mainstream systems can help both to prevent people’s homelessness and address their needs after they become homeless. It is critical to obtain data that profiles the current interaction between mainstream systems and homeless persons, because such information is a vital component in developing strategies and informing planning for the future. The Schwab Foundation has commissioned this report to:

- ★ explore what prevents mainstream programs from serving the homeless population
- ★ summarize strategies being tested nationwide to maximize mainstream services to homeless populations, including ways that mainstream services can prevent homelessness
- ★ identify the ways philanthropic funding could assist mainstream systems in becoming effective agents in nationwide efforts to end homelessness

Mainstream Systems

Mainstream systems are publicly-funded programs that provide services, housing and income supports to poor persons whether they are homeless or not. They include programs providing welfare, health care, mental health care, substance abuse treatment and veterans' assistance. People who experience homelessness are almost always clients of these systems, yet mainstream programs are not realizing their potential to be a major player in ending homelessness. As the National Alliance to End Homelessness points out in its Ten Year Plan, mainstream systems have deferred to homeless assistance programs rather than joining forces with them, thereby evading the cost and responsibility of helping their most disadvantaged clients. This must change because the resources dispersed by mainstream programs are an indispensable component of success. Only when the homeless and those at risk for homelessness fully utilize the resources of mainstream systems and available housing supports, will stable housing situations be within their grasp. This report identifies what needs to change to achieve full utilization of mainstream services and income supports. Change will occur by bringing mainstream systems into the planning process for ending homelessness.

Barriers to Service from Mainstream Programs

The report details how the condition of homelessness itself makes it difficult to access benefits of mainstream programs. The many possible barriers that have been identified include a lack of transportation to service sites, difficulty in obtaining information by phone or by mail and the time required to find shelter and food on a daily basis. In addition, the report documents barriers that exist within the agencies and programs. These range from the fragmentation of services and a lack of accountability in serving homeless people to the absence of incentives and resources which are required to render appropriate services.

Strategies

Already, programs at state and national levels are attempting to dismantle barriers that prevent homeless persons from availing themselves of mainstream services. This report describes a number of these efforts, which encompass such varied strategies as eviction prevention/housing retention programs and the development of respite/recuperative care facilities for persons too ill for shelters. The report also presents data regarding the effectiveness and outcomes of those initiatives which have been evaluated

A Role for Philanthropy

Because government provides the funding and enacts the regulations that govern mainstream systems, it must lead the effort to make these systems responsive to homeless populations and accountable for homelessness. However, there are many areas in which foundations can play a pivotal role, for example, in educating both clients who need to learn about eligibility for various services and mainstream agencies that must learn how to coordinate their services.

Funds are needed to staff collaborative programs among agencies, to provide incentives for collaborating, and to fill gaps in coverage while people wait to have eligibility for various programs confirmed. Foundations also could play a role in funding and disseminating the growing body of research which demonstrates the savings that could be realized by making delivery of mainstream systems to homeless groups more effective.

Perhaps the most fundamental impact foundations could have would be to partner with mainstream service providers to plan for their new role. Done well, such planning could transform mainstream service providers. Historically, they have not taken responsibility for homelessness. In the future, they could be on the front line of preventing it.

I. PURPOSE OF THIS REPORT

The Charles and Helen Schwab Foundation is committed to making a significant contribution to national and local efforts to prevent and end homelessness and engaging other philanthropic institutions in this endeavor. Our first research report on the subject, *Homelessness: Key Findings and Possible Grantmaking Strategies*, investigated various investment strategies intended to further the goal of ending homelessness. That report identified the failure of government-funded programs for persons with low incomes (“mainstream services”) to adequately serve the subgroup of their homeless clientele and to prevent homelessness from occurring. The report recommended that the Schwab Foundation conduct further research to identify exactly how private philanthropy could improve homeless persons’ access to mainstream services, and how private philanthropy could encourage providers of mainstream services to coordinate their efforts and accept accountability for their clients’ need for housing. This report presents that follow-up research.

THE OBJECTIVES OF THIS REPORT ARE TO:

- ★ Describe the commonly identified barriers to mainstream programs and agencies that provide appropriate services to homeless people and those at risk of homelessness

- ★ Provide examples of efforts that have been undertaken, or are being initiated at this time, by mainstream agencies or communities to address these barriers

- ★ Propose action areas that the Schwab Foundation, in collaboration with other philanthropic organizations, could develop into an initiative on mainstream services

This report is intended as a first phase in the general exploration of the potential for philanthropy to impact mainstream services systems and their relationship to homelessness. A second phase of more specific research into one or more of the highlighted areas is likely to be necessary or beneficial prior to launching a funding initiative in this area.

II. RESEARCH METHODOLOGY

The research methodology used for this report was a combination of interviews with experts in the field of homelessness and/or mainstream service systems and a review of the related literature. In-person or telephone interviews were conducted with 25 representatives of public agencies involved in addressing homelessness at federal, state and local government levels and with researchers and advocates from national and regional organizations. The latter included Policy Research Associates, Urban Institute, the Corporation for Supportive Housing, HomeBase and the National Center on Family Homelessness. Interviews were focused around questions regarding efforts to address mainstream service barriers in which the interviewees were involved or of which they were aware, strategies they believed to be the most promising for this work, and what role they saw for philanthropy in facilitating successful strategies. Interviews were supplemented by two national conferences sponsored by the Corporation for Supportive Housing and by the National Alliance to End Homelessness.

The methodology also included a broad literature review of published documents, unpublished reports and brochures, and internet-based documents and Web sites. Publications reviewed included academic journals and government-sponsored studies on barriers to services and evaluations of service improvement or integration efforts. In addition, the literature review included reports and pamphlets published by national and regional advocacy organizations, community-wide plans and program reports by local and state governments, recent newspaper articles, conference summaries and findings, and information from specific funding sources, such as requests for proposals and evaluation reports. In total, more than 70 articles, documents and other written or electronic materials were reviewed for this report. The primary research for this report took place between March and October of 2002.

III. INTRODUCTION TO MAINSTREAM SERVICES

Mainstream services are government-funded services that are intended to meet the critical needs of low-income households. They do not specifically target homeless persons. These services include health and mental care, housing, employment training and income supports, among others. Mainstream services are defined as “mainstream” in contrast to “targeted programs,” which are programs specifically intended to serve persons who are homeless or at high risk of homelessness, and for which eligibility is generally dependent upon homeless status. According to the General Accounting Office, federal assistance to homeless people includes 50 programs, only 16 of which are targeted specifically to homeless people.¹

Mainstream services can be community-based, such as health centers and outpatient substance abuse programs; entitlement or benefit programs, such as Temporary Assistance to Needy Families (TANF); or providers of institutional care, such as public psychiatric hospitals. Mainstream services may be delivered by local governments, nonprofit organizations and even private for-profit agencies, but they are substantially or entirely funded through public funds, and the rules regarding their provision are established by government regulations. Many of the largest mainstream services are “entitlements,” meaning that all persons who qualify have a right to receive the benefits of the programs. Funding sources and programs that are thought of as critical mainstream services for the homeless/at-risk population include:

- ★ Income support programs including Temporary Assistance to Needy Families (TANF), Supplemental Security Income (SSI) and supplements such as Food Stamps and Women, Infants and Children (WIC)
- ★ Medicaid and other health service programs, including Community Health Centers and Veterans Health Assistance
- ★ Mental health and substance abuse services funded through a variety of federal block grant programs
- ★ Workforce Initiative Act (WIA) designed to provide training and secure employment for low-income workers receiving benefits
- ★ Housing subsidy programs, such as Section 8 and public housing

In addition to these programs, there are significant government responsibilities and services that are designed to serve the entire community, but which often disproportionately impact low-income people. These include public schools, jails and prisons, child protective services and foster care. While these institutions are intended to serve the general public, they are included in the discussion of mainstream services because they have significant impact on homeless persons and those at risk of homelessness.

IV. BARRIERS TO HOMELESS PEOPLE AND THOSE AT RISK RECEIVING MAINSTREAM SERVICES

There is an extensive body of literature documenting a wide variety of barriers to mainstream services experienced by homeless people. The thrust of these findings is aptly summarized in a single sentence by the Urban Institute: “There is ample evidence that ... mainstream services often prefer not to serve homeless clients, often are not readily accessible to homeless people, and usually do not have enough resources to serve their non-homeless target populations.”²

Barriers to mainstream services are by no means unique to homeless people – they exist for low-income people generally. However, homeless people and those at highest risk of homelessness, almost by definition, are among the lowest income and generally have the greatest personal barriers. For example, while lack of insurance is the biggest barrier to health care for all low-income people, lack of insurance is 50% higher for homeless people than for low-income people who are housed.³ The barriers that low-income people experience in trying to access or receive services are acute among the homeless. Some of these barriers are a direct result of the conditions of homelessness, while others are structural barriers within the programs themselves.

A. Barriers Resulting From the Conditions of Homelessness

The conditions of homelessness that increase or create additional barriers to service access and utilization include:

- ★ An even greater lack of financial resources than among low-income people
- ★ A higher propensity to suffer from conditions such as poor health, mental illness and substance use disorders
- ★ Limited or no social support networks
- ★ The lack of stable housing from which to receive services

Studies, including a lengthy report by the General Accounting Office and articles by academic researchers, have found that many obstacles to services are created or exacerbated by these conditions among homeless people, including:

- ★ **Lack of information about programs** — Generally, homeless people have even less information about the services for which they are eligible than low-income people, and the conditions of their lives may interfere with getting information.
- ★ **Difficulty completing applications/proving eligibility** — Application processes for many mainstream programs, especially entitlement programs such as SSI and Medicaid, can be lengthy, complicated and involve extensive paperwork and documentation. The SSI process takes an average of three months before a decision is made and often requires

an appeal process lasting up to a year. The length of time required for these applications complicates follow through for homeless persons, who move around frequently. Many homeless people have no ability to store the documents needed to prove citizenship, health conditions, income or even identity.

★ **Lack of transportation:** Most homeless people in urban areas rely on public transportation to reach service destinations. This transportation is relatively expensive, may not be convenient to a given destination, or simply may not exist at all, particularly in suburban and rural areas.

★ **Competing priorities:** Homeless people spend significant time and energy meeting their basic subsistence needs for food, clothing and shelter. Even if they have a health condition needing attention, or would like assistance finding employment, often the pressing demands of their daily lives make seeking these services a lesser priority. This reality also leads to higher rates of acute health care needs among homeless people than among the housed poor. Homeless people may also be unwilling to risk the loss of their possessions or of a place to sleep while pursuing services or may have no one to care for their children.

★ **Inability to benefit from service for lack of housing:** The physical lack of housing makes some programs more difficult for homeless people to participate in and benefit from. For example, homeless persons without access to kitchens have a difficult time storing or preparing food, while food stamps generally cannot be used to purchase hot meals. Medication normally prescribed by health care providers may be unable to be properly stored or taken on a regular schedule with meals.

B. System Barriers

In addition to the barriers created by the conditions of homelessness, the studies reviewed cite many significant barriers within the structures of the service programs themselves. The primary barriers cited are:

★ **Fragmentation:** Perhaps the greatest barrier to homeless persons receiving effective services is the fragmentation of mainstream services. Separate funding streams, regulations and organizational or professional cultures create isolated services that often do not coordinate or work together. Fragmentation is a barrier both to access and to the successful delivery of services:

□ **Fragmented access:** Eligibility requirements, applications, documentation and time frames are different for virtually every government program. This causes confusion and leads to delays, frustration and often the inability of a homeless person to receive a needed service.

□ **Fragmented delivery:** Homeless people who have multiple and complex needs are often forced to receive services for each “issue” in isolation. This leads to the homeless person attempting to manage relationships with multiple professionals making different demands. It can also mean that clients are bounced back and forth between systems unwilling to take them until some other issue has been “dealt with.” For example, a recent book on addiction and homelessness describes substance

abuse treatment programs that do not know how to work with persons with a mental illness, and mental health providers who will not accept a client for treatment until she has addressed her drug addiction.⁴

★**Lack of expertise:** Mainstream programs often do not have providers with experience and expertise in serving people who are homeless. As such, staff may exhibit a lack of sensitivity to the needs of homeless clients or not understand that the methods they are using will not succeed with a client who has no home.

★**Lack of accountability:** Many of the major mainstream programs, including SSI, Food Stamps and Medicaid, are not required to report whether they are serving homeless people or even to identify housing status at intake. Other programs, such as the Community Health Centers program, are only required to estimate how many homeless people they serve. Staff of these programs may assume that if a client provides them with an address at intake that he/she is not homeless. If a client is identified as homeless, most of the mainstream programs have no responsibility to assist her, or even to ensure that she is referred to appropriate services.

★**Lack of incentives/resources:** Mainstream services are often under-funded for the clients they already serve. It is not surprising that service providers may view outreach or special services for the homeless as a diversion of their scarce resources, particularly because homeless people may have more problems and be more expensive to serve. Some performance measures — such as placement and retention expectations in work force training programs, for example — actually deter programs from addressing harder-to-serve populations.

All these barriers — including those deriving from the conditions of homelessness — are also systemic. The systems do not adequately address the conditions common to homeless people, effectively precluding access or effective use of the service.

C. Barriers to Homeless Prevention

Besides barriers to people who have been homeless receiving mainstream services, these services are often unable to prevent homelessness among their clients who are at risk of becoming homeless. Failure to appropriately discharge persons leaving institutional care is a contributing cause of homelessness. Public systems may fail to prevent homelessness because they are not held responsible for doing so, and because they often do not have the resources and expertise. In some cases they have strong financial incentives to discharge people as quickly as possible.

Most of the research on barriers to homeless prevention in mainstream services focuses on government systems that provide temporary “housing” as a part of their responsibility — particularly public hospitals, jails and prisons, and the foster care system. These systems contribute to the creation of homelessness when their “housing services” end without an appropriate transition to a community-based residence. The Department of Health and Human Services (HHS) found that over 30 percent of emancipated foster youth experience homelessness within two years after being discharged from the foster care system.

Not only are people who were “housed” by the institution or system no longer housed when they exit, the support networks and the benefits to which they were entitled before they entered have

often been lost as well. For example, inmates with mental illness (16% of all inmates nationally) who receive SSI and who are incarcerated for more than a year must reapply for SSI benefits upon release. They may also lose Medicaid benefits.⁶

There has been far less written about the barriers to homeless prevention within community-based mainstream services, such as health care centers and employment programs, but generally these are similar to the system barriers mentioned above. Mainstream agencies often do not know if the clients they serve are at risk of homelessness, since they are not required to ask questions that would determine this. Even agencies that identify homelessness among their clients generally do not ask questions that would identify someone as being at high risk of losing their housing.⁷

Those programs that do record housing status at the time of entry, such as block-grant funded substance abuse treatment programs, generally do not follow up to ensure that housing has been obtained or retained. There is no widely accepted standard for determining whether a household is at risk for losing housing. Even if an agency does determine that someone is at risk of homelessness, they often lack the knowledge of how to help and have no additional resources with which to assist clients in maintaining their current housing or finding appropriate housing.

D. Concurrent Barriers Experienced by Homeless Subpopulations

Some of the barriers that homeless people face are similar to, or exacerbated by, barriers faced by other subgroups to which they may belong, including ethnic minorities, women and people with disabilities. In “Opening Public Agency Doors,” the Bazelon Center for Mental Health Law documented the results of an evaluation of barriers to public services for people with mental illness.⁸ Among the barriers identified in this study are:

- ★ **Attitudinal barriers:** Consumers with mental illness report that staff in public agencies often treat them differently because of their mental illness, are rude or impatient, and don’t take the time to listen carefully or offer clear explanations. As a result, many consumers choose not to seek services.
- ★ **Lack of information:** Consumers, their families and advocates, as well as program staff serving them, report lacking knowledge about the services that are available and about their rights to services under the Americans with Disabilities Act (ADA).
- ★ **Scheduling and waiting:** Many agencies do not allow appointments to be scheduled in advance and require waits of as long as several hours for applications or services. Prolonged waiting can create frustration for some people with mental illness and can cause problems with arrangements for child care and transit. Also, consumers said that the atmosphere in waiting areas is often uncomfortable and in need of ventilation, water and something for people to do.
- ★ **Barriers to applying:** Consumers report being given difficult forms to fill out with no human assistance. They also report being interviewed or asked to answer questions about sensitive topics in places that provide no privacy.

A study of barriers to women seeking addiction services had similar findings, reporting “evidence to indicate that staff and services characteristics may affect recruitment and retention rates, client satisfaction and treatment outcome.”⁹ This study hypothesized that the stigma of seeking services for substance addiction was greater for women, and that women were more likely to experience shame and embarrassment in the entry process — a possible barrier for some homeless women seeking services as well.

The Robert Wood Johnson Foundation (RWJ) funded a study of the socio-cultural barriers to health services for racial and ethnic minorities. This study found that language and nonverbal communication, including different interpretations of nonverbal cues, is often a barrier. Other obstacles reported include different cultural health practices and beliefs, confusion about how and when to seek care, and fear of being unknowingly submitted to experimental procedures by medical personnel. All of these factors, in addition to those related specifically to homelessness, may be at work for homeless persons who are also members of these population groups.

Despite all the barriers to mainstream services experienced by homeless people, it would be a gross overstatement to assume that mainstream services do not serve homeless people, or that they do not assist in preventing homelessness for many households. It is impossible to know how many more families would be homeless without TANF or food stamps, or how many more single individuals would be homeless without SSI. A study of soup kitchens in Chicago showed that “the most consistent difference between domiciled and homeless persons with mental illness was access to income supports (particularly SSI).”¹⁰ Families at high risk of homelessness who receive TANF may also receive homeless prevention assistance, without which they might become homeless in most states. Case managers in community health centers report regularly assisting people with housing referrals if they are identified as having a housing need.

There is evidence that many homeless people do receive the mainstream services to which they are entitled, but that these are simply inadequate to keep some number of people from becoming homeless, or ending their homelessness. A 1995 report by the HHS Office of the Inspector General found that most homeless families (69%) were already receiving welfare (AFDC) when they become homeless. And a significant number who were not receiving welfare had received it in the past but had lost it due to sanctions, change in eligibility or other administrative reasons.¹¹ Nevertheless, the evidence that mainstream services do not fully reach homeless people, and that they do not do enough to prevent homelessness from occurring, is dramatic.

V. CURRENT CLIMATE: THE CONVERSATION HAS BEGUN

The issue of the mainstream services' responsibility for addressing homelessness is receiving a good deal of attention currently. The failure of targeted homeless programs to effectively end, or even stem, the tide of homelessness has driven some people to question the wisdom of continuing to promote targeted services, especially since the funding available for these programs is minuscule relative to the mainstream systems. At the same time, studies by Dennis Culhane and other experts in homelessness research have documented that a year of homelessness, particularly among those deemed as "chronically" homeless, is at least as expensive as providing permanent housing and services. This information and the lack of progress on homelessness overall seem to have inspired a focus on shifting responsibility for addressing homelessness away from specialized homeless service programs and back onto the mainstream systems.

A. Federal and National Activity

There is significant activity occurring at the federal level that points to a new approach to this issue. Some of these activities include:

★ **Reactivation of the Interagency Council:** The federal Interagency Council on the Homeless, which coordinates the activities of 15 federal agencies in providing services to homeless people, resumed meeting in July 2002 for the first time in six years. On the agenda for the Council is improved coordination of mainstream services.

★ **Policy Academies:** During the past year, the Health and Human Services (HHS) the Department of Housing and Urban Development (HUD) and the Veterans Administration (VA) jointly convened two Policy Academies for states, one on family homelessness and another on chronic homelessness. The purpose of the academies was "to support state and local executive, legislative, administrative and private sector policy-

makers and other stakeholders in developing a coordinated state-level action plan that can be realistically implemented at the state and community levels to improve access to mainstream health and human services programs by persons who are homeless.”¹² Fifteen states sent teams of system and program administrators to the academies to develop their plans, and these teams have ongoing access to technical assistance.

★ **Efforts within HHS to improve programs for homeless:** An HHS blueprint to address homelessness was expected to be released by the end of 2002. It’s anticipated that the draft blueprint will be vetted by national organizations, as well as stakeholders at various levels throughout the country.

★ **“No Child Left Behind”:** Congress recently passed landmark education legislation that includes a requirement for an identified homeless liaison in every school district.

★ **New resources:** In July 2002, HUD Secretary Martinez announced the availability of \$35 million from HUD, HHS and VA for a demonstration program which will promote coordinated efforts to address the issue of chronic homelessness. The request for proposal was issued in January 2003.

★ **National advocacy:** Much of the interest in improving mainstream services has come from the work of national advocacy organizations, particularly the National Alliance to End Homelessness (NAEH) and the Corporation for Supportive Housing (CSH). In addition to advocating with state and federal government, these organizations provide technical information about how mainstream services, such as Medicaid and TANF, can be made to serve homeless people more effectively, particularly through supportive housing. CSH is expected to publish a report in early 2003 on successful system-integration strategies.

In addition to these efforts that focus directly on the mainstream issue, activity at the federal level presents opportunities to improve the capacity of mainstream services to meet the needs of people who are homeless or at-risk. These include TANF reauthorization (delayed in 2002 but expected to be taken up in the coming Congress), which could improve the provisions governing how TANF funds may be used for homeless prevention and housing assistance, and the establishment of the President’s New Freedom Commission on Mental Illness, charged with conducting a comprehensive study of the U.S. mental health service delivery system and advising the president on methods of improving it.¹³

B. Efforts in the State of California

California has also begun to address this issue. During the past four years, several new programs were created at the state level that address the needs of persons at very high risk of homelessness, such as former inmates and persons with mental illness or other disabilities. These programs include the Supportive Housing Initiative Act, Integrated Services for Homeless Adults with Mental Illness (A.B. 2034) and the Mentally Ill Offenders Crime Reduction grant (MIOCR). Each of these programs is premised on the collaboration of various sectors of the mainstream services system. The current budget crisis in California has resulted in sharp reductions or no funding for many of these programs in the coming year. However, previously funded programs across the state continue to operate based on multiple-year funding.

In mid-2002, Governor Davis held a statewide summit on the issue of homelessness and directed an Interagency Task Force on Homelessness to prepare a state plan for reducing the incidence of homelessness in California. The Task Force was co-chaired by the secretaries of the Business, Transportation and Housing agency and the Health and Human Services agency. Several other agencies and departments — including Corrections, Employment Development, Social Services, Alcohol and Drugs, Mental Health, Education and Veterans Affairs — participated.

While recognizing the critical role that local governments and providers play in serving homeless people, the recommendations of the Task Force, released in August 2002, focus specifically on the functions of state agencies. Several recommendations emphasize the importance of incorporating homelessness prevention and discharge planning into California's major agencies and programs that serve high-risk households. Proposed actions include developing discharge planning protocols for state hospitals, making homeless prevention a key mission of state agencies, and developing prevention and intervention assessment protocols. Other recommendations include improving integration and coordination among the state's current homeless-serving programs, such as those mentioned above, and continuing the work of the Task Force as a standing Council on Homelessness.

VI. STRATEGIES IN ACTION AROUND THE COUNTRY

While the call for increased accountability of mainstream services is gaining widespread support, actually making meaningful change in these enormous systems is proving difficult. In the Urban Institute’s national study of communities with the highest-scoring Continuum of Care applications (required to receive federal homeless dollars), they found little progress in this area. “Despite recognizing the importance of mainstream services, relatively few of the 25 communities in this study were successful at integrating mainstream agencies and systems whose clients include, but are not limited to, homeless people.”¹⁴ They concluded that more information is needed about best practices for involving and working with mainstream agencies.¹⁵

Major barriers to improving the participation and accountability of mainstream services are the difficulties of moving funds to cover new approaches and reinvesting savings. For example, even with evidence that supportive housing saves money in decreased use of emergency care services, it is exceedingly complicated to move funds to cover the costs of additional supportive housing. The housing-based services may be funded by the state or county mental health budget or from HUD programs, but savings are likely to be realized in public hospital or jail costs. Even if savings can be documented, no simple mechanism exists to apply these savings to the cost of the services.

Making improvements is also complex because many of the key mainstream programs, such as TANF, Medicaid, substance abuse treatment and mental health services, are funded through grants to state governments. The inconsistency in how states implement the programs makes developing successful coordination strategies more intricate and problematic.

Despite the difficulties inherent in addressing mainstream services issues, many organizations and communities have undertaken efforts to address one or more aspects of the problem. These strategies include single agency or program efforts, dual- or multi-agency collaborative efforts, and community-wide systems integration approaches involving multiple departments and agencies in a city, county or state. Some strategies are aimed specifically at preventing

homelessness from occurring, while others target improving services for people who are homeless. Most of the community-wide efforts affect, or are anticipated to affect, both issues.

A. Strategies to Prevent Homelessness Among Users of Mainstream Services

Eviction Prevention/Housing Retention

Housing retention strategies seek to keep people who are at-risk from losing the housing they already have. The mainstream program that does the most in this respect is TANF. TANF funds can be used to provide grants or loans to families with children to prevent eviction or foreclosure on a one-time basis for up to four months. This use of TANF funds does not count as “assistance,” and therefore does not trigger the 60-month lifetime benefit cap. Because TANF uses are determined at the state level, there is a great deal of variance in how states utilize this capacity, but more than half of the states offer some assistance program. Current advocacy around TANF reauthorization includes efforts to extend the period for which housing assistance can be offered.

Some communities are combining short-term prevention options, such as those allowable under TANF, with links to permanent subsidies. In Massachusetts, the Public Housing Authority gives first preference for Section 8 vouchers to applicants who are subject to a court-ordered eviction due to non-payment of rent when the applicant’s rent exceeds 40 percent of their income. The vouchers cannot be used to pay past rent, but the TANF program will cover up to three months of rent arrears if the family’s income is below 130% of the poverty level.¹⁶ In Missouri, the Department of Mental Health Supported Housing Program provides funding for temporary vouchers for people with serious mental illness who are on the Section 8 waiting list. The vouchers are administered by local Public Housing Authorities, and the Department of Mental Health provides services through contracts with local mental health agencies.¹⁷

Providing funds for rent coverage while people are in treatment so that they do not lose their housing is another mainstream housing retention strategy. In Minnesota, the legislature recently approved \$50,000 for a fund to pay for rental housing for up to 90 days while an individual with serious mental illness is in inpatient treatment.¹⁸

Discharge Planning

Public systems that are required to “house” people — foster care, hospitals, jails and prisons — must also discharge them when they are no longer eligible, appropriate or required to remain in the system. Too often people leave these systems with no place to go or are sent to a shelter or homeless agency. Discharge planning efforts ensure that people discharged from institutional systems are linked to services and housing prior to their departure.

The most widely recognized discharge planning efforts have been undertaken during the past six years in Massachusetts. The Massachusetts Housing and Shelter Alliance (MHSA), a nonprofit advocacy agency, found that the shelter systems were “bailing a leaky boat” as they increasingly sheltered persons who had been recently discharged from institutional care. With support from their local community foundation, they conducted research on the paths that led people to the homeless shelters. With their findings in hand, they convened meetings with representatives of the different mainstream systems, beginning with mental health. The conversations were difficult at first, but were aided by the willingness of MHSA to advocate for the resources that the mainstream systems would need in order to make discharge planning work. After working

with the mental health departments, MHSA held similar discussions regarding substance abuse treatment, corrections and foster care.

A central element in Massachusetts' success was convincing the state government, which provides or contracts for the services, to evaluate agencies on the basis of new performance measures which make homelessness a bad performance outcome and housing a good performance outcome. Ultimately, these outcomes are tied to penalties and incentives for the systems. The discharge planning process has also led to more integrated services in the facilities. For example, prisoners can now be deemed eligible for Medicaid while still in prison and automatically enrolled on the day of their release. Many also make a community health center connection before leaving. An overview of the Massachusetts' planning process and useful materials are now available on the web from the National Health Care for the Homeless Council.

Post-Discharge Linkage/Follow-Up Services

Discharge planning alone, even if it leads to housing placement and links to services, is not always adequate to ensure that people remain housed, especially those with chronic mental illness. A study of shelter users in Philadelphia showed that connection to outpatient mental health services was effective in decreasing the risk of homelessness for persons with a mental illness who had one shelter stay prior to a psychiatric inpatient hospitalization. For repeat shelter users, the connection to outpatient services was not significant for preventing a repeated episode of homelessness.¹⁹

Supportive housing, which provides support services linked to housing, is a strategy that has been shown to be very effective in helping persons with disabilities and a history of homelessness break the cycle of repeated homeless episodes. Providing strong links to community-based services has also been shown to be effective. A study in New York City showed that repeat episodes of homelessness among men with mental illness were dramatically reduced through Critical Time Intervention (CTI) services.²⁰ CTI provided transitional support to connect people discharged from a psychiatric facility and staying in a shelter with supportive services in the community. CTI workers did not provide the services themselves but assisted persons leaving the shelter in plugging into a wide variety of community supports and services. CTI services lasted nine months and the results were reexamined at 18 months. The days homeless for CTI groups averaged 30, compared to 91 for the usual services group, and the gap increased with time, even after CTI services were withdrawn.

This type of service is similar to what is occurring under California's Mentally Ill Offender Crime Reduction (MIOCR) program, which is not specifically targeted at ending homelessness. The primary objective of MIOCR is to determine "what works" in reducing crime, jail crowding and criminal justice system costs associated with the mentally ill offender population. The target population is identified as cycling through jails, hospitals and homelessness. Because this is a demonstration program, the counties receiving funds are taking different approaches. Santa Clara County's program provides 60 days of follow-up case management after release, while San Mateo County is providing two years, and Alameda County is providing a transitional rental subsidy program. No results are available yet from this program.

Overall Prevention Planning

The strategies mentioned above, as well as others, may be developed and implemented through an agency or a community-wide prevention plan. The report of the California Interagency Task Force on Homelessness includes the recommendation that agencies interacting with populations at high risk for homelessness should be required to develop a prevention strategy, create a single point of contact for homeless issues, and identify opportunities for collaboration.

The plan specifically recommends that the Department of Mental Health produce such policies for the state hospitals and develop models of discharge planning for counties.²¹ In addition, the plan calls for the creation of a Committee on Assessment that will design tools and protocols for identifying people at risk.²² The work of this committee will be noteworthy because a major challenge in prevention strategies is developing an accurate definition of “at-risk for homelessness.”

In Michigan, the state is encouraging prevention planning at the local level by allocating \$1 million as a challenge to local communities to begin working on this issue. Applications for these funds will require:

- ★ The development of a comprehensive prevention plan
- ★ That applicants work with local community foundations to match state funds
- ★ That the process be grounded in the local Continuum of Care process²³

B. Making Mainstream Programs Work to Serve Homeless People Better

The strategies outlined above are intended to prevent homelessness from occurring. The following strategies are designed to improve access to and benefit from services for people who are already homeless. Because homelessness is not a static condition, and people can fall in and out of homelessness, these strategies may also be beneficial to those persons at risk of homelessness.

Outreach/Liaison Projects

Because mainstream systems are so large and controlled by regulations that are difficult to impact, some projects provide assistance to help applicants access services and help users benefit fully from them. This support can come from within the mainstream agency/system, or externally from another organization.

The SSI Outreach Project in Baltimore, highlighted as a best practice by NAEH, began as a demonstration program of the Social Security Administration (SSA) and continues today as a separate program. The project provides outreach to homeless people who are eligible for SSI and assists them throughout the difficult application process. In addition to helping the client produce the required documentation, prepare for the interview, and file an appeal if needed, the program provides presumptive benefits for those waiting for the eligibility determination. Since the program’s inception, only two of the more than 400 people deemed eligible by the project were ultimately denied coverage.²⁴ The SSA is now working on a plan for conducting its own outreach to homeless people.

Another type of outreach is dissemination of information about programs and eligibility requirements to potential clients. As part of the Interagency Task Force report, California is proposing the creation of a pre-screening tool for CALWORKS that could be administered

by other agencies, or online, to help determine if someone is eligible. While it will not replace in-person screening at a local welfare office, it may help applicants become more aware of, and better prepared for, the application process.

On a national level, the “No Child Left Behind” legislation requires that every state have a homeless coordinator and each school district identify a homeless liaison. School districts have selected persons in various positions to serve as liaisons, including dedicated homeless liaisons, special programs officers (such as migration officers and community liaisons), registrars, counselors, teachers, principals and superintendents. The primary focus of most liaisons appears to be facilitating entry into schools and creating access to school services, such as breakfast and lunch programs, as well as providing access to transportation. The California Department of Education recently accepted applications for new McKinney funds, up to \$75,000 per school district, to implement strategies to reach homeless children.

The application required information from the district about coordination with homeless services providers, but unfortunately there was no requirement to coordinate with the local Continuum of Care board, the Public Housing Authority or mainstream service providers.

Targeted Frequent User Initiatives

As described above, one of the primary barriers to developing mainstream approaches to address homelessness is the lack of perceived incentives for serving homeless people and the lack of consequences for not doing so. Consequently, mainstream systems may not see the benefit in initiating efforts to solve the problem, or may resist them actively if they think they will cost additional resources or detract from their mission.

One area that has potential interest for mainstream agencies is cost-saving initiatives dedicated to reducing “frequent users.” San Francisco General Hospital piloted a case management intervention program with 53 persons who had used the Emergency Department five or more times in the previous 12 months. The case management program was responsible for providing and coordinating all needed services, including crisis intervention, therapy, housing and financial benefits arrangements, and links to other community agencies. A year later, average emergency visits among the target group had dropped by 40%, and inpatient costs had dropped by two-thirds. Even more impressive was the fact that homelessness had decreased by 57%. The cost savings of each dollar invested in case management was estimated at \$1.44.²⁵

The California Endowment and the California Health Care Foundation recently launched a major statewide initiative to support communities that want to undertake frequent user programs in health care. They developed an extensive report that describes a variety of programs in use around the country to decrease high-cost care usage among frequent user populations, noting that homeless people are often a significant portion of the population. Programs highlighted in the report share many features — analysis of past usage data to select a finite target group for services, voluntary participation, intensive case management and links to community services, all of which have the intent of decreasing dependence on emergency and high-end health care services. Communities will be selected for the initiative in spring 2003.

California’s MIOCR program, mentioned earlier, is also a “frequent user” program, designed to reduce recidivism among a particular offender group. While these types of programs are not necessarily motivated by the desire to end homelessness, they are expected to affect homelessness because they provide care designed to increase stability.

Respite/Recuperative Care

One factor that impacts efforts to prevent and end homelessness is the shortage of appropriate places for people who are too ill or disabled to be in a shelter, yet who should not be in an institutional setting. Homeless people have higher rates of hospitalization than low-income people, and their length of stay is also longer (an average 4.1 days longer.)²⁶ Public hospital staff report that longer stays are primarily due to lack of housing. Physicians are also more likely to keep longer the homeless people who require follow-up care out of concern that they may lose track of their patients if they are released without an appropriate placement.²⁷

Keeping people in hospitals and skilled nursing facilities longer than necessary is both costly and undesirable for the client. Yet discharging people in recovery from illness or surgery to a shelter, or even to an available housing unit, is often inappropriate. The Boston Healthcare for the Homeless program operates 90 recuperative care beds in two facilities. These facilities were developed to provide a bridge from hospital to community, and are an integral part of discharge planning efforts in Boston. Developing these facilities was a long and complex process, but it has paid off for the program, which reports 103% occupancy. Similar results have been seen in Savannah, where a collaboration of hospitals, foundations, local government and the leading homeless provider developed a 32-bed respite care site for homeless people. In its first quarter, the facility is estimated to have saved the two hospitals \$1.8 million, more than doubling their individual \$250,000 investments.²⁸

Flexible Funds

Because myriad rules and restrictions govern how mainstream program funds can be used, it is hard for mainstream agencies to utilize these funds, even in small amounts, to meet individual client needs. One strategy to improve how mainstream services serve homeless clients is to provide them with a little “flexible funding.” In Des Moines, the state Maternal and Child Health (MCH) program provides its contractors with an “empowerment fund.” This flexible fund allows the contractors to pay for housing, utilities, clothing or anything else that the program deems necessary to help a pregnant woman, or a mother of a child under the age of two, obtain the conditions necessary for health. MCH programs are evaluated based on performance measures such as lower infant mortality and higher rates of immunization. As long as the performance measures are met, the Iowa programs have great flexibility in how the empowerment funds are used. Similarly, in Alaska, the Division of Mental Health and Developmental Disabilities has provided flexible service funds of up to \$2,000 per client to use for any expense needed to keep the client housed in the community.

Service Integration

Service integration projects bring together the services offered by two or more organizations or agencies to either facilitate access to service or to meet a broader array of consumer needs. Service integration projects bring the players together at the level at which services are delivered to the client. They are not specifically intended to change how the broader systems function, but rather to improve the delivery of services and client outcomes.

One well-documented example of a successful dual-agency integration effort to facilitate access is the SSI/VA demonstration in which local SSA field offices co-located a claims analyst for SSI at four VA medical centers. The VA designated a social worker to refer potential applicants to the SSI analyst, assist in developing the claims, and obtain needed medical records for the applicants. A disability analyst at the SSA office was assigned to coordinate the applications.

The result of this demonstration was that veterans at the sites with the SSI analyst were almost twice as likely to apply for benefits and receive awards. The number of applications increased, as did the total number of recipients.²⁹

Broader service integration models specifically targeting homeless people include the Health, Housing and Integrated Services Networks (HHISN) sponsored in the Bay Area by CSH, and California’s Integrated Services for Homeless Adults with Mental Illness (A.B. 2034). These programs bring together a number of provider agencies, both public and nonprofit, to meet multiple client needs. The HHISN model is formed around a provider team connected to one or more housing sites that provide case management and specialized services, such as substance abuse treatment, health care, mental health and employment training. These teams often include nonprofit agencies and staff from local mental health or health care departments. The A.B. 2034 program has a number of different service delivery models but also focuses on “intensive, integrated outreach and community-based services.” Both these team approaches have been shown to reduce costs to the larger mainstream service system, including reduced rates of hospitalization, incarceration and use of the homeless system.³⁰

Systems Integration

By far the biggest and most challenging area of improvement for mainstream services is systems integrations. Activities in this area address many of the system barriers described in Section IV, with particular emphasis on the issue of service fragmentation. Researchers distinguish between “service integration,” in which services are brought together at the program or client level only, and “systems integration,” in which the services systems themselves are coordinated and relationships between mainstream agencies are changed. Deborah Dennis and others who have written on the topic state that, in order to be effective, strategies for client-level change and administrative-level change must be undertaken together.

The most widely studied systems integration experiment in the field of homelessness is the Access to Community Care and Effective Services and Supports (ACCESS) Project. A joint project of the Robert Wood Johnson Foundation and the Substance Abuse and Mental Health Services Administration (SAMHSA), the ACCESS project was designed to determine if integration initiatives implemented at the program, policy and organizational levels improved outcomes for homeless persons with serious mental illness. The ACCESS Project selected 18 sites in nine states. One site in each state was selected to be the experimental site and the other to be a comparison site. Both types of sites received outreach and case management funds. The demonstration sites also received funding specifically for systems integration.

The demonstration sites undertook several different integration strategies, including:

- ★ Interagency coalitions
- ★ Interagency teams for service delivery (considered service integration)
- ★ Interagency MIS and client tracking
- ★ Cross training
- ★ Interagency agreements and memoranda of understanding
- ★ Pooled or joint funding
- ★ Flexible funding
- ★ Uniform applications, eligibility and intake assessments
- ★ Co-location of services

In the second year of the five-year program, the project sponsors found that many of the sites were struggling to implement their system integration plans. They identified four primary obstacles:

- ★ The project sites did not have a clear vision of what they were trying to achieve.
- ★ Their integration plans were not adequately developed (not specific to resources, activities; no dedicated staff person).
- ★ The interagency groups had too little responsibility or authority (they were advisory, not change agents; critical mainstream systems were underrepresented; members were not high enough in their own agency hierarchies to make decisions.).
- ★ They lacked joint/shared funding.³¹

To respond to these problems, the project provided technical assistance to all project sites, both demonstration and control, many of which had independently launched their own system integration efforts. In the end, marked improvements were documented for clients at almost all the sites, both experimental and comparison. However, the results of the study regarding systems integration impact on client outcomes were somewhat mixed and inconclusive. Although a positive association was found between increased systems integration and improved housing outcomes, no association was found for other service and quality of life outcome areas.³²

These results are similar to the results of another RWJ study of the Program on Chronic Mental Illness. This study also promoted local systems integration, through development of a Local Mental Health Authority. The study compared the function of the local systems and the results for clients early in the integration process and later in the study period. At the end of the study, measures of inter-organizational relationships showed that the systems in demonstration cities were less fragmented and more centralized, and that agencies had more contact with one another. The families of clients reported experiencing less of a burden on them. However, while participants were found to be more likely to have a case manager and to retain that case manager throughout the study's follow-up period, there were no differences in clinical, social or quality of life outcomes. The best outcomes were reported for those who received HUD Section 8 certificates, which were not available to everyone in the program.³³

Despite the mixed results of these formal studies, many communities are now undertaking ambitious systems integration efforts. Unlike the studies described above, many of the current integration efforts are being driven internally by government agencies. Examples of leaders in this area include the state of Michigan, the city of Philadelphia, and a city/state partnership in the greater Chicago area. Each community is bringing together representatives from a variety of mainstream agencies at the highest levels to approach system barriers and fragmentation.

In Michigan, the state first developed a multi-agency team eight years ago to address the needs of people with serious mental illness and substance abuse. The agencies included representatives of state programs in mental health, substance abuse and special needs housing. The group quickly resolved to pursue other common areas, including needs of homeless adults and families. The group has recently evolved to become the executive-level Interagency Collaboration Team which works to “develop strategic planning, policy and program support, cross-sector training strategies, and other initiatives associated with Michigan’s commitment to ‘closing the housing gap for persons who are homeless and most in need.’”³⁴

The primary emphasis of the Michigan work thus far has been on developing joint projects/ programs to increase supportive housing, and the Interagency Collaboration Team has produced more than 500 new units already. The team’s work is led by the state Housing Finance Agency, and has received significant technical assistance from CSH. The state is now working to encourage the creation of similar coordinating bodies at the local level to support the multiple service needs associated with supportive housing.

In Philadelphia, the lead agency in promoting service integration is the Managing Director’s Office, with strong support from the mayor. To break through the many “service silos,” the city has united all critical departments under one organizational umbrella. A managing director oversees all the “operating departments,” including Child Welfare, Health, Behavioral Health Care (mental health and alcohol and drug services), Adult Services (homeless and housing service, shelters, transitional housing and permanent supportive housing), Recreation, Jails and Prisons, and a number of commissions. All the directors and commissioners meet weekly. The emphasis has been on moving to performance-based outcomes, which are being incorporated into the contracts of organizations doing business with the city. As in the Massachusetts discharge model, this outcomes-based model seeks to make a shelter stay a negative outcome and housing a positive outcome, even for the nonprofit agencies that provide shelter services to the city. Developing and implementing these outcomes is still in process; however, Philadelphia has already begun to decrease its number of shelter beds by 5% annually.

In Chicago, systems integration work focusing on people with mental illness, is led by the state Office of Mental Health’s Bureau of Chicago Network Operations. The bureau was created in 1999 to promote systems integration among the large bureaucracies that constitute the “functional system of care” in the greater Chicago area. To facilitate both services and systems integration, the bureau formed a Mental Health Service System Planning Council with more than 50 members, including representatives from the state Mental Health and Attorney’s offices; the county Department of Corrections and county hospital system; city Human Service; Health and Police departments; and consumers, advocates and community providers.

Through planning and developing relationships on the council, they have been able to implement many cross-department and cross-jurisdictional projects, including a working partnership with 72 local shelters to ensure mental health assessments and treatment are available to all shelter residents who need them. A key tool under development is a data system for extracting queries from various databases to identify people who “slosh” between jails, shelters and community psychiatric hospitals, traveling a well-worn loop. By identifying people who overlap the systems, they will be able to work together to develop intervention plans that involve multiple players. Already, Community Mental Health Centers are able to anticipate an individual’s release from jail, arrange for him to receive a two-week supply of medication, and schedule appointments for housing. In addition to working on projects together, and participating in the Planning Council, commission heads come together bi-monthly for a “coffee klatch” to discuss common issues and develop collaborative problem-solving strategies.³⁵

There has been no formal evaluation of efforts, although the Michigan collaboration has been well-documented by CSH. Nevertheless, the communities that were interviewed are enthusiastic about their promise. In each case, there appears to be a leading force, a person or an agency (referred to by some as a “boundary spanner”), that has brought together the key players, presented the vision, and provided staffing for the process. According the Urban Institute,

“Integrating the services and delivery systems of multiple agencies is extremely labor intensive work. Having a paid staff person, not only from the homeless assistance system but also from mainstream agencies who are dedicated to system integration, can greatly increase the likelihood of success.”³⁶

Involvement of Business/Private Sector

Though not providers of mainstream services, business interests are definitely mainstream and are often missing from the table where homeless services are planned. Businesses, especially in downtown areas of major cities, are directly impacted by homelessness. Sometimes business leaders are perceived as being disinterested or opposed to efforts to serve homeless people, preferring that the problem (and the people) be swept away. But in some communities, the business sector has become an important ally in providing homeless services, and has even had an impact on the provision of mainstream services to homeless people.

In Washington D.C., the Downtown Business District responded to the large numbers of homeless people living on the streets by developing a downtown service center. As part of this effort, they requested that city staff from alcohol and drug programs be co-located to their site. Thanks to the business association’s influence with the city, the mayor ensured that staff was on-site to precertify people for detox beds. In Seattle, the Downtown Business Association, which includes many national corporations, has assessed itself a one-cent tax Business Improvement District (BID) tax for homeless services, which it uses to support services for homeless people in the downtown area.

VII. POTENTIAL PHILANTHROPIC INITIATIVES

It is clear from the research conducted for this report that the central role in making the mainstream systems responsive to, and accountable for, homelessness lies ultimately with government. This is logical, because the funds for these services originate with government and the regulations controlling the services are imposed by government. Much of the analysis that has been conducted to date by groups like CSH and NAEH has primarily focused on public sector reforms. For example, CSH has issued a paper with many recommendations for actions that would allow Medicaid to be more widely used in supportive housing. Virtually all the recommendations involve state and local policy change. Likewise, the recommendations emerging from the 2000 national conference, “Building Partnerships for Access to Health Care,” include numerous goals for increasing mainstream health service access for homeless people — only one of which mentions the need for providers to partner with foundations to develop innovative “gap funding.”³⁷

Nevertheless, there are definitely areas in which foundations can be instrumental. Many of the strategies described above, such as discharge planning in Massachusetts, were assisted by foundation support, and some, such as the ACCESS Program, were driven largely by a foundation. As one interviewee said, “If there is money, people will do it. If there is a mandate, people will do it. And if they know how to do it, people will do it.”

The Schwab Foundation and other philanthropic entities, working independently or in partnership, can initiate actions that make technical assistance and training available to communities who want to learn how to address this issue, provide direct financial support for research or coordination efforts, and/or undertake and support advocacy to create the mandates that require accountability. Each action suggested below was mentioned specifically by one or more interviewees, and many were widely supported in the interview process.

A. Provide Education/Technical Assistance to Communities about Mainstream Services and Strategies

★ **Develop training or training materials on how to better access/utilize existing systems** — Many sources cite the need to educate providers about how to access critical mainstream services for their clients and/or educate clients directly about their rights and opportunities. This could include funding a curriculum on access and eligibility issues and training people to be experts in the more difficult application processes, particularly SSI and Medicaid.

★ **Convene gatherings and disseminate information about systems integration strategies** — The Urban Institute report on the Continuum of Care calls for more information on best practices for involving and then working with mainstream agencies.³⁸ There is a great need for communities to learn about what others are doing. The opportunity to hear or see firsthand what is happening in other communities is cited as critical by many people. Options include holding conferences or workshops, and inviting representatives from communities such as Philadelphia, Chicago, Michigan and Massachusetts to make presentations to community leaders and key officials. CSH will soon be releasing a report on the key factors for successful systems integration and how to identify such opportunities, which could also be the basis for local dissemination and training.

★ **Provide technical assistance for developing recuperative/respite care options** — Most communities lack sufficient recuperative or respite care beds to house people too sick to be in a shelter. Developing, operating and financially supporting these facilities is complex and expensive. CHSF could develop the tools and expertise to assist communities, or support providers, such as Boston Health Care for the Homeless, to train and assist others.

★ **Support the development of collaborations with business** — The involvement of business leaders and interest groups in homeless advocacy and service provision has proven very beneficial in communities where this occurs, and has even leveraged mainstream systems. CHSF could educate community leaders and homeless advocates about approaches to business, or convene forums in which these sectors can get to know each other and seek common ground.

B. Fund Local Planning and Coordination efforts

★ **Fund discharge planning efforts** — Information about the Massachusetts approach to discharge planning is now widely available. Their approach, however, required an up-front investment to document the presence in the shelter system of persons discharged from institutional care, and funds to allow for advocacy, meetings, etc. Funding the costs associated with discharge planning activities at the state or local level could be an initiative. These efforts can target a single system, such as foster care or prisons, or can address all the major systems in a specific community or statewide. The California Interagency Task Force has recommended that state agencies be directed to determine whether they regularly interact with persons at high risk of becoming homeless and develop prevention strategies to reduce the incidence of homelessness within these populations.

The Schwab Foundation could work with state agencies, or with advocacy groups representing at-risk populations, to ensure that these plans are developed with input from localities and affected population groups and that incentives for implementation are available.

★ **Fund staffing for the development of system integration strategies** — Everyone involved in system integration work agrees that the ultimate goal is to utilize existing resources more efficiently, not to require significant new resources. Yet, to begin the process generally requires additional staff time and expertise that most communities do not have and do not know how to pay for.

Communities engaged in systems integration report that the presence of a “boundary spanner” to lead systems integration conversations, and develop and monitor agreements among participants, is essential. As one interviewee said, “everyone buys into the notion of collaboration, but no one funds the cost of creating, cultivating and sustaining collaboration.” Foundation funds could be used to provide resources to local communities to hire or redirect staff to ensure that dedicated staff time is available to initiate dialogues and provide support to system integration efforts. In some communities, the Continuum of Care Council may be poised to serve this function, while in others it may be more appropriate to work directly with a local government agency, a special commission or community group. Assessing local communities’ interest in and experience with system integration, and identifying a lead agency with both enthusiasm for the work and credibility within the community, would be a critical first step before making an investment in a particular community or issue area.

★ **Provide incentives for collaboration:** An obstacle to systems integration work is the fear that costs may increase, and the reality that communities have little money to fill the gaps that collaboration may expose. Foundation funds could be used to create incentives for collaboration through a “hold harmless” or guarantee program that would pay for overruns if costs increase, since agencies are taking greater risks. Alternatively, funds could be offered as a bonus to systems that undertake reform and be used for normally ineligible activities such as temporary housing assistance, or to cover other gaps.

★ **Fund coverage gaps for people qualified for mainstream system support:** Rules about who qualifies for benefits such as SSI and Medicaid often leave eligible people unsupported while they await a determination. Programs such as the SSI Outreach Project establish “presumptive eligibility” and cover people during the application period. The Schwab Foundation could provide such funds in exchange for expedited processing from local systems.

★ **Support the development of HMIS systems that include mainstream systems:** The establishment of Homeless Management Information Systems (HMIS) throughout the country is a current focus of HUD. All communities receiving federal homeless funds are required to have these systems in place by 2004. There is no requirement, however, that mainstream services be part of these systems. Many communities report that getting the data to show overlaps and gaps across systems is essential to engendering or “forcing” collaboration. For the most part, communities with

better systems integration and discharge planning also have a history of implementing HMIS or requiring data collection from mainstream agencies. The foundation could continue and expand its support for HMIS development, including providing incentives for the inclusion of mainstream services in the systems.

★ **Provide targeted matching funds for new programs that utilize mainstream resources:** A demonstration program with coordinated funding from HUD, HHS and VA has just been announced. Applicants will be required to match or show leveraging of other funds to apply.

In the next year, CSH and NAEH are expected to approach Congress for new funds from HHS that are structured to help state and localities leverage mainstream services, either as a new program or as targeted “carve-outs” from existing programs. If such a program is created, it is also likely to require a match. The foundation could set aside funds specifically to be used to leverage these new federal initiatives.

C. Fund and/or Conduct State and National Advocacy

★ **Develop a public education/media campaign:** Several people interviewed felt that broader public knowledge about the issue of mainstream services and “what works” would provide much needed support for improvement efforts and would release public money. The work of Dennis Culhane showing cost savings from supportive housing has been very influential in some communities and was cited repeatedly by interviewees as information that needs to be more broadly promoted. States that participated in the HHS/HUD policy academies specifically stress that public education assistance from a foundation would support their work.³⁹ Others suggest developing a targeted goal in a community, such as reducing homelessness by a specified amount or building an exact number of new units of supportive housing, in tandem with a public relations effort to support that particular effort.

★ **Engage national and state mainstream system trade groups around the issues:** Welfare system administrators, mental health directors, corrections officials, etc. have professional associations at the state and national levels. The Schwab Foundation could support work to engage these national/state trade groups in a conversation about what works for ending homelessness.⁴⁰ Such an effort could provide basic education about the issue (bringing researchers such as Culhane to present) and encourage association members to convene and talk about it. Identifying members of these organizations who are engaged in successful work, and who could talk peer-to-peer, would be a critical piece of such a strategy.

★ **Fund state and national advocacy:** Getting mainstream resources and systems to work better at the state and national levels will require legislation to facilitate coordination and reduce eligibility and funding barriers. Building the political will to pass such legislation is essential.⁴¹ Funding national advocacy groups and efforts, and developing a state level voice on these issues in California, are areas that the foundation could support.

Many of the suggested actions above could be complementary. For example, funding systems integration planning in local communities could be combined with information dissemination

about best practices or a public relations/media campaign to bring attention to the issues. Development of recuperative care facilities and discharge planning could also be complementary.

All the suggested strategies are possible for CHSF to undertake alone, though some of the larger efforts – such as systems integration support, community-wide or statewide discharge planning, or public education – would benefit from a philanthropic partnership. Several of the proposed initiatives might also involve grant making to local or state government agencies, although CHSF would need to consider whether that is compliant with its general approach and guidelines.

VIII. A FINAL NOTE ON THE IMPORTANCE OF HOUSING

The role that mainstream services can and should play in serving homeless people and in reducing overall homelessness is enormous and has only begun to be tapped. However, the research for this report and the people interviewed almost universally emphasized that without adequate housing resources available in the community, these efforts can only go so far. This caveat applies to both prevention efforts and to efforts to improve services for homeless people.

A prevention approach is an attractive strategy – it is much cheaper to keep someone housed than to have her enter the homeless system, and it is generally preferable for the individual or family affected as well. Nevertheless, researchers Shinn and Baumohl, in their article *Rethinking the Prevention of Homelessness*, make powerful arguments against a narrow prevention focus:

“Eviction prevention programs show some promise but have not been rigorously evaluated and tend to exclude people at highest risk of homelessness ... There is even less evidence for the usefulness of planning discharges from institutions ... However, even if expanded to reach 100 percent of their target populations and even if 100 percent successful, all of these programs together would reach only a minority of the people who become homeless each year, and targeting efforts would yield many false alarms for each future case of homelessness correctly identified.”⁴²

They argue that prevention strategies alone will not end homelessness unless our definition of prevention is widened to include the provision of adequate affordable housing, decent wages and income supports, and assistance to low-income communities from which the majority of homeless people emerge.

Many of the states and communities that are doing well at prevention, discharge planning and system integration efforts (such as Massachusetts, Michigan and Columbus, Ohio) are also investing in permanent supportive housing and have made significant inroads with public housing authorities to direct housing resources to homeless people and those at-risk more efficiently. This report has not specifically emphasized supportive housing, but it is important to note that supportive housing is itself a strategy that needs participation and funding of mainstream services to be most effective. Housing in general must be more widely available in order for any mainstream strategy for ending or reducing homelessness to be successful.

APPENDIX A: KEY INFORMANTS INTERVIEWED

Name	Title	Organization/Affiliation
Lynnette Araki	Program Analyst	U.S. Department of Health and Human Services, Health Resources and Services Administration
Lynn Aronson	Consultant	New Freedom Commission on Mental Illness
Martha Burt	Senior Fellow	Urban Institute
Keith Bussey	Adult Emergency Services Shelter Director	Contra Costa County
Deborah Dennis	Vice President for Technical Assistance	Policy Research Associates
Marty Fleetwood	Executive Director	HomeBase
Margaret Gregg	Homeless Coordinator	Santa Clara County, County Administrator's Office
Debbie Grieff	Consultant	Frequent Users of Health Services Initiative
Jonathan Harwitz	Director of Public Policy	Corporation for Supportive Housing
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Dr. Tom Simpatico	Bureau Chief	Bureau of Chicago Network Operations, Illinois Department of Human Services
Mark Trotz	Director	San Francisco Department of Public Health, Housing and Urban Health Section
Carol Wilkins	Director of Intergovernmental Policy	Corporation for Supportive Housing

APPENDIX B: BIBLIOGRAPHY

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ENDNOTES

These endnotes make references to documents listed in the Bibliography or to information from interviews with persons cited in the Key Informants List

¹ GAO, p. 3

² Urban Institute, p. 69

³ Kushel, et al p.203

⁴ Shavelson

⁵ First Place Fund for Youth

⁶ Bazelon Center for Mental Health Law, *Finding the Key to Successful Transition from Jail to Community*

⁷ Based on research being conducted by the author on HRSA funded programs

⁸ Opening Public Agency Doors, pp. 3-5

⁹ Schober and Annis, p. 87

¹⁰ Rosenheck, Frisman and Kawprow, p. 524

¹¹ HHS OIG, p.3

¹² from “Request for Applications”

¹³ www.whitehouse.gov/news/releases/2002/04/20020429-2.html

¹⁴ Urban Institute, p. 70

¹⁵ Urban Institute, p. 152

¹⁶ Center on Budget and Policy Priorities, p. 14

¹⁷ Lezak and Edgar, p. 20

¹⁸ Lezak and Edgar, p. 24

¹⁹ Averyt

²⁰ Susser

²¹ Recommendations of the Interagency... p. 69-70

²² Recommendations of the Interagency... p.18-22

²³ Chuck Kiefer

²⁴ From the NEAH web site, www.naeh.org/best/mdssioutrch.htm

²⁵ Greiff, et al., Draft Report

²⁶ In “Placemakers” p. 19

²⁷ Sant, et. al, Hospitalization costs, p. 1739

²⁸ Placemakers, p. 19

²⁹ Rosenheck, Frisman and Kawprow

³⁰ Effectiveness of Integrated Services... p.5

³¹ Randolph

³² The ACCESS Demonstration Project, p.6

³³ Goldman

³⁴ Michigan’s Supportive Housing Programs...

³⁵ Bureau of Network Operations

³⁶ Urban Institute, p. 72

³⁷ Building Partnerships for Access to Health Care and Services

³⁸ Urban Institute, p. 152

³⁹ Deborah Dennis

⁴⁰ Jonathan Harwitz

⁴¹ Rob Hess

⁴² Shinn and Baumohl, p.1

⁴³ Marty Burt