ENDING LONG-TERM HOMELESSNESS IN MINNESOTA

Report and Business Plan of the Working Group on Long-Term Homelessness

Submitted by

Minnesota Department of Human Services
Minnesota Department of Corrections
Minnesota Housing Finance Agency

Prepared for

The Minnesota Legislature

March 2004

ENDING LONG-TERM HOMELESSNESS IN MINNESOTA
REPORT SUMMARY

1. Introduction and Purpose of Report

In 2003, the Minnesota legislature, at the request of Governor Tim Pawlenty, directed the state Commissioners of Human Services, Corrections, and Housing Finance to convene a broadly representative working group to address the issue of long-term homelessness in Minnesota.[1] In response, a Working Group on Long-Term Homelessness was established in the summer of 2003. As requested by the legislation, this document provides a status report on the efforts of the Working Group. The Working Group, as well as other stakeholders and interested parties, devoted thousands of hours to better understand long-term homelessness and, most importantly, to develop a comprehensive strategy, a business plan, to end it.

The materials that comprise this report, including the appendices and the bibliography, provide a comprehensive set of reference materials on long-term homelessness and set forth the broad and varied perspectives and experiences that Working Group members and other stakeholders, including persons who are currently homeless, contributed. Not all of this information could be included in the report itself, but all of it will be part of the official record of the Working Group so that it can inform implementation of the business plan.

Persons who experience long-term homelessness represent a subset of the overall homeless and near homeless population in Minnesota. As requested by the legislature, the focus of this report and the recommended business plan is on the needs of persons experiencing long-term homelessness. However, as the needs of individuals, youth, and families with children experiencing long-term homelessness are addressed, it is important to not lose focus on the needs of the broader homeless population and those who are at risk of homelessness. This plan is structured, and must be implemented, so that the broader homeless situation is not made worse.

The remainder of this summary, and the full report, is set forth as follows:

- Working Group Process (Section 2);
- Homelessness: An Overview (Section 3);
- Long-Term Homelessness: An Overview (Section 4);
- Supportive Housing (Section 5);
- Response to Questions and Issues Posed to the Working Group (Section 6);
- Seven Year Approximately $540 Million Business Plan to End Long-Term Homelessness (Section 7); and
- Conclusion: An Opportunity to Succeed (Section 8).

[1] Long-term homelessness is defined as being without permanent shelter for at least 12 months or four times in the last three years. Long-term homelessness is also often referred to as "chronic" homelessness; this report will use the term "long-term homelessness".

2. Working Group Process

The Working Group consisted of 30 members representing counties, state agencies, the federal government, philanthropic organizations, local housing and redevelopment authorities, nonprofit organizations, faith-based organizations, developers and business interests. The Working Group was chaired by the Commissioners of Human Services (Kevin Goodno and designee Assistant Commissioner Maria Gomez), Corrections (Joan Fabian), and Housing Finance (Tim Marx). Approximately 200 other stakeholders, representing 100 organizations, provided valuable input. In addition, a number of less formal meetings with service providers, local governments, developers, architects, contractors, property owners and landlords, and persons currently experiencing homelessness provided valuable input into the process. Finally, a committed group of knowledgeable state agency and department staff from Human Services, Corrections, Housing Finance, Employment and Economic Development, and Finance met regularly to review data, plan agendas, draft reports, and keep the process moving.

The Working Group conducted six formal meetings beginning in July, 2003 and concluding in February, 2004. Many members contributed many hours of work in addition to the formal meetings to assist this effort. Each meeting was designed to address a particular issue set forth in the legislation. Extensive briefing materials were prepared in advance of each meeting, meeting minutes were prepared, and Working Group members and others offered their perspective on issues with written comments. The appendices to the report contain all of these materials.

Long-term homelessness and strategies to address it are multi-disciplinary (human service, health, corrections, and housing); multi-jurisdictional (federal, state, and local); and multi-sector (government, business, and non-profit). All of these perspectives were represented on the Working Group, and members worked hard to be transparent about their own perspective and understand the perspectives of others. The report and business plan have benefited from this "creative tension", and the Working Group process has laid the groundwork for continuing to meld the various perspectives into holistic strategies for addressing the needs of persons experiencing long-term homelessness.

3. Homelessness: An Overview

To be homeless is to be without a permanent place to live that is fit for human habitation. According to the United States Interagency Council on Homelessness, there are approximately 2 million homeless Americans during the course of a year. In Minnesota, the Amherst H. Wilder Foundation has conducted a comprehensive survey and analysis of homelessness in Minnesota every three years since 1991.[2] The most recent survey conducted was in October 2003. Summary information from the 2003 Wilder survey is included in this Report. A comprehensive analysis of the survey will be available in the summer of 2004.

Key points from the 2003 Wilder survey are as follows:

[2] Funding for the survey is provided by the Housing Finance Agency; the Department of Human Services; the Department of Employment and Economic Development; the Department of Health; the Department of Veterans Affairs; the Veterans Home Board; the Family Housing Fund; the Greater Minnesota Housing Fund; and the Amherst H. Wilder Foundation.

- 20,347 persons were estimated to be homeless or at imminent risk of losing housing,
- 7,854 persons were staying in emergency shelters, transitional housing, detox facilities, or were interviewed while living on the streets or in other unsheltered locations;
- 2,862 children accompanied the persons surveyed;
- 17% reported living in shelter facilities as a child; and
- 13% persons of those surveyed reported that they were employed full-time.

4. Long-Term Homelessness: An Overview

The Working Group defined long-term homelessness as "lacking a permanent place to live continuously for a year or more or at least four times in the last three years." This definition mirrors the duration and reoccurrence components of the definition of the U.S. Department of Housing and Urban Development (HUD). According to the federal Interagency Council on Homelessness and other research, about 200,000 Americans experience long-term homelessness. According to the year 2003 Wilder survey there are about 3,300 persons experiencing long-term homelessness in Minnesota over the course of a year, in approximately 2,800 households. This includes nearly 500 children.

According to the U.S. Department of Health and Human Services, long-term homelessness is associated with extreme poverty, poor job skills, lack of education, and serious health conditions, mental illness and chemical dependency. A leading researcher in the area, Dennis Culhane from the University of Pennsylvania, determined that persons experiencing long-term homelessness consume 50%-60% of the shelter services available to persons experiencing homelessness and account for only 10%-15% of the homeless population. Persons experiencing long-term homelessness also disproportionately consume other "crisis" services including emergency room and detox services.

5. Supportive Housing: A Proven Strategy for Persons Experiencing Long-Term Homelessness

Addressing the issue of long-term homelessness is a national effort. President Bush has established a goal of ending long-term homelessness in ten years and re-established the federal Interagency Council on Homelessness. The key strategy to address long-term homelessness is a "housing first" strategy, which places a priority on providing persons experiencing homelessness a permanent place to live and then the necessary support services so that they can be successfully housed over the long-term. In its 2003 "Blueprint for Change" report on housing for the chronic homeless who have a mental illness or chemical dependency, the U.S. Department of Health and Human Services stated that "without housing, services and supports cannot be effective."

There is significant experience nationally and in Minnesota in providing supportive housing to persons experiencing long-term homelessness. In the past this has included community-based housing options, transitional housing, and more recently supportive housing. In Minnesota there are at least 2,000 units of permanent supportive housing for homeless persons and another 1,500 currently under development.

The available evidence demonstrates that supportive housing is effective in reducing crisis service costs; however, the evidence is not sufficient at this time to demonstrate that supportive housing results in net savings that can be used for state and other budgeting purposes. The evidence on reduced crisis service costs includes a study conducted by the University of Pennsylvania of supportive housing developments in New York City which calculated that persons with mental illness experiencing long-term homelessness used an average of $40,500 per year of shelter, corrections, and health services before being provided supportive housing, and $12,145 of such services after being in supportive housing. Data from Minnesota also demonstrates savings. According to an April, 2003 report from Hennepin County, one supportive housing development resulted in a reduction of crisis costs of $6,200 per family and a shift to supportive and preventive services. Another March, 2003 Hennepin County report indicated that 1,032 admissions to detox were prevented as a result of supportive housing and the median cost of health care was reduced from just over $9,000 per year per resident to just over $5,000.

Producing and sustaining supportive housing is challenging. Necessary capital, operating, and service funds come from a variety of sources, each of which has its own restrictions and rules. As a result, transaction costs are high, and matching available funding to the needs of persons experiencing long-term homelessness is difficult. Supportive housing is an effective strategy. The challenge is to reform our housing and social service funding and delivery systems to better take advantage of this strategy.

6. Response to Questions and Issues Posed to the Working Group

The 2003 legislation asked the Working Group to address several issues. Three key issues are as follows: characteristics of persons experiencing long-term homelessness, housing and service models, and funding gaps and strategies to address them.

Characteristics of Persons Experiencing Long-Term Homelessness. Based on 2003 Wilder Survey results is it estimated that about 3,300 adults and unaccompanied youth, including nearly 500 children, experience long-term homelessness annually. According to the 2003 Wilder Survey, the following are characteristics of adults and unaccompanied youth experiencing long-term homelessness:

- 52% serious or persistent mental illness
- 33% chemical dependency problem
- 24% dual diagnosis of both mental illness and chemical dependency
- 16% veterans
- 48% chronic health condition
- 24% history of being victimized by domestic violence
- 26% criminal history that affected their housing

This data provides valuable information for determining what types of housing and related support services are needed in the future.

Housing with Support Service Models. The Working Group reviewed extensive information on a variety of models of housing with support services. Among the many models are:

- housing provided on a scattered-site basis where a social service provider will agree with a landlord and tenants to provide tenants necessary services;
- multi-unit single room occupancy developments with efficiency apartments and linkages to support services; and
- multi-unit family apartments where extensive services are available on-site or are coordinated and provided off-site.

The Working Group determined that different housing models would work in different situations, that best practice, evidence-based models should be pursued and consumer choice should be maximized.

Similarly, the types and intensity of services must be responsive to individual needs. Service needs will fluctuate over time for individuals even if the disabilities being treated are similar. Children who have experienced long-term homelessness have different service needs from their parents. As with housing, best practice, evidence-based models should be utilized.

Finally, it is important to recognize that significant and patient efforts to reach out and engage some of the persons experiencing long-term homelessness will be necessary before they will accept permanent housing and related services that will best work for them.

Funding Gaps and Strategies. A comprehensive catalogue of existing and potential funding sources was developed and strategies were discussed for the gaps that were identified. For example, many individuals experiencing long-term homelessness appear to be eligible for Supplemental Security Income (SSI) payments and Medial Assistance (MA) benefits due to a disability, but have difficulty navigating the process. A special outreach effort is planned to address this issue.

A key challenge is obtaining resources for service funding for the residents of a specific housing development. Housing resources can more easily be targeted to a particular housing development, while human service and corrections funds are based on individual eligibility. This makes it very difficult to assure adequate service funding over the long-term to particular housing developments. A successful strategy for obtaining long-term flexible service funding is critical to an effort to provide more supportive housing opportunities for persons experiencing long-term homeless. Persons experiencing long-term homelessness are often eligible or can become eligible for regularly provided "mainstream" social services (e.g. case management). It will be necessary to maximize the use of "mainstream" services and be able to use the associated funding more flexibility to meet specific housing support needs.

7. A Business Plan to End Long-Term Homelessness in Minnesota by 2010

The leadership of Governor Pawlenty, the energy and commitment of the Working Group and those they represent, and a successful track record of providing housing to persons experiencing long-term homelessness provide Minnesota a break-through opportunity to set and deliver on the goal of ending long-term homelessness. The Working Group recommends that the state seize this opportunity and establish the goal of ending long-term homelessness in the state. The following summarizes a "business plan" to reach this goal by the end of 2010.

The Need: Provide Housing with Support Service Opportunities to 4,000 Additional Households. Based on the 2003 homelessness survey of the Wilder Foundation, Minnesota should plan to provide housing and support services to an additional 4,000 long-term homeless households by 2010. This would accommodate some growth in population of persons experiencing long-term homelessness over the seven-year period.

It will be important, of course, to update the plan and be prepared to pursue other strategies based on the 2006 Wilder survey and other available data. For example, it is anticipated that providing significant additional housing with support opportunities will free up shelter and transitional housing space for those experiencing homelessness on a temporary basis. If this does not occur, and there is a demonstrated shortage of temporary housing opportunities for persons experiencing homelessness, separate strategies to address this issue should be pursued. In addition, it is necessary that existing housing opportunities with support services for persons experiencing homelessness be maintained so that existing units are not lost.

The Strategy: Cost Effective Reforms for Providing Housing and Support Services. The evidence reviewed by the Working Group demonstrates that permanent supportive housing works. Outcomes for persons experiencing long-term homelessness are enhanced, and the costs of crisis services are reduced. Providing housing with adequate supports to 4,000 households is a major challenge financially and to the capacity of our housing and social service delivery systems. To maximize the amount of supportive housing available, the Working Group reviewed strategies to provide supportive housing more cost-effectively by utilizing strategies including:

- controlling development costs by using innovative designs, alternative materials, and limiting transaction costs;
- maximizing the use of the private, competitive rental market to avoid the costs of new construction;
- carefully scrutinizing support service levels to focus on those that relate directly to being successfully housed over the long-term; and
- requiring tenants to pay a portion of their rent from available sources and use financial incentives to minimize the amount of state support necessary.

The Financing Plan: Initial State Leadership to Leverage other Resources.

The following table summarizes the financing plan, which estimates a total approximate cost of $540 million over seven years. It is important to note that this financing plan is a unique effort to estimate over time the costs and potential sources for providing housing and support services from multiple funding sources each of which have different allowable uses and eligibility criteria. As a result, the plan provides an estimated order of magnitude, not precision, for the costs and potential sources. This plan will require continued updating as implementation proceeds.

Financing Plan Estimate (2004 - 2010)
(in millions)

Sources		Costs/Uses	
Identified Sources			
State General Obligation Bonds ($16.2 million in 2002; $20 million in 2004; remainder in 2006 and 2008)	$ 90	New Construction (500 units)	$ 85
		Acquisition and Rehabilitation (1,500 units)	$125
Minnesota Housing Finance Agency State Appropriated Programs and Agency Resources	$ 90	New Units Integrated into Mixed-Income Developments (400 units)	$ 50
Private Tax Credit Equity (MHFA allocation)	$ 60	Rental/Operating Assistance (1,600 units for available units in the rental market -$40 million; remainder to support other new units identified above - $60 million)	$100
Department of Human Services	$120		
Remaining Sources: Federal Government Local Government Philanthropic/Non-Profit State (Departments of Human Services, Corrections, and MHFA)	$180	Housing Support/Community Living Services/Income Supplements	$180
Total	**$ 540**	**Total**	**$ 540**

Key points related to the financing plan include:

- *Phase-in*. The dollar figures represent the additional resources necessary to house and serve an estimated 4,000 long-term homeless households based on an estimated schedule for providing the housing and support services over the seven-year period.
- *Identified Sources*. The "identified" sources represent those that can be reasonably anticipated based on existing funding levels and with minor changes to some

programs. They are, however, not guaranteed. The identified sources are general obligation bonds, funds from the state appropriated housing trust fund, MHFA resources from the Agency's bond funds, and service funds allocated by the Department of Human Services. Department of Human Service funding is not available in a "lump sum" or "pool" as individual determinations of eligibility must be made. However, approximately $10 million has been initially identified for use as part of a flexible service fund.

- *Remaining Sources*. By identifying and attempting to quantify the "remaining sources", it is clear that state government cannot finance this plan alone. Filling the gaps requires at least two strategies. First, leveraging state resources to obtain federal, local, and philanthropic resources. These sectors have contributed to past and on-going efforts for persons experiencing long-term homelessness and there is reason to believe they may continue and enhance their efforts, particularly if the state provides continued leadership. Second, addressing the identified service funding gaps requires exploring opportunities to increase the use of "mainstream" services as defined earlier, and targeting resources to the needs of persons experiencing long-term homelessness. To the extent additional state resources are necessary but unavailable, the ability to achieve the goal, or the timetable within which it can be achieved, will be affected.

- *On-Going Costs*. After 2010 there will be ongoing costs for rental assistance and for support services. Reducing or eliminating these costs to the state would require successful "mainstreaming" of most support service costs and for the federal government to fulfill its role of providing rental assistance. A very imprecise estimate of these costs by 2010 is $88 million annually. To the extent such funding is necessary and unavailable in 2010, the housing would become part of the affordable housing supply primarily for those other than persons experiencing long-term homelessness.

- *Savings and Benefits*. These figures do not include an estimate of the reduced costs to counties, other local units, and the state of reduced use of "crisis" services by persons experiencing long-term homelessness. Nor do they account for the benefits associated with the better outcomes that should be achieved by persons experiencing long-term homelessness such as increased employability.

<u>The Implementation Plan: Establish Accountability and be Proactive.</u>

The Working Group process has resulted in a wealth of knowledge and a committed group of stakeholders. An essential element of implementing the business plan will be to take advantage of and build on this knowledge and to continue to involve stakeholders. The business plan should be implemented, in general, as follows:

- *Continued Interagency Cooperation.* The Departments of Human Services and Corrections and the Housing Finance Agency should enhance and institutionalize their joint efforts to proactively solicit and fund supportive housing for persons experiencing long-term homelessness. Proposals that serve families with children experiencing long-term homelessness should be prioritized.

- *Develop the System for Supportive Housing*. The state agencies should also continue their work to develop creative funding strategies that allow a more natural "system" to develop to provide for the development of supportive housing. It will be critical to involve the federal government, counties and other local governments, and non-profit funders as partners in addressing funding and funding system issues.

- *Evaluation*. Rigorous evaluation, tracking of data on homelessness, and search for best practices should be integrated into the implementation process.

- *Stakeholder Participation and Capacity Building*. A broadly representative advisory body like the Working Group should be established to assist in implementation of the business plan and track progress. Persons who have or are experiencing homelessness should be involved. In addition, it will be necessary to work with local governments, developers, and service providers to develop and maintain the capacity to implement the plan and assist in addressing siting and similar issues.

- *A long-term homeless director without new bureaucracy*. A director for ending long-term homelessness should be engaged, using existing resources, to coordinate implementation of the business plan. The director should report to the commissioners of Human Service, Housing Finance, and Corrections.

8. Conclusion: An Opportunity to Succeed

The Working Group has sought to develop a plan that addresses a complex social issue in a business-like way. Proceeding to implement the plan offers significant benefits and few risks. The benefits will accrue to persons experiencing long-term homelessness in increased productivity and qualify of life, and to the rest of Minnesota in reduced crisis service costs and in knowing that the needs of some of our most vulnerable citizens are being addressed. The risk of proceeding is confronting obstacles that we fail to overcome, not achieving the goal, and being held publicly accountable. Even if this occurs, a bold, ambitious effort would have been undertaken that will create affordable housing that can be made available to others, and services would have been provided to those who need them.

Establishing goals that improve quality of life, developing implementation plans, aligning resources, and being held accountable—for success or failure—are essential principles of good public governance. The Working Group on long-term homelessness advocates putting these principles to work for persons experiencing long-term homelessness, and calls on the "many hands" that are necessary to pursue success.

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Submitted by

Minnesota Department of Human Services
Minnesota Department of Corrections
Minnesota Housing Finance Agency

Prepared for

The Minnesota Legislature

March 2004

March 15, 2004

Governor Tim Pawlenty
State of Minnesota

Senator Ellen Anderson, Chair
and Jobs, Energy and Community
Development Committee Members

Senator Linda Berglin, Chair
and Health, Human Services and Corrections
Budget Division Members

Senator Leo Foley, Chair
and Crime Prevention and Public Safety
Committee Members

Senator Keith Langseth, Chair
and Capital Investment Committee Members

Senator Becky Lourey, Chair
and Health and Family Security Committee
Members

Senator Dallas Sams, Chair
and Environment, Agriculture and Economic
Development Budget Division Members

Representative Lynda Boudreau, Chair, and
Health and Human Services Policy Committee
Members

Representative Fran Bradley, Chair
and Health and Human Services Policy
Committee Members

Representative Greg Davids, Chair
and Commerce, Jobs and Economic
Development Committee Members

Representative Bob Gunther, Chair
and Job and Economic Development Finance
Committee Members

Representative Philip Krinkie, Chair
and Capital Investment Committee Members

Representative Steve Smith, Chair
and Judiciary Policy and Finance Committee
Members

Re: Ending Long-Term Homelessness in Minnesota—Working Group Status Report and Business Plan

We are pleased to submit the status report of the Working Group on Long-Term Homelessness required by Laws of Minnesota 2003, Chapter 128, Article 15, Section 9.

Persons experiencing long-term homelessness represent a portion of our broader homeless population who regularly experience homelessness or are homeless for long periods of time. Most of the estimated 3,300 persons experiencing long-term homelessness are single adults, but there are a significant number of families with children. The vast majority suffer from a mental illness, chemical dependency, or experience other significant disabilities and difficulties.

Persons experiencing long-term homelessness have fallen through the cracks of our housing and social service safety net. Homelessness can be life threatening and is a tragic loss of human potential. This is particularly true for children who are homeless, as nearly one in ten homeless children become homeless

adults. Persons experiencing long-term homelessness also consume a disproportionate amount of expensive "crisis services" provided by emergency rooms, shelters, detox facilities, the child protection system, and criminal justice systems. This is unnecessarily costly to taxpayers.

Minnesota and the nation have not ignored the crisis of homelessness. Federal, state, and local government, in partnership with the private sector, foundations, and nonprofit organizations, have helped thousands move out of the despair of long-term homelessness and have prevented thousands more from falling victim to it. We have learned much from these efforts.

The 2003 legislature, at the request of Governor Tim Pawlenty, asked us to convene a broadly representative working group to build on what we have learned and develop a comprehensive plan to address the issue of long-term homelessness in Minnesota. In response, a knowledgeable, enthusiastic, and committed working group, as well as other stakeholders, and the staffs of numerous agencies and organizations devoted thousands of hours over the last several months to this effort. (Attached is a list of Working Group members.) In addition, several interviews were conducted with persons experiencing long-term homelessness. The result is an estimated $540 million "business plan" to end long-term homelessness in Minnesota by the end of 2010.

This goal is an aggressive, stretch goal and a call to continued action to the "many hands" whose participation is essential. State government cannot do it alone. Success will require resources, but we must also aggressively pursue reforms and efficiencies in our housing and social service delivery systems. Success also will require accountability, so there must be rigor in measuring and reporting outcomes and making necessary changes to the plan as we implement it. Finally, success will require persistence, as all of the stakeholders must stay at the table until the goal is achieved.

The accompanying status report and business plan provides factual background on persons experiencing long-term homelessness, housing and social service recommendations, and financial and implementation strategies. As we proceed with the necessary work to review, refine, and implement the plan, it will be important to not lose focus on the stark and tragic reality of long-term homelessness to persons who experience it, and the compelling opportunity we have to replace their current despair with opportunity and hope for the future.

On behalf of the Working Group on Long-Term Homelessness, to whom we express our thanks and appreciation for their hard work and dedication, we are pleased to present this report. We are also pleased to report that the members of the Working Group have unanimously endorsed this report.

Sincerely,

Kevin Goodno
Commissioner
Department of Human Services

Joan Fabian
Commissioner
Department of Corrections

Tim Marx
Commissioner
Housing Finance Agency

Attachment

cc: Secretary of the Senate
Chief Clerk of the House
Legislative Reference Library

WORKING GROUP ON LONG-TERM HOMELESSNESS

The report "Ending Long-Term Homelessness In Minnesota" is presented by the following members of the Working Group on Long-Term Homelessness pursuant to *Laws of Minnesota, 2003, Chapter 128, Article 15, Section 9.*

Joan Fabian, Commissioner
MN Department of Corrections

Kevin Goodno, Commissioner
MN Department of Human Services

Tim Marx, Commissioner
MN Housing Finance Agency

Richard Amos
St. Stephens Shelter

Linda Anderson **
St. Louis County

Alan Arthur
Central Community Housing Trust

Carol Berde
McKnight Foundation

Tracy Berglund
Catholic Charities

Dick Brustad
Community Housing Development Corporation

Claudia Dengler
Wilder Foundation

Gail Dorfman, Commissioner
Hennepin County Board of Commissioners

Tom Fulton
Family Housing Fund

Maria Gomez
MN Department of Human Services

Sam Grabarski
Minneapolis Downtown Council

Jon Gutzmann *
St. Paul Public Housing Authority

Susan Haigh, Commissioner
Ramsey County Board of Commissioners

Warren Hanson
Greater Minnesota Housing Fund

Mary Hartmann
New Foundations

Jennifer Ho
Hearth Connection

Shawn Huckleby **
U.S. Housing and Urban Development

Susan Kimberly
Office of Senator Norm Coleman

Rachel Kincade
Life House

Lee Koch
Capital City Partnership

John Labosky
Capital City Partnership

Mari Moen
Corporation for Supportive Housing

Bob Meyer **
Blue Earth County

Kristin Robbins
American Experiment Quarterly

Terry Schneider
South Metro Human Services

Louise Simon
Salvation Army

Mark Stutrud **
Lutheran Social Services

Mark Ulfers
Dakota County Community Development Agency

Marshall Weems
St. Cloud Housing and Redevelopment Authority

* Barbara Sporlein left the St. Paul PHA, January 2004

** Appeared as an alternate: Lisa Potswald, St. Louis County, for Linda Anderson; Tom Koon, U.S. Housing and Urban Development, for Shawn Huckleby; Kelly Harder, Blue Earth County, for Bob Meyer; and Bill Vanderuall, Lutheran Social Services, for Mark Stutrud.

The Working Group on Long-Term Homelessness acknowledges and thanks those who provided invaluable assistance to this effort:

Sharon Autio, Department of Human Services; Kathy Bique, Department of Employment and Economic Development; Keith Bogut, Department of Finance; Katie Burns, Department of Finance; Janel Bush, Department of Human Services; Bill Donnay, Department of Corrections; Christine Eilertson, Department of Human Services; Ward Einess, Office of Governor Pawlenty; Duane Elg, Department of Human Services; Donald Eubanks, Department of Human Services; Maria Gomez, Department of Human Services; June Heineman, Wilder Research Center; Jim Huber, Department of Human Services; Doug Green, Department of Finance; Connie Greer, Department of Human Services; Tom Harren, Department of Finance; George Hoffman, Department of Human Services; Connie Hoye, Minnesota Housing Finance Agency; Leona Humphrey, Department of Employment and Economic Development; Louis Jambois, Department of Employment and Economic Development; Carolee Kelley, Department of Human Services; Marcia Kolb, Minnesota Housing Finance Agency; Mari Konesky, Department of Human Services; Tim Lanz, Department of Corrections; Vern LaPlante, Department of Human Services; Pat Leary, Department of Human Services; Troy Mangan, Department of Human Services; Eric Mattson, Minnesota Housing Finance Agency; Rhonda McCall, Minnesota Housing Finance Agency; Emily Farah Miller, Department of Human Services; Bob Odman, Minnesota Housing Finance Agency; Tonja Orr, Minnesota Housing Finance Agency; Patricia Orud, Department of Corrections; Greg Owen, Wilder Research Center; Wayne Raske, Department of Human Services; Dave Schultz, Department of Human Services; Ellen Shelton, Wilder Research Center; Cherie Shoquist, Minnesota Housing Finance Agency; Ron Solheid, Department of Corrections; Diane Sprague, Minnesota Housing Finance Agency; Julie Stahl, Minnesota Housing Finance Agency; and Heidi Whitney, Minnesota Housing Finance Agency.

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The Working Group consisted of 30 members representing counties, state agencies, the federal government, philanthropic organizations, local housing and redevelopment authorities, nonprofit organizations, faith-based organizations, developers and business interests. The Working Group was chaired by the Commissioners of Human Services (Kevin Goodno and designee Assistant Commissioner Maria Gomez), Corrections (Joan Fabian), and Housing Finance (Tim Marx). Approximately 200 other stakeholders, representing 100 organizations, provided valuable input. In addition, a number of less formal meetings with service providers, local governments, developers, architects, contractors, property owners and landlords, and persons currently experiencing homelessness provided valuable input into the process. Finally, a committed group of knowledgeable state agency and department staff from Human Services, Corrections, Housing Finance, Employment and Economic Development, and Finance met regularly to review data, plan agendas, draft reports, and keep the process moving.

The Working Group conducted six formal meetings beginning in July, 2003 and concluding in February, 2004. Many members contributed many hours of work in addition to the formal meetings to assist this effort. Each meeting was designed to address a particular issue set forth in the legislation. Extensive briefing materials were prepared in advance of each meeting, meeting minutes were prepared, and Working Group members and others offered their perspective on issues with written comments. The appendices to the report contain all of these materials.

Long-term homelessness and strategies to address it are multi-disciplinary (human service, health, corrections, and housing); multi-jurisdictional (federal, state, and local); and multi-sector (government, business, and non-profit). All of these perspectives were represented on the Working Group, and members worked hard to be transparent about their own perspective and understand the perspectives of others. The report and business plan have benefited from this "creative tension", and the Working Group process has laid the groundwork for continuing to meld the various perspectives into holistic strategies for addressing the needs of persons experiencing long-term homelessness.

3. Homelessness: An Overview

To be homeless is to be without a permanent place to live that is fit for human habitation. According to the United States Interagency Council on Homelessness, there are approximately 2 million homeless Americans during the course of a year. In Minnesota, the Amherst H. Wilder Foundation has conducted a comprehensive survey and analysis of homelessness in Minnesota every three years since 1991.[2] The most recent survey conducted was in October 2003. Summary information from the 2003 Wilder survey is included in this Report. A comprehensive analysis of the survey will be available in the summer of 2004.

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[2] Funding for the survey is provided by the Housing Finance Agency; the Department of Human Services; the Department of Employment and Economic Development; the Department of Health; the Department of Veterans Affairs; the Veterans Home Board; the Family Housing Fund; the Greater Minnesota Housing Fund; and the Amherst H. Wilder Foundation.

Key points from the 2003 Wilder survey are as follows:

- 20,347 persons were estimated to be homeless or at imminent risk of losing housing,
- 7,854 persons were staying in emergency shelters, transitional housing, detox facilities, or were interviewed while living on the streets or in other unsheltered locations;
- 2,862 children accompanied the persons surveyed;
- 17% reported living in shelter facilities as a child; and
- 13% persons of those surveyed reported that they were employed full-time.

4. Long-Term Homelessness: An Overview

The Working Group defined long-term homelessness as "lacking a permanent place to live continuously for a year or more or at least four times in the last three years." This definition mirrors the duration and reoccurrence components of the definition of the U.S. Department of Housing and Urban Development (HUD). According to the federal Interagency Council on Homelessness and other research, about 200,000 Americans experience long-term homelessness. According to the year 2003 Wilder survey there are about 3,300 persons experiencing long-term homelessness in Minnesota over the course of a year, in approximately 2,800 households. This includes nearly 500 children.

According to the U.S. Department of Health and Human Services, long-term homelessness is associated with extreme poverty, poor job skills, lack of education, and serious health conditions, mental illness and chemical dependency. A leading researcher in the area, Dennis Culhane from the University of Pennsylvania, determined that persons experiencing long-term homelessness consume 50%-60% of the shelter services available to persons experiencing homelessness and account for only 10%-15% of the homeless population. Persons experiencing long-term homelessness also disproportionately consume other "crisis" services including emergency room and detox services.

5. Supportive Housing: A Proven Strategy for Persons Experiencing Long-Term Homelessness

Addressing the issue of long-term homelessness is a national effort. President Bush has established a goal of ending long-term homelessness in ten years and re-established the federal Interagency Council on Homelessness. The key strategy to address long-term homelessness is a "housing first" strategy, which places a priority on providing persons experiencing homelessness a permanent place to live and then the necessary support services so that they can be successfully housed over the long-term. In its 2003 "Blueprint for Change" report on housing for the chronic homeless who have a mental illness or chemical dependency, the U.S. Department of Health and Human Services stated that "without housing, services and supports cannot be effective."

There is significant experience nationally and in Minnesota in providing supportive housing to persons experiencing long-term homelessness. In the past this has included community-based housing options, transitional housing, and more recently supportive housing. In Minnesota there

are at least 2,000 units of permanent supportive housing for homeless persons and another 1,500 currently under development.

The available evidence demonstrates that supportive housing is effective in reducing crisis service costs; however, the evidence is not sufficient at this time to demonstrate that supportive housing results in net savings that can be used for state and other budgeting purposes. The evidence on reduced crisis service costs includes a study conducted by the University of Pennsylvania of supportive housing developments in New York City which calculated that persons with mental illness experiencing long-term homelessness used an average of $40,500 per year of shelter, corrections, and health services before being provided supportive housing, and $12,145 of such services after being in supportive housing. Data from Minnesota also demonstrates savings. According to an April, 2003 report from Hennepin County, one supportive housing development resulted in a reduction of crisis costs of $6,200 per family and a shift to supportive and preventive services. Another March, 2003 Hennepin County report indicated that 1,032 admissions to detox were prevented as a result of supportive housing and the median cost of health care was reduced from just over $9,000 per year per resident to just over $5,000.

Producing and sustaining supportive housing is challenging. Necessary capital, operating, and service funds come from a variety of sources, each of which has its own restrictions and rules. As a result, transaction costs are high, and matching available funding to the needs of persons experiencing long-term homelessness is difficult. Supportive housing is an effective strategy. The challenge is to reform our housing and social service funding and delivery systems to better take advantage of this strategy.

6. Response to Questions and Issues Posed to the Working Group

The 2003 legislation asked the Working Group to address several issues. Three key issues are as follows: characteristics of persons experiencing long-term homelessness, housing and service models, and funding gaps and strategies to address them.

Characteristics of Persons Experiencing Long-Term Homelessness. Based on 2003 Wilder Survey results is it estimated that about 3,300 adults and unaccompanied youth, including nearly 500 children, experience long-term homelessness annually. According to the 2003 Wilder Survey, the following are characteristics of adults and unaccompanied youth experiencing long-term homelessness:

- 52% serious or persistent mental illness
- 33% chemical dependency problem
- 24% dual diagnosis of both mental illness and chemical dependency
- 16% veterans
- 48% chronic health condition
- 24% history of being victimized by domestic violence
- 26% criminal history that affected their housing

This data provides valuable information for determining what types of housing and related support services are needed in the future.

Housing with Support Service Models. The Working Group reviewed extensive information on a variety of models of housing with support services. Among the many models are:

- housing provided on a scattered-site basis where a social service provider will agree with a landlord and tenants to provide tenants necessary services;
- multi-unit single room occupancy developments with efficiency apartments and linkages to support services; and
- multi-unit family apartments where extensive services are available on-site or are coordinated and provided off-site.

The Working Group determined that different housing models would work in different situations, that best practice, evidence-based models should be pursued and consumer choice should be maximized.

Similarly, the types and intensity of services must be responsive to individual needs. Service needs will fluctuate over time for individuals even if the disabilities being treated are similar. Children who have experienced long-term homelessness have different service needs from their parents. As with housing, best practice, evidence-based models should be utilized.

Finally, it is important to recognize that significant and patient efforts to reach out and engage some of the persons experiencing long-term homelessness will be necessary before they will accept permanent housing and related services that will best work for them.

Funding Gaps and Strategies. A comprehensive catalogue of existing and potential funding sources was developed and strategies were discussed for the gaps that were identified. For example, many individuals experiencing long-term homelessness appear to be eligible for Supplemental Security Income (SSI) payments and Medial Assistance (MA) benefits due to a disability, but have difficulty navigating the process. A special outreach effort is planned to address this issue.

A key challenge is obtaining resources for service funding for the residents of a specific housing development. Housing resources can more easily be targeted to a particular housing development, while human service and corrections funds are based on individual eligibility. This makes it very difficult to assure adequate service funding over the long-term to particular housing developments. A successful strategy for obtaining long-term flexible service funding is critical to an effort to provide more supportive housing opportunities for persons experiencing long-term homeless. Persons experiencing long-term homelessness are often eligible or can become eligible for regularly provided "mainstream" social services (e.g. case management). It will be necessary to maximize the use of "mainstream" services and be able to use the associated funding more flexibility to meet specific housing support needs.

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7. A Business Plan to End Long-Term Homelessness in Minnesota by 2010

The leadership of Governor Pawlenty, the energy and commitment of the Working Group and those they represent, and a successful track record of providing housing to persons experiencing long-term homelessness provide Minnesota a break-through opportunity to set and deliver on the goal of ending long-term homelessness. The Working Group recommends that the state seize this opportunity and establish the goal of ending long-term homelessness in the state. The following summarizes a "business plan" to reach this goal by the end of 2010.

The Need: Provide Housing with Support Service Opportunities to 4,000 Additional Households. Based on the 2003 homelessness survey of the Wilder Foundation, Minnesota should plan to provide housing and support services to an additional 4,000 long-term homeless households by 2010. This would accommodate some growth in population of persons experiencing long-term homelessness over the seven-year period.

It will be important, of course, to update the plan and be prepared to pursue other strategies based on the 2006 Wilder survey and other available data. For example, it is anticipated that providing significant additional housing with support opportunities will free up shelter and transitional housing space for those experiencing homelessness on a temporary basis. If this does not occur, and there is a demonstrated shortage of temporary housing opportunities for persons experiencing homelessness, separate strategies to address this issue should be pursued. In addition, it is necessary that existing housing opportunities with support services for persons experiencing homelessness be maintained so that existing units are not lost.

The Strategy: Cost Effective Reforms for Providing Housing and Support Services. The evidence reviewed by the Working Group demonstrates that permanent supportive housing works. Outcomes for persons experiencing long-term homelessness are enhanced, and the costs of crisis services are reduced. Providing housing with adequate supports to 4,000 households is a major challenge financially and to the capacity of our housing and social service delivery systems. To maximize the amount of supportive housing available, the Working Group reviewed strategies to provide supportive housing more cost-effectively by utilizing strategies including:

- controlling development costs by using innovative designs, alternative materials, and limiting transaction costs;
- maximizing the use of the private, competitive rental market to avoid the costs of new construction;
- carefully scrutinizing support service levels to focus on those that relate directly to being successfully housed over the long-term; and
- requiring tenants to pay a portion of their rent from available sources and use financial incentives to minimize the amount of state support necessary.

The Financing Plan: Initial State Leadership to Leverage other Resources.

The following table summarizes the financing plan, which estimates a total approximate cost of $540 million over seven years. It is important to note that this financing plan is a unique effort to estimate over time the costs and potential sources for providing housing and support services from multiple funding sources each of which have different allowable uses and eligibility criteria. As a result, the plan provides an estimated order of magnitude, not precision, for the costs and potential sources. This plan will require continued updating as implementation proceeds.

Financing Plan Estimate (2004 - 2010)
(in millions)

Sources		Costs/Uses	
Identified Sources			
State General Obligation Bonds ($16.2 million in 2002; $20 million in 2004; remainder in 2006 and 2008)	$ 90	New Construction (500 units)	$ 85
		Acquisition and Rehabilitation (1,500 units)	$125
Minnesota Housing Finance Agency State Appropriated Programs and Agency Resources	$ 90	New Units Integrated into Mixed-Income Developments (400 units)	$ 50
Private Tax Credit Equity (MHFA allocation)	$ 60	Rental/Operating Assistance (1,600 units for available units in the rental market -$40 million; remainder to support other new units identified above - $60 million)	$100
Department of Human Services	$120		
Remaining Sources: Federal Government Local Government Philanthropic/Non-Profit State (Departments of Human Services, Corrections, and MHFA)	$180	Housing Support/Community Living Services/Income Supplements	$180
Total	**$ 540**	**Total**	**$ 540**

Key points related to the financing plan include:

- *Phase-in*. The dollar figures represent the additional resources necessary to house and serve an estimated 4,000 long-term homeless households based on an estimated schedule for providing the housing and support services over the seven-year period.
- *Identified Sources*. The "identified" sources represent those that can be reasonably anticipated based on existing funding levels and with minor changes to some

programs. They are, however, not guaranteed. The identified sources are general obligation bonds, funds from the state appropriated housing trust fund, MHFA resources from the Agency's bond funds, and service funds allocated by the Department of Human Services. Department of Human Service funding is not available in a "lump sum" or "pool" as individual determinations of eligibility must be made. However, approximately $10 million has been initially identified for use as part of a flexible service fund.

- *Remaining Sources*. By identifying and attempting to quantify the "remaining sources", it is clear that state government cannot finance this plan alone. Filling the gaps requires at least two strategies. First, leveraging state resources to obtain federal, local, and philanthropic resources. These sectors have contributed to past and on-going efforts for persons experiencing long-term homelessness and there is reason to believe they may continue and enhance their efforts, particularly if the state provides continued leadership. Second, addressing the identified service funding gaps requires exploring opportunities to increase the use of "mainstream" services as defined earlier, and targeting resources to the needs of persons experiencing long-term homelessness. To the extent additional state resources are necessary but unavailable, the ability to achieve the goal, or the timetable within which it can be achieved, will be affected.

- *On-Going Costs*. After 2010 there will be ongoing costs for rental assistance and for support services. Reducing or eliminating these costs to the state would require successful "mainstreaming" of most support service costs and for the federal government to fulfill its role of providing rental assistance. A very imprecise estimate of these costs by 2010 is $88 million annually. To the extent such funding is necessary and unavailable in 2010, the housing would become part of the affordable housing supply primarily for those other than persons experiencing long-term homelessness.

- *Savings and Benefits*. These figures do not include an estimate of the reduced costs to counties, other local units, and the state of reduced use of "crisis" services by persons experiencing long-term homelessness. Nor do they account for the benefits associated with the better outcomes that should be achieved by persons experiencing long-term homelessness such as increased employability.

<u>The Implementation Plan: Establish Accountability and be Proactive.</u>

The Working Group process has resulted in a wealth of knowledge and a committed group of stakeholders. An essential element of implementing the business plan will be to take advantage of and build on this knowledge and to continue to involve stakeholders. The business plan should be implemented, in general, as follows:

- *Continued Interagency Cooperation.* The Departments of Human Services and Corrections and the Housing Finance Agency should enhance and institutionalize their joint efforts to proactively solicit and fund supportive housing for persons experiencing long-term homelessness. Proposals that serve families with children experiencing long-term homelessness should be prioritized.

- *Develop the System for Supportive Housing*. The state agencies should also continue their work to develop creative funding strategies that allow a more natural "system" to develop to provide for the development of supportive housing. It will be critical to involve the federal government, counties and other local governments, and non-profit funders as partners in addressing funding and funding system issues.

- *Evaluation*. Rigorous evaluation, tracking of data on homelessness, and search for best practices should be integrated into the implementation process.

- *Stakeholder Participation and Capacity Building*. A broadly representative advisory body like the Working Group should be established to assist in implementation of the business plan and track progress. Persons who have or are experiencing homelessness should be involved. In addition, it will be necessary to work with local governments, developers, and service providers to develop and maintain the capacity to implement the plan and assist in addressing siting and similar issues.

- *A long-term homeless director without new bureaucracy*. A director for ending long-term homelessness should be engaged, using existing resources, to coordinate implementation of the business plan. The director should report to the commissioners of Human Service, Housing Finance, and Corrections.

8. Conclusion: An Opportunity to Succeed

The Working Group has sought to develop a plan that addresses a complex social issue in a business-like way. Proceeding to implement the plan offers significant benefits and few risks. The benefits will accrue to persons experiencing long-term homelessness in increased productivity and qualify of life, and to the rest of Minnesota in reduced crisis service costs and in knowing that the needs of some of our most vulnerable citizens are being addressed. The risk of proceeding is confronting obstacles that we fail to overcome, not achieving the goal, and being held publicly accountable. Even if this occurs, a bold, ambitious effort would have been undertaken that will create affordable housing that can be made available to others, and services would have been provided to those who need them.

Establishing goals that improve quality of life, developing implementation plans, aligning resources, and being held accountable—for success or failure—are essential principles of good public governance. The Working Group on long-term homelessness advocates putting these principles to work for persons experiencing long-term homelessness, and calls on the "many hands" that are necessary to pursue success.

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ENDING LONG-TERM HOMELESSNESS IN MINNESOTA REPORT

1. Introduction, Purpose and Structure of Report

At the request of Governor Pawlenty, the 2003 Minnesota Legislature directed the Commissioners of the Department of Human Services, Department of Employment and Economic Development[3], Department of Corrections and the Minnesota Housing Finance Agency to establish a Working Group to develop and implement strategies to foster the development of supportive housing options in order to:

- reduce the number of Minnesota families and individuals that experience long-term homelessness;
- reduce the inappropriate use of emergency health care, shelter, chemical dependency, corrections, and similar services; and to
- increase the employability, self-sufficiency, and other social outcomes for individuals and families experiencing long-term homelessness.

Laws of Minnesota, 2003, Chapter 128, Article 15, Section 9.

This report on the status of Working Group efforts includes comprehensive information on homelessness and long-term homelessness and provides recommendations to improve the effectiveness of the delivery and coordination of services and access to housing for individuals and families experiencing long-term homelessness.

The structure of this report is as follows:

- The Working Group Process (Section 2),
- Homelessness: An Overview (Section 3),
- Long-Term Homelessness: An Overview (Section 4),
- Supportive Housing: The Primary Strategy for Persons Experiencing Long-Term Homelessness (Section 5)
- Response to Specific Charges from the Legislature (Section 6)
- Recommendations and Next Steps: A Business Plan to End Long-Term Homelessness by 2010 (Section 7)
- Conclusion: An Opportunity to Succeed (Section 8)

[3] Staff from the Department of Employment and Economic Development participated in pertinent interagency discussions.

2. The Working Group Process

Members

The Working Group included metropolitan area and Greater Minnesota representatives of:

- counties;
- housing authorities;
- nonprofit and faith-based organizations knowledgeable about supportive housing;
- nonprofit and faith-based organizations experienced in the provision of services to persons experiencing homelessness;
- developers and other business interests;
- philanthropic organizations; and
- other representatives identified as necessary to the development of the plan, including other government agencies.[4]

In addition, over 200 stakeholders from over 100 organizations participated in Working Group meetings and in meetings held in preparation for Working Group meetings.

Interagency staff and Working Group members met with:

- persons currently experiencing long-term homelessness to listen to their housing and service needs, and to ensure that the efforts of the working group are consistent with their assessments of need;[5]
- over 25 county and nonprofit service providers, individually and in group meetings, to discuss supportive housing models and best practices;
- service providers to discuss support service costs;

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4 The list of Working Group members is included at the beginning of this report.

Members participated as representatives from the following thirty agencies and organizations: Minnesota Department of Human Services, Minnesota Department of Corrections, Minnesota Housing Finance Agency, Blue Earth County, Hennepin County Board of Commissioners, Ramsey County Board of Commissioners, St. Louis County, St. Paul Public Housing Authority, Dakota County Community Development Agency, St. Cloud Housing and Redevelopment Authority, Corporation for Supportive Housing, New Foundations, Life House, Hearth Connection, South Metro Human Services, Catholic Charities, Salvation Army, Lutheran Social Services, St. Stephens Shelter, Wilder Foundation, Community Housing Development Corporation, Central Community Housing Trust, Capital City Partnership, Minneapolis Downtown Council, Family Housing Fund, Greater Minnesota Housing Fund, The McKnight Foundation, American Experiment Quarterly, Office of Senator Norm Coleman, and U.S. Department of Housing and Urban Development.

5 Two meetings with people experiencing long-term homelessness were arranged by Central Lutheran Church in Minneapolis. Many other informal meetings occurred between interagency staff and people currently experiencing long-term homelessness throughout the working group process. A tour for Working Group members and stakeholders to meet with formerly homeless people living in supportive housing was arranged by Metro-wide Engagement on Shelter and Housing.

- more than 25 contractors, developers, architects, property owners, landlords, and providers of supportive housing to discuss cost reduction and gaps in resources;

- homeless youth housing and service providers, Minnesota Association of Runaway Youth Services, and the Runaway Homeless Youth Coalition to discuss issues facing long-term homeless youth;

- transitional housing providers to discuss the role of transitional housing in serving persons experiencing long-term homelessness;

- Continuum of Care coordinators from each of the 13 regions; seven in Greater Minnesota and six in the Twin Cities metropolitan area; and

- representatives from the Association of Minnesota Counties (AMC) and the Minnesota Association of County Social Service Administrators (MACSSA) to elicit their comments and suggestions.

Additionally, state agency and department staff from Human Services, Corrections, Housing Finance, Employment and Economic Development, and Finance met regularly to review data, prepare agendas and meeting documents, draft reports and resolve issues to move the initiative forward.

Additional member and stakeholder contributions and other matters not set forth in the body of the report as Commissioner's recommendations are recorded for potential future consideration.[6]

The Working Group held six formal meetings between July 2003 and February 2004. Primary discussion topics at Working Group meetings included: goals, outcomes, key characteristics of persons experiencing long-term homelessness; models of supportive housing and best practices, and available resources; gaps in resources, and barriers to filling gaps in capital, operating, and services funding; the interagency decision making process and criteria for funding, and a plan and timetable for funding.

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3. Homelessness: An Overview

To be homeless is to be without a permanent place to live that is fit for human habitation. Homelessness has become an enduring presence in American society. Despite two decades of federal support, statewide planning, and local initiatives, an estimated 637,000 adults in the United States are homeless in a given week, with 2.1 million adults experiencing homelessness over the course of a year. *Burt, M.R., Aron, L.Y., Lee, F. & Valente, J. (2001). Helping America's homeless: Emergency Shelter or Affordable Housing? Washington, DC: Interagency Council on the Homeless.*

[6] Meeting summaries and formal comments from Working Group members and stakeholders are included in the Appendix.

There are an estimated 20,000 homeless and precariously housed individuals, youth, and families with children in the State of Minnesota on any given night. *Amherst H. Wilder Foundation, Homeless in Minnesota 2003, Key Facts from the Survey of Minnesotans Without Permanent Housing, February 27, 2003, and Homeless Adults and Children in Minnesota: Statewide Survey of People Without Permanent Shelter, Wilder Research Center, Greg Owen, June Heineman, Justine Nelson-Christinedaughter, and Ellen Shelton ("The Statewide Survey")*.

The Amherst H. Wilder Foundation has conducted a statewide survey of persons without permanent shelter and a comprehensive study of homeless adults and children and homeless youth in Minnesota every three years since 1991. The most recent statewide survey of homelessness was conducted on October 23, 2003. The final comprehensive analysis from the 2003 survey will be available in summer 2004.

For many, homelessness is a result of a crisis, a lack of income and a lack of affordable housing that leads to the loss of stable housing that can be overcome in time. A main cause of homelessness is poverty.

The gap between wages and housing costs plays an increasing role in homelessness:

- Affordability is the most common barrier to stable housing reported by adults experiencing homelessness.
- 30% of persons experiencing long-term homelessness are employed. 13% are employed full-time, of whom nearly 60% earn less than $10 an hour. At this rate, a full-time worker would spend 40%-50% of his or her income for a one-bedroom apartment.
- Only 20% of all persons surveyed (including persons fitting crisis, episodic and long-term homelessness criteria) reported an income of $800 or more.

The Statewide Survey.

Many people who are homeless are also working:

- 30% of persons experiencing homelessness are employed.
- 13% are employed full-time.
- 29% of long-term homeless are employed.
- 12% of long-term homeless are employed full-time.

The Statewide Survey.

The majority of people that become homeless due to crisis caused by an unexpected event such as loss of employment, serious health problems, fire, or other housing disasters are without a place to live only for a short period of time. Additional barriers such as unemployment; serious physical; mental and chemical health problems; criminal background; poor credit; poor rental history; and court evictions prevent people from finding and maintaining housing.

Patterns of homelessness vary by duration or recurrence.

- Crisis or temporary homelessness is the first episode of homelessness lasting a short period of time, typically much less than a year.
- Episodic homelessness is the second or third episode of homelessness lasting less than a year.
- Long-term homelessness is four or more episodes of homelessness within three years or a current episode of homelessness lasting a year or more.

In Minnesota:

- 36% (1,729) of all persons surveyed experienced crisis homelessness.
- 16% (1,018) of all persons surveyed experienced episodic homelessness.
- 48% (2,090) of all persons surveyed experienced long-term homelessness.

The Statewide Survey.

A point in time study will disproportionately represent persons experiencing long-term homelessness. Persons who experience homelessness only for a short time have less chance of being found by a single-day survey.

One study of all shelter users in two large cities, over the course of three years, found that 80% were temporarily homeless, 10% were episodically homeless, and 10% were long-term homeless. *Kuhn, R. amd Culhave, D. (1998). Applying cluster analysis to test a typology of homelessness by pattern of shelter utilization: Results from the analysis of administrative data. American Journal of Community Psychology.*

4. Long-Term Homelessness: An Overview

This section addresses three items: 1) an overview of long-term homelessness in the United States and in Minnesota; 2) the costs of long-term homelessness; and 3) the status of national and Minnesota efforts to address long-term homelessness.

4.1 Long-Term Homelessness in the United States and in Minnesota

Nationally, the estimated 200,000 people who experience long-term or "chronic" homelessness tend to have disabling health and behavioral health problems. *U.S. Department of Health and Human Services, Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and/or Co-Occurring Substance Use Disorders, 2003.* The United States Department of Housing and Urban Development defines chronic homeless 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. *Federal Register, Vol. 68, No. 80, Friday, April 25, 2003, Notices, 21598.*

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The Working Group defines long-term homelessness more broadly than the federal government by adopting the same duration of time, also including families with children, and excluding requirements related to disability. In Minnesota, approximately one-third of the persons experiencing long-term homelessness are families with children.

In Minnesota, approximately 3,300 individuals, youth and families with children experience long-term homelessness over the course of a full year. This includes approximately 2,800 adults and unaccompanied youth and nearly 500 children. *The Statewide Survey.*

4.2. The Costs of Long-Term Homelessness

The costs of long-term homelessness have been examined from a number of different perspectives. It is recognized in housing, health and human services, and criminal justice systems that individuals, youth, and families with children that remain homeless for a year or more, or experience homelessness repeatedly, and frequently use crisis services such as emergency shelter, hospitals, mental health institutions, child protection, foster care, jails and prisons. The real costs of long-term homelessness come in lost opportunity for employment, self-sufficiency, and improved social outcomes for children, youth and adults.

National Data

The U.S. Department of Health and Human Services found that "individuals experiencing chronic homelessness are heavy users of services - 10% of the users of homeless shelters consume 50% of the days. " *Ending Chronic Homelessness, Strategies for Action, Department of Health and Human Services, Report from the Secretary's Work Group on Ending Chronic Homelessness, March 2003.* Studies examining the costs of long-term homelessness have found that "individuals that are repeatedly homeless for a year or more are known to have severe mental illness, disabling behavioral and physical health conditions, and are extensive users of other acute care service systems." *Strategies and Collaborations Target Homelessness by Dennis Culhane, Fannie Mae Foundation Housing Facts & Findings, Volume 4, Issue 5, 2003.*

Similar findings are reported by the President's New Freedom Commission on Mental Health. The shortage of affordable housing and accompanying support services causes persons with serious mental illness to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in mental health institutions; or to live in seriously substandard housing. Persons with serious mental illness represent a large percentage of those who are repeatedly homeless or are homeless for long periods of time. In fact, they are over-represented among the homeless, especially those persons experiencing long-term homelessness. Persons with mental illness that are long-term homeless are likely to: have acute and chronic physical health problems; use alcohol and drugs; have escalating, ongoing psychiatric symptoms; and become victimized and incarcerated. The lack of decent, safe, affordable housing integrated with services is a significant barrier to full participation in community life for persons with serious mental illness. The President's report suggests that supportive housing is a critical form of treatment for mental illness. *Report of the President's New Freedom Commission on Mental Health, 2003.*

Minnesota Data

The social costs of long-term homelessness have also been examined in Minnesota. In the 2003 Wilder Survey, adults experiencing long-term homelessness report:

- 21% recent admission to a detox center (in the past 2 years),
- 13% recent residence in a facility for persons with mental health problems, and
- 39% receipt of care in an emergency room in last six months.

Homeless youth report:

- 21% outpatient mental health care,
- 12% inpatient alcohol or drug treatment, and
- 12% admission to detox (9% in the last 2 years).

The Statewide Survey.

Hennepin County identified the 200 most expensive families that utilized more than $29 million per year in human services funding of a total county human services budget of over $345 million in 1996 and over $377 million in 1997.

- 53% of these families experienced homelessness.
- 95% received services from child protective services.
- 80% received adult chemical health services.
- 75% received adult mental health services.
- 65% were under adult probation.
- 60% of the children were under juvenile probation.

Additional service costs identified include: residential treatment, foster care, child emergency shelter, group home, day treatment, and juvenile correctional placement. *Hennepin County 200 Families Phase 1 Report, 1997 and Phase 2 Report, 1999.*

Homelessness harms children's physical health, interferes with children's development and prevents children from performing well in school. *Family Housing Fund, Homelessness and It's Effects on Our Children, Ellen Hart-Shegos, 1999.* Students in Minneapolis schools who moved three or more times in six months had average reading scores that were half those of students who did not move. *Kids Mobility Project Report, Family Housing Fund, Hennepin County Office of Planning and Development, Minneapolis Pubic Schools and the University of Minnesota, March 1998.* Nearly one in ten homeless children become homeless as adults. *Statewide Survey 2000.*

4.3. Efforts to End Long-Term Homelessness

Ending chronic homelessness in this decade is an explicit objective of the Bush Administration as recommended by the United States Interagency Council on Homelessness, which is chaired by the Secretary of the United States Department of Health and Human Services and includes 20

federal departments - Justice, Veterans Affairs, Housing and Urban Development, and others. The commitment to ending long-term homelessness involves additional federal resources to improve the access to and coordination of essential health and social services and to provide housing and support services for individuals and families experiencing long-term homelessness. The U.S. Conference of Mayors passed a resolution in June of 2003 endorsing the Administration's efforts to end chronic homelessness and supporting the ten-year planning process for cities.

A number of important steps have been taken at both the federal and state level to develop improved strategies for persons experiencing homelessness. These steps range from efforts to better coordinate activities among state agencies, to the development of multi-disciplinary regional plans, to additional funding from philanthropic organizations.

A key element of national and state efforts has been the recognition of the important relationship between housing and support services for persons who were living in institutional settings and persons who were experiencing or at risk of homelessness. This recognition occurred in Minnesota in the late 1970's with agencies that were working with families with children and adults in recovery from mental illness or chemical dependency, in response, in part, to the closing of state mental hospitals. Seeking pragmatic solutions to homelessness, many organizations expanded their social service missions and created transitional housing programs. At the same time, mental health and chemical dependency systems began to detach the availability of programs and supports from a person's housing, thereby fostering community models that offered support for housing and recovery without predicating one upon the other. The 1987 Comprehensive Mental Health Act for Adults promoted these principles of community-based services. The Act was amended shortly thereafter to include a housing mission statement that maximizes community integration and provides supports regardless of where a person with mental illness chooses to live.

With the passage of the McKinney-Vento Act in 1987 to address the many and complex causes of homelessness, the federal government officially recognized that there is "no single, simple solution to the crisis of homelessness" and their "clear responsibility and an existing capacity to fulfill a more effective and responsible role to meet the basic human needs and to engender respect for the human dignity of the homeless." *McKinney-Vento Homeless Assistance Act of 1987 42 USC 11301 et seq*.

In the past two decades, communities in Minnesota have come together to craft plans and create the infrastructure needed to address homelessness. Created in 1990 to coordinate services and activities of all state agencies relating to homelessness, the Minnesota Interagency Task Force on Homelessness[7] works to effectively use state resources to prevent and end homelessness. Currently ten state agencies serve on the task force to carry out its mission.

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[7] The Minnesota Interagency Task Force on Homelessness identifies, reduces, and eliminates barriers to ending homelessness; maximizes the capacity of the state to effectively access and manage federal and state resources; and directs and advises the Family Homeless Prevention and Assistance Program, created in 1993, and the Continuum of Care which developed the first plans to end homelessness regionally in 1996.

Regional Continuum of Care[8] planning processes provide a coordinated, locally developed system to obtain federal homeless assistance resources to assist homeless persons, especially long-term homeless, to move to self-sufficiency and housing stability. Prevention, emergency shelter, transitional housing, permanent supportive housing, public housing, very low and low-income rental housing, and homeownership opportunities are all important pieces of the continuum and are essential to preventing and ending homelessness. Each Continuum of Care region should have a plan to end chronic and long-term homelessness and will help implement the statewide plan to end long-term homelessness at local, city, county, and regional levels.

Since the first Minnesota Housing Finance Agency, Family Housing Fund[9] and Metropolitan Council consolidated request for proposal process in 1995, the movement towards permanent supportive housing and away from emergency shelter and time limited transitional housing models has become progressively evident with each funding round. These efforts were strengthened with the addition of the Greater Minnesota Housing Fund.

The Corporation for Supportive Housing established an office in Minnesota in 1993.[10] The Legislature funded the Supportive Housing and Managed Care Pilot in 1999, managed by Hearth Connection, to test and evaluate supportive housing models for persons with long histories of homelessness, mental illness and chemical dependency.

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[8] Regional Continuum of Care planning processes provide a coordinated, locally developed system to obtain federal homeless assistance resources to assist homeless persons, especially the chronically homeless, to move to self-sufficiency and housing stability. Continuum of Care planning also addresses prevention, emergency shelter, transitional housing, and other needs in coordination with existing programs - BRIDGES is an example. Each Continuum of Care region should plan to end chronic and long-term homelessness and will help implement the statewide plan to end long-term homelessness at local, city, county and regional levels.

[9] The Family Housing Fund's More Than Shelter Program funds the development of supportive housing for individuals and families who are vulnerable to homelessness. Supportive housing developments provide low-cost housing along with services to address the personal difficulties that have prevented residents from maintaining stable housing, such as chemical dependency, mental illness, or physical health problems. Similar to its rental housing program, the Fund assists supportive housing projects by pooling its funds with other subsidies so that housing providers can meet their costs while charging the low rents that residents can afford. Since 1980, the Fund has spent a total of $17,123,064 to assist 100 More Than Shelter projects. These projects have provided a total of 2,466 of new supportive housing units as well as rental subsidies for 445 individuals.

[10] The Corporation for Supportive Housing provides technical assistance and has committed over $6 million in funding to more than 1,000 new units of supportive housing for disabled, homeless people in Minnesota. These resources also helped put more than 600 additional units of supportive housing into development. Additionally, the Corporation for Supportive Housing has committed over $1 million in grants and offered other capacity building support to more than 50 organizations.

Approximately 2,000[11] new units of permanent supportive housing for persons experiencing homelessness of many different models have been created in the last decade. Hundreds of organizations have participated in the creation, financing and operation of these programs, offering many lessons learned and a solid foundation upon which to build a state plan to end long-term homelessness.

5. Supportive Housing: The Primary Strategy for Persons Experiencing Long-Term Homelessness

This section describes supportive housing, summarizes the evidence demonstrating its effectiveness and reviews several housing with support service developments.

Supportive Housing

Supportive housing is permanent affordable rental housing with linkages to services necessary for individuals, youth and families with children to maintain housing stability, live in the community, and lead successful lives. By providing housing first, supportive housing has the potential to reduce inappropriate crisis costs to health care, mental health, chemical health, corrections, law enforcement, education, child welfare and housing systems or achieve improved outcomes for individuals, youth, and families with children without increasing costs.

Supportive housing provides "housing first" which is based on the premise that issues such as mental illness and chemical dependency cannot be addressed without a stable place to live. Housing stability is needed first, and then an individual, youth or family will be better able to work on other issues that may lead to self sufficiency and better outcomes for the individual, youth, or family with children and society as a whole. Without housing, services and supports cannot be effective. *U.S. Department of Health and Human Services, Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and/or Co-Occurring Substance Use Disorders, 2003.*

Studies of supportive housing nationwide and in Minnesota show a better use of housing and service resources that results in improved outcomes for individuals, youth, and families with children without substantially increasing costs.

Supportive Housing Nationwide

The only longitudinal study that measures the costs and outcomes of housing stability for long-term homeless persons was conducted by the Center for Mental Health Policy and Services Research, University of Pennsylvania, and financially supported by the Fannie Mae Foundation. The study tracked 4,679 homeless persons with serious mental illness who were placed into 3,615 units of supportive housing created by the 1990 New York-New York Agreement to House Homeless Mentally Ill Individuals. The study calculated that long-term homeless

[11] This estimate is based on Minnesota Housing Finance Agency funded permanent supportive housing information from the Corporation of Supportive Housing and HousingLink, *An Inventory of Housing With Support Services in the Seven County Metropolitan Area,* February, 2004.

individuals with severe mental illness used an average of $40,500 (in 1999 dollars) a year in public shelters, corrections, and health care services. For those placed in the supportive housing program, a homeless mentally ill person's use of publicly funded services was reduced by an average of $12,145 (in 1999 dollars) per year. The reduced use of the acute care system nearly offset the costs of supportive housing.

The study showed a 33% decrease in the use of medical and mental health services, a 60% decrease in use of state psychiatric centers; fewer and shorter hospitalizations with a 59% decrease in use of Veterans Administration hospitals and 39.9% decrease in use of private hospitals; a reduced rate of incarceration with a 74% decrease in the use of state prisons and a 40% decrease in the use of city jails; and an 85% decrease in emergency shelter use.

"The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative," by Dennis P. Culhane, Stephen Metraux, and Trevor Hadley, Center for Mental Health Policy and Services Research, University of Pennsylvania, Housing Policy Debate, Fannie Mae Foundation, May 2002.

The Connecticut Supportive Housing Demonstration Program produced 281 units of service-enriched permanent housing for homeless and at-risk populations in nine single site projects with 25-40 housing units. Tenants decreased their use of inpatient medical health services (by 38% for tenants who made their Medicaid information available, by 58% for tenants who stayed in the housing for at least two years, and by 18% for tenants with more severe disabilities). Tenants increased their utilization of necessary ongoing healthcare and support such as homecare, outpatient mental health and outpatient substance abuse treatment that enabled tenants to remain in the community.

Connecticut Supportive Housing Demonstration Program – Program Evaluation Report, Corporation for Supportive Housing, Arthur Anderson LLP, University of Pennsylvania Health System, Department of Psychiatry, Center for Mental Health Policy and Services Research, Kay E. Sherwood, TWR Consulting 1999.

Supportive Housing in Minnesota

Supportive housing in unlicensed community-based settings in Minnesota is relatively new. These programs are built, however, on a strong foundation of state effort to provide community-based housing and services. There are inherent limitations on evaluations of new supportive housing programs making it difficult to track the costs and savings associated with providing permanent supportive housing this early in time. Minnesota is providing effective services for persons experiencing homelessness, as the following examples show a better use of housing and service resources and improved social outcomes:

- **Portland Village and Perspectives: Supportive Housing for Families with Children.** Two supportive housing projects for families with children in Hennepin County, Portland Village and Perspectives, show reductions in the use of county-funded crisis services in child protection, out of home placement, and substance abuse treatment and a shift toward long-term stability in overall service usage.

Crisis costs declined by an average of $6,200 per family and there was a significant shift from crisis services to supportive preventative services. Hennepin County found that supportive housing for chronically homeless families is essentially cost neutral. *Summary of Key Findings to Date on Cost-Effectiveness of Supportive Housing for Families, Hennepin County, April 2003*.

Portland Village is site-based housing and services for families with children, where 60-days of sobriety before entering the program is required. Overall, social service cases, out-of-home placements, social work time, and payments for crisis services declined significantly from the six-month pre-entry to the six-month post-entry period for 18 out of 24 Portland Village residents. *Portland Village Supportive Housing For Families, Six Months Pre and Post Analysis of Service Utilization and Costs, Hennepin County, February 2003.*

Similarly, in Perspectives, payments for crisis services declined significantly from the six-month pre-entry to the six-month post-entry period from 90% to 35% for all 43 families and from 89% to 23% for the 25 families living there at least 6 months and the 8 families who successfully moved into other permanent housing. Perspectives is scattered-site housing with on and off site services, where families primarily came from state prison or treatment centers. *Perspectives Housing For Families, Six Months Pre and Post Analysis of Service Utilization and Costs, Hennepin County, February 2003.*

- **Dakota County Supportive Housing: Supportive Housing for Families With Children.** In Dakota County's supportive scattered-site apartments with private landlords, 89% of the families with children served were still in stable housing six months after their case was closed. Dakota County's Supportive Housing Unit is the primary focal point in directing and accepting referrals for persons with housing needs. Case managers follow the family from shelter to housing and assist them in, obtaining benefits and accessing programs for which they are eligible, working on the necessary skills to successfully live in the community and maintain their housing. Services are delivered on or off site based on the individual needs. Use of mainstream financial resources and access to social service programs is maximized by managing Dakota County's Supportive Housing Unit from the Employment and Economic Assistance Department. *Dakota County Strategies to Combat Homelessness, Dakota County Employment and Economic Assistance, 2003.*

- **Crestview: Supportive Housing for Families with Children.** New Foundations Crestview Apartments, a supportive housing program that delivers services to chemically dependent women and their children, shows improved outcomes for families. In 2003, Crestview served 31 single mothers who came from jails, shelters, and straight from the streets as well as from treatment programs. All were recovering from chronic drug dependency, and all were living at or below poverty level. In addition, 92% were unemployed, 87% has experienced physical and/or sexual abuse, 85% had criminal histories, 55% had the dual diagnosis of chemical dependency and mental illness, and 31% had lost permanent custody of one or

more of their children. During the year, 75% found employment and/or enrolled in school, 12 out of 14 children were reunited with their mothers, and 89% of school-age children completed the entire academic year at the same school. All of the families were enrolled in regular health clinics. *"Target Digs New Foundations," Pamela S. Lund, Women's Business Minnesota, December 2003.*

- **Supportive Housing and Managed Care Pilot: Supportive Housing for Families with Children and Individuals.** The Supportive Housing and Managed Care Pilot is a demonstration project that to date has partnered with 83 families with 241 children and 87 single adults who have long histories of homelessness. Under the auspices of the Minnesota Department of Human Services, it began in March 2001 and is scheduled to be completed in June 2007. Ramsey County and Blue Earth County host the pilot. Hearth Connection leads the public-private initiative.

  The Supportive Housing and Managed Care Pilot incorporates fundamental aspects of systems change: participants getting what they want and need; systems working together to help participants attain these outcomes; and cost justifications and mechanisms for financing a statewide effort to end long-term homelessness. Early findings from an independent evaluation being conducted by the National Center on Family Homelessness indicate that the project is making significant progress in all three of these areas. *The Supportive Housing and Managed Care Pilot, Process Evaluation: Year One, Prepared for Hearth Connection by The National Center on Family Homelessness, February 2003.*

  Although the expected quantitative cost and utilization study will more definitively determine whether and how the pilot impacts service use patterns, decreased use of detox facilities is reported for single participants and increased use of primary care doctors is reported for both singles and families. *The Supportive Housing and Managed Care Pilot, Qualitative Evaluation: Year Two, Prepared for Hearth Connection by The National Center on Family Homelessness, January 2004.* Blue Earth County reports that child protection incidents have decreased by 57% among participants since enrollments began. School attendance has significantly improved for school age children of the families participating in the pilot.

- **American House and Wilder Apartments: Supportive Housing for Individuals.** The Wilder Single Room Occupancy Housing Program provides 127 units of housing with for single adults with available services to help residents find employment, obtain medical care and manage mental health issues, secure transportation, maintain sobriety, and address financial matters and other challenges. Residents reported achievement of greater stability in their lives by: improving their general living situation (89%); being employed and/or enrolled in school (79%); and reduced personal problems and barriers to self -sufficiency. *Amherst H. Wilder Foundation Single-Room Occupancy Housing, May 2001.*

- **Anishinabe Wakiagun: Safe Haven Supportive Housing for Individuals.** Anishinabe Wakiagun in Minneapolis provides unique permanent housing environment in which sobriety is encouraged for chronically intoxicated homeless men and women. Residents typically have twenty or more admissions to detoxification centers in the last three years, multiple police interventions, two or more attempts at chemical dependency treatment, use of hospital emergency room services, physical deterioration due to alcohol use, show evidence that they are incapable of self-management due to alcohol use, and have been homeless for most of the last five years.

  The average cost for one admission to area detox is $300. Anishinabe Wakiagun's costs to provide board, lodging, and supportive services to this population are about $18,750 per year per person. Because this program is provided in a licensed boarding lodge with special services, the state-funded Group Residential Housing program (GRH) can provide up to $16,628 of the $18,750 per year per eligible resident. A March 2003 Analysis of Hennepin County's Housing For Chronic Inebriates, suggests that providing supportive housing for the 120 residents of Anishinabe Wakiagun and the Glenwood prevented 1,032 detox admits at approximately $300 a visit and reduced the median cost of health care from $9,297 per year to $5,218. This program stabilizes the living situations of these individuals resulting in a better standard of living at a lower cost.

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6. Response to Specific Charges from the Legislature

6.1 Key characteristics of individuals, youth and families experiencing long-term homelessness.

This section identifies the key characteristics of individuals, youth and families with children experiencing long-term homelessness and provides data regarding the characteristics.

Key Characteristics of Persons Experiencing Long-Term Homelessness

According to the *Statewide Survey* approximately 3,300 individuals experience long-term homelessness over the course of a year, which includes 2,800 adults and unaccompanied youth and 500 children.

Characteristics:

An individual, unaccompanied youth, or family with children:

- who has either lacked a permanent place to live continuously for a year or more,
- at least four times in the past three years,
- or prior to any incarceration or institutionalization.

Additional characteristics may include: mental illness, chemical dependency, or co-occurring mental illness and chemical dependency, domestic abuse and neglect, criminal history, cognitive limitations, chronic health conditions (including HIV/AIDS), among others.

These conditions will not be used as an eligibility standard, but to gain understanding of population needs in order to develop appropriate plans for housing and services.

Examination of the barriers, other than income that persons experiencing long-term homelessness report, is useful in planning for service needs and appropriate housing models.

Mental illness, chemical dependency and co-occurring mental illness and chemical dependency are prevalent in individuals experiencing long-term homelessness. Chronic health conditions, domestic violence, and criminal history are also likely to affect the length of time a person might be homeless. One in seven (14%) of the persons experiencing homelessness for a year or more are children.

It is important to note that (excluding persons that may have difficulty getting or keeping housing due to mental illness, alcohol or chemical abuse, criminal background, abuse of others, physical disabilities, less than a high school education and unemployment), it is estimated that about 10% of persons experiencing long-term homelessness just need affordable housing because they did not report barriers that indicate a need for additional services. *The Statewide Survey.*

Mental Illness and Chemical Dependency Data:

Of the adults and unaccompanied juveniles identified as long-term homeless:
- 52% reported a serious or persistent mental illness
- 33% reported a chemical dependency problem
- 24% reported a dual diagnosis of both mental illness and chemical dependency

Of all long-term homeless unaccompanied juveniles:
- 39% reported mental illness
- 15% reported a chemical dependency problem
- 42% have considered suicide; over half (54%) of those who have considered have attempted suicide

Other Characteristics Data:

Of the adults and unaccompanied juveniles identified as long-term homeless:
- 47% reported a chronic health condition
- 30% possible brain injury
- 24% reported a history of domestic violence
- 26% had a criminal history affecting their housing status
- 16% are military veterans
- 22% were placed in foster care as a child

Race/Ethnicity Data

- 36% African American
- 2% African Native
- 8% American Indian
- 1% Asian/Pacific Islander
- 43% White
- 3%Other Race
- 6% Hispanic/Latino

Data on Children:

Of the children in families headed by chronically homeless adults and juveniles:
- 43% lived with a parent who reported a serious mental illness
- 12% lived with a parent who reported a serious alcohol or chemical dependency problem

Of children with chronically homeless families that did not report mental illness or chemical dependency:
- 19% lived with a parent with a chronic health problem
- 11% lived with a parent who had been a victim of domestic violence
- 6% lived with a parent who had a criminal history

The Statewide Survey.

Hennepin County Data on Families with Children:

200 families with significant risk factors in Hennepin County reported:

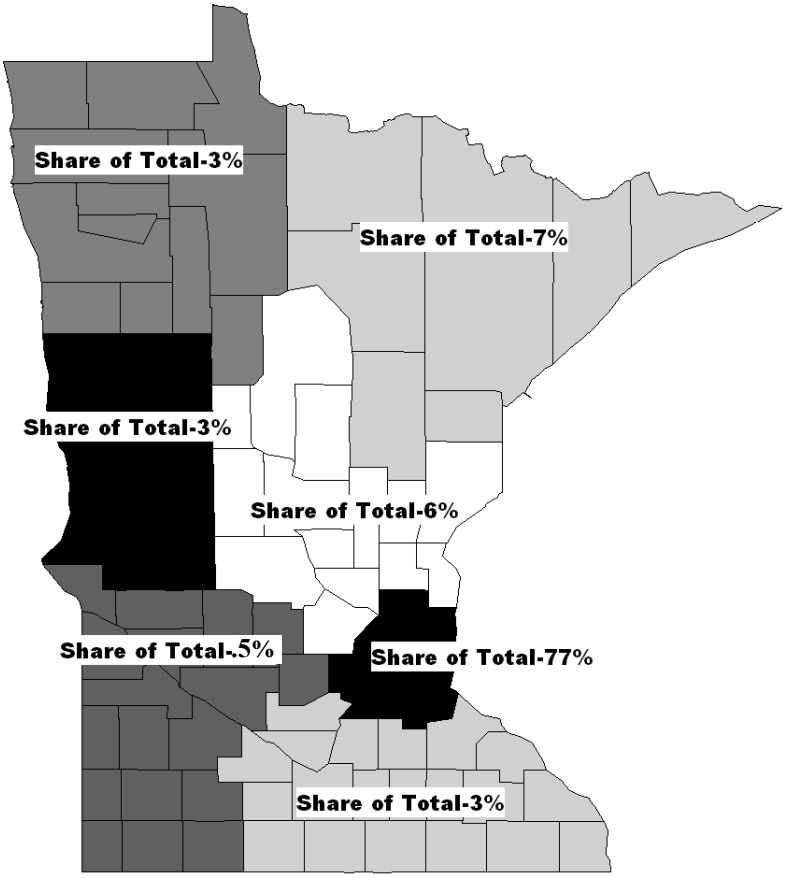
95% domestic violence
89% criminal history
85% chemical dependency
70% mental health issues
63.5% use of cash grants or Food Stamps
53% homelessness

Hennepin County 200 Families Phase 1 Report, 1997 and Phase 2 Report, 1999.

Geographic Distribution:

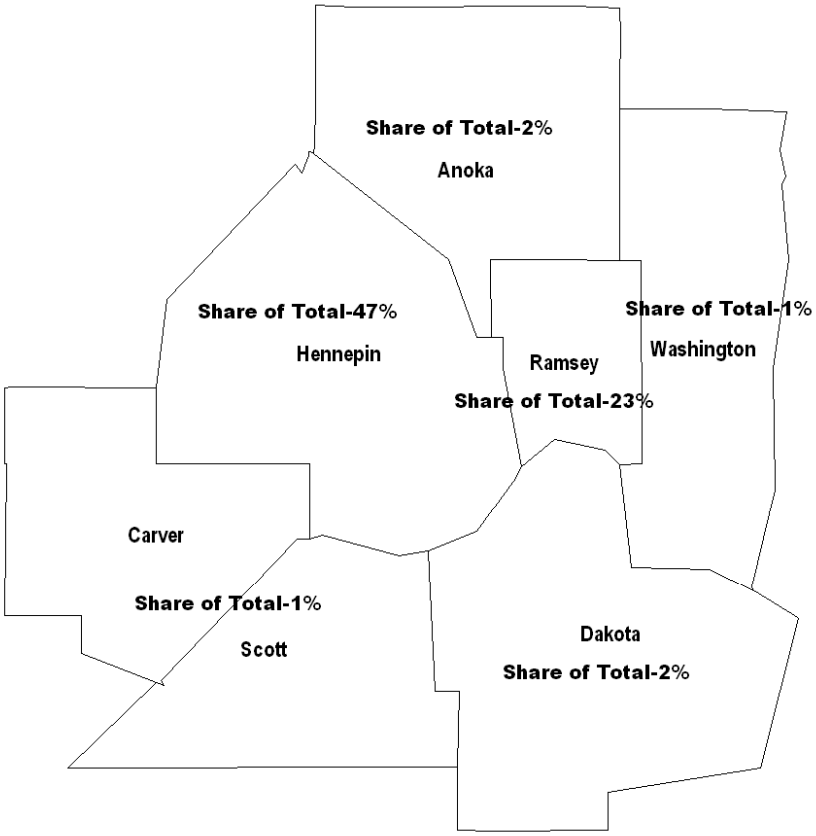
Approximately 75% of individuals, youth, and families with children experiencing long-term homelessness are located in the seven county Twin Cities Metropolitan Area and that 25% are located in Greater Minnesota, primarily in and around Duluth, Mankato, Moorhead, Rochester and St. Cloud.

Distribution of Persons Experiencing Long-Term Homeless by Region, 2003



The Statewide Survey

Distribution of Persons Experiencing Long-Term Homeless by County, 2003



The Statewide Survey

6.2. Housing with support service models that address the different needs of individuals, youth and families experiencing long-term homelessness

This section sets forth the principles adopted by the Working Group and identifies housing options and service choices.

Principles

The Working Group adopted the following principles to guide the selection of housing and support service models for individuals, youth and families with children experiencing long-term homelessness. These principles are vital to carrying out the goal of ending long-term homelessness of individuals, youth and families with children in Minnesota.

- Maximize choice of housing and services for families and individuals; ensure flexible housing and service options that respond to need.
- Encourage families and individuals to utilize services, but do not mandate services as a condition of tenancy in all cases.

- Utilize innovative practices that result in reduced costs and use evidence-based models for service and housing that have demonstrated positive results.
- Prioritize models that connect families and individuals in communities near public transportation and services.
- Provide the necessary housing tenancy supports to find and maintain housing, a critical service need for persons who have experienced long-term homelessness.

Housing Options and Service Choices

One of the most important principles is to maximize choice of housing and services for families and individuals and ensure flexible housing and service options that respond to need. An array of housing options must be available at the time that an individual, youth or family with children needs housing so that they may obtain the right housing type and situation to meet their needs, and not take the only available option which may not be the best option to provide ongoing housing stability. Housing and tenancy supports to find and maintain housing are necessary, but it is even more crucial that the supports are flexible to meet the needs of the individual, youth or family with children as their needs change over time. As needs fluctuate, housing and services must change to meet those needs. For a more detailed discussion, refer to Housing Options and Service Choices, Appendix at A-209.

Housing Options

Housing should be provided to individuals, youth and families through a range of options: leasing rental units, rehabilitating existing units, and developing new units. All housing must be affordable.

Types of housing include:

- scattered-site single family homes, townhouses, duplexes or apartments;
- clustered apartments;
- small single-site developments (4-12 units);
- medium single-site developments (13-30 units);
- large single-site apartment buildings (31+ units);
- single-site SRO: single room occupancy (may have shared bath and kitchen); or
- other housing types.

Housing should be provided through new construction and acquisition or rehabilitation of existing units.

The housing options for individuals, youth and families with children are the same: housing first is the primary goal for all. Additionally, a housing safe haven that is inappropriate for families with children, works well for some individuals. For some individuals who have experienced long-term homelessness for many years, outreach and engagement are key and a safe haven may be preferable as a step between the streets and permanent housing. A tiered or phased approach providing a permanent housing safe haven or service model of harm reduction may be most

appropriate to engage individuals who have mental and chemical health issues. Supportive housing works better for young adults than for unaccompanied youth who benefit from family centered housing support. [12] For families with children, providing housing first with appropriate services, including harm reduction, in some cases, is the only option that makes sense.

Single Site: Single site developments work well for individuals, youth and families with children and are inducive to on-site services. Single site developments for individuals and youth may be small to provide ongoing intensive services, medium to large with the level of services to fit the needs of residents, or larger single room occupancy developments where a less intensive level of services is needed for housing stability success. Single site developments for families may be medium to large and may provide services on site or in the community.

Smaller projects are preferable from a community-building standpoint; however, larger projects are better from the standpoint of development and operating cost efficiencies. With single site supportive housing there is a service economy of scale within a safe environment where there is an opportunity to see others succeed.

Individuals and families may choose to leave the community as they stabilize, or may wish to leave the community due to issues with oversight. Individuals and families may also be resistant to change when they are otherwise ready to leave the community. As individuals and families stabilize, the reduction in services may inhibit the economy of scale; however, stabilized individuals and families may provide hope and support to others. Careful attention to the mix of residents is necessary. Services as needed could be provided on site or in the community. There will likely be difficulty in siting new single site developments.

Clustered or Scattered-Site: Scattered-site single-family homes, townhouses, duplexes or apartments and clustered apartment models also work well for individuals, youth and families with children. With scattered or clustered site units, individuals and families are prepared to function in the community, identify and access services as needed, and may remain in community as they stabilize. Some individuals, youth, and families with children prefer to live in scattered-site units. Yet, individuals and families may feel isolated. Scattered-site supportive housing may not be appropriate immediately following treatment. Service delivery to unit may be inefficient and costly. Incentives for mixed-income development projects to include supportive units are needed.

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[12] Supportive Housing or transitional living programs are almost always not the answer for 12 to 16 year old unaccompanied youth experiencing long-term homelessness. Youth need families and family-centered housing support. Alternative placements should be provided by child protection services. For some 16-17 year olds, supportive housing or transitional living programs may be the best option. There is great demand for supportive housing for 18 to 22 year olds transitioning out of out-of-home placements that may be experiencing developmental disabilities due to childhood trauma from physical abuse or neglect.

Service Choices

Service choices will depend on the service needs of the individual, youth, or family with children. Services can be delivered either on-site or off-site, with the exceptions of front desk and security staffing.

There are three categories of service needs that will impact the choice of housing options:

- outreach and engagement;
- intensive services; and
- stabilization.

Services choices identified by the Working Group include, but are not limited to:

- outreach and engagement,
- housing and tenancy-related support, including access to rental assistance
- case management
- assessment
- service planning and coordination
- assistance applying for other programs and benefits
- employment
- education and training
- financial management
- chemical dependency support
- mental health and trauma-related support
- domestic abuse, violence and safety planning
- crisis planning and response
- health care, including HIV/AIDS/STD education and support
- criminal justice resolution and diversion
- transportation
- stress reduction
- recreation
- social supports

With families, there are some unique support needs:

- parenting,
- child safety,
- development,
- health and education,
- child care,
- respite, and
- reunification.

Housing Tenancy Support Services

Housing tenancy support services are those services necessary to assist a household in finding and helping them maintain suitable housing. Housing tenancy support services can include services such as a concierge-like watchful eye or front desk service that alerts supportive service providers when a tenant appears to need some additional attention.

Virtually all of the persons experiencing long-term homelessness initially will need some form of housing tenancy support services. The lack of a recent, positive rental history will need to be overcome in order for persons experiencing long-term homelessness to be housed in the private sector. Several good models for providing these services exist; these models are most often funded by the Family Homeless Prevention and Assistance Program and the Hard-to-House tenant pilot program. These programs serve relatively small numbers of households each year and are not entitlement programs. The lack of stable funding and inadequate amounts of funding is the biggest barrier to providing these services.

6.3. Existing resources that may fund the models for individuals, youth and families who are experiencing long-term homelessness. Gaps in capital, operating, and service funding that affect the ability to develop supportive housing models

Capital, operating and service funding resources, gaps, and strategies to fill the gaps are discussed individually in this section.

6.3.1. Resources

A complete listing of relevant federal and state capital, operating and service funding, see the Department of Human Services, Minnesota Housing Finance Agency, Department of Employment and Economic Development, and Department of Corrections Funding Catalogs is found in the Appendix at A-1, A-17, A-25 and A-45, respectively.

6.3.2. Gaps

Capital Costs

Capital costs are the costs of the "bricks and mortar" of supportive housing (including common or service space), whether new construction, acquisition, or acquisition and rehabilitation.

The gaps in capital funding are twofold. First, the demand for capital funding far exceeds the amount of funds available. Typically, in any MHFA funding round requests are four times the amount of funds available. Second, the costs of new construction of supportive housing have tended to be even higher than comparably sized affordable rental housing.

Operating Costs

Operating costs are the costs of maintaining the property (taxes, insurance, utilities, maintenance, reserves, any debt service). Operating costs may be covered by tenant rent payments or rental

subsidies, if tenant incomes are insufficient to pay rent. Congress has provided no additional vouchers since fiscal year 2002. Approximately 1-in-4 low-income families eligible for vouchers receives any type of federal housing assistance. Criminal histories, particularly for drug offenses, may be a barrier to use of federal rental assistance for some persons.

The largest gap in operating funds for supportive housing is caused by the fact that the incomes of persons experiencing long-term homelessness are usually insufficient to pay rent to cover the operating costs of housing or supportive services. Only 25% of all persons experiencing long-term homelessness reported an income of over $800. *The Statewide Survey.*

Persons who are able to work full-time are often not able to secure full-time work on a regular basis or with a high enough wage to cover market rate rents. Not all persons are receiving all of the income supports for which they are entitled. Current income supplement programs for the disabled and for very low income families are inadequate to pay market level rents in many instances.

Services

Supportive services costs include the costs of outreach and engagement, crisis management and intervention, health care, case management, life skills, employment and training services and housing tenancy support services necessary to support stable housing. Support services in housing with supports are typically a subset of all health and human services needed or available to a family or individual.

Some, but not all necessary services can be provided by or fully paid for under current programs and current funding levels. There are, however, a number of support services that are needed by persons experiencing long-term homelessness that lack a source of funding or that cannot be funded under mainstream programs. Funding levels for some services that can be provided under mainstream programs are inadequate. New ways to stabilize service funding even as tenant needs change or they move out are essential. Start-up program funding can also be an issue for some models of supportive housing.

There is a great deal of pressure at the federal, state, and local level to control Medical Assistance costs. Costs are controlled through a variety of mechanisms including eligibility, payment rates, billing and reporting requirements. One of the challenges over the next several years will be to determine if cost savings in other service systems such as crisis support or in-patient treatment can be captured to help off-set increased expenditures in MA or other support services.

Examples of areas where service funding gaps exist are in outreach and engagement and housing tenancy support services. Research on best practices shows that for some individuals experiencing long-term homelessness, intensive outreach and engagement services are vital. For a variety of reasons, many people experiencing long-term homelessness are often resistant to and suspicious of attempts to engage with service providers. Establishing a trusting relationship requires frequent and consistent attempts at outreach. This process cannot be viewed as a short-term intervention; rather it is a process that requires multiple contacts over an extended period of time.

Housing tenancy support services for persons experiencing long-term homelessness pose a special funding challenge because there is no single definition of these services nor is there a single funding stream currently available to pay for them.

In addition to gaps in resources, a number of other issues affect the provision of supportive services including the complexity of Medicaid programs, the requirement of individual eligibility, and the lack of flexible funding for services that cannot be covered by traditional social service programs.

Minnesota has a state-supervised, county-administered human service system. Under this system, the county is the direct manager of human service programs. This has the advantage of allowing for planning to address local needs but there is variation in the amount and range of services provided across counties. Counties provide the required financial match for a number of important health and human service programs. Changes at the state or federal level in how existing programs are accessed, or increases in the scope of services or utilization mean increases in county funding requirements. Not all counties would be equally able to address this funding challenge.

Because of these issues, it is very difficult to determine in advance the percentage of funding from public sources that might be available for new housing with support service programs. Based on Department of Human Service's estimates, the contribution of mainstream programs under current law and funding levels is not expected to exceed 50% of the cost of necessary services.

Basic structural issues between the housing development and human service system also need to be addressed. Strategies need to be developed that address the fact that supportive housing involves two systems – housing and supportive services – with incompatible delivery mechanisms. Housing assistance – at least in terms of development and redevelopment – is delivered through a property. Supportive services are delivered to an individual and, except for those persons who are institutionalized, the services follow a person to wherever they happen to live. Merging these two systems is a significant challenge.

Housing providers need to feel confident that the services needed for a resident to remain a good tenant are secure over the long-term. Service funding works on a much shorter time frame that is tied to state and local government budget cycles. In many cases, efficiencies of scale from a housing provider's standpoint would attach services to the housing so that a large portion of the residents would have access to the services. From the service provider's perspective, individuals or households and not supportive housing projects or other groups are deemed eligible for a program's benefits. It is necessary to determine eligibility on an individual basis and services must be tailored to each individual's unique needs and cannot be provided as one size fits all.

Furthermore, there is a great deal of concern about not recreating the institutional setting that failed in the past. The principles adopted by the Working Group related to consumer choice and matching the provision of services to demonstrated individual need should be maintained as funding strategies are explored. The Working Group process has demonstrated that there is no "silver bullet" strategy to integrating the housing and social service delivery systems. However,

a number of incremental strategies were identified that should be explored as set forth below. The aggressive pursuit of these strategies could result in the "system change" that is necessary to better integrate housing and service funding streams for the purpose of providing housing and necessary support services to persons experiencing long-term homelessness.

6.3.3. Strategies to Address the Gaps in Capital, Operating and Services Funding

This part describes a wide array of strategies that might be employed to address the gaps identified in the Working Group, by cost category. There are a number of possible changes that should be explored over the next several years. Not every avenue that is explored ultimately will be productive. It will be noted where there are immediate opportunities to pursue a strategy as part of the business plan.

The goal of providing housing and necessary support services for individuals, youth and families with children experiencing long-term homelessness can be attained with maximum access to federal resources, reallocation of state resources, change within existing systems, and development of additional resources from federal, state and philanthropic sources. More cost-effective services and delivery mechanisms must go hand-in-hand with increases in resources.

Given the estimated size of the population, long-term homelessness in Minnesota is a manageable problem that should be able to be solved. The system change necessary to accomplish the goal of ending long-term homelessness will have a positive impact on the entire housing and service systems serving individuals and families experiencing homelessness.

6.3.3.1. Capital Cost Strategies

Increase Funding for Capital Costs:

General obligation (GO) bond proceeds are one useful resource to meet capital costs of supportive housing. The 2004 capital bonding legislation is an opportunity to increase this resource.

Federal tax credits are the largest source of equity for low- and moderate-income rental housing development. The Minnesota Housing Finance Agency's allocation and selection plan will prioritize permanent supportive housing for persons experiencing long-term homelessness. A combination of state GO bond proceeds and tax credit syndication proceeds may be an effective combination of resources; however, a number of legal issues complicate the coordination of these two resources. Every effort should be made to determine whether and how these two resources could be effectively combined.

General obligation bond proceeds may be an attractive resource for public owners to use to purchase the land for supportive housing and establish a land trust. Federal tax credits could possibly be used to assist with the financing of the building. Creative use of resources should be encouraged.

Increases to state appropriated programs that fund capital costs, such as the Housing Trust Fund, can help fill the capital cost gap as well as some reallocation of state appropriated funds.

Community Development Block Grant (CDBG) funding is a potential federal resource for both capital costs and services costs. Consideration should be given to the consolidation of CDBG activities with Continuum of Care efforts and other resources in order to access and target assistance to end long-term homelessness in local communities.

Capital Cost Efficiencies:

Factors such as the site, the availability of other community space nearby, and community concerns will impact a project's costs. Efforts must be undertaken to reduce development costs while not jeopardizing quality.

The process by which funding is committed and loans are closed must be continually reviewed and efficiencies implemented.

Continued efforts are necessary to examine, develop, and apply cost reduction strategies in four areas: design, technology, building delivery systems, and land, regulation, and siting.

- Design: design strategies warrant further exploration including: a uniform or standard design for the interior spaces; smaller sized units; simplified rooflines; standardized building platforms and unit sizes; inter-changeable pre-built components; simpler cabinets and utilization of inmate-built cabinets and other components. The size, configuration, and need for community or program space should be thoroughly analyzed for each project.

- Technology: Certain technological innovations show promise for cost savings in construction and/or ongoing operating costs. Alternatives to costly full basements; systems to improve moisture control; less costly wall, floor, and roof systems; and durable, maintenance free, energy efficient windows should be utilized.

- Building Delivery Systems: The building delivery system including the bid process, change orders and construction oversight should be re-examined to improve efficiencies.

- Land Use Regulation and Siting: Further examination should be given to incentives for local units of government to ease land use regulations that add to the costs of developing supportive housing and to remove barriers to siting supportive housing. It will be necessary for state, local government and other community leaders to help resolve issues that make it difficult to site housing for those experiencing long-term homelessness.

- The Department of Corrections has seven Institution/Community Work Crews (ICWC) building affordable workforce housing in Greater Minnesota in partnership with five different nonprofit agencies. These programs vary in cost efficiency due to the skills and abilities of the carpenters, developers and general contractors

involved. The developers are typically able to reduce the labor cost in houses built by approximately 50% by using ICWC. The Department of Corrections also has a very large cabinet shop at MCF-Faribault that is capable of providing cabinets, pre-finishing of millwork and other services or products at very competitive rates.

6.3.3.2. Operating Cost Strategies

Increase Access To Income Supplements:

Income maintenance programs reduce the need for rental assistance since they increase the amount of a tenant's contribution to rent. The following are several strategies to increase income for eligible persons experiencing long-term homelessness.

- Minnesota Supplemental Assistance (MSA): Expand eligibility for Minnesota State Supplement shelter needy assistance to individuals leaving Rule 36 Mental Health treatment facilities. Persons who had experienced long-term homelessness before entering treatment facilities may benefit from this change. This change would increase their income and lower the amount of operating costs or rental assistance subsidy to serve them.

- SSI Outreach and Assistance: Establishing eligibility for SSI brings not only increased income to the household and potentially reduces the costs to the State for state-funded income supports, it also leads to Medical Assistance eligibility, which in turn means expanded opportunities for supportive services reimbursement. One immediate strategy that DHS will implement is to increase funds for efforts to educate persons experiencing homelessness about SSI and MA eligibility criteria, benefits, and application procedures and to assist in the application and process and establishment of eligibility. Much of the work currently being been done around SSI eligibility is focused on the appeal process after a denial of an application for benefits.

- The federal government also has recognized the importance of this strategy and issued a request for proposals for funding for long-term homelessness outreach and evaluation. At least four providers in Minnesota have applied for federal funding; decisions are expected early 2004. Minnesota should pursue any future opportunities for federal funding for this activity.

- Group Residential Housing: Expand the availability of Group Residential Housing base funding to Housing with Service settings for persons experiencing long-term homelessness funded with state bond proceeds, described in the business plan. This will significantly increase the contribution to rent that an eligible tenant can provide in these settings.

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Increase Availability of State-funded Rental Assistance or Operating Cost Subsidies:

State funding for rental assistance or operating cost subsidies will be increased on a temporary basis from MHFA resources. Resources will be made available in 2004; however, these resources will be exhausted in six-seven years.

Increases to State appropriated rental assistance programs such as Housing Trust Fund and Bridges could also help fill this gap.

Increase Availability Of Federally-Funded Rental Assistance:

Section 8 rental assistance subsidizes the difference between a HUD-established fair market rent (FMR) and 30% of a tenant's income. Without additional rental assistance for persons experiencing long-term homelessness, or other funds becoming available that would mitigate the need for on-going rental assistance, the goal of ending long-term homelessness cannot be accomplished.

Local housing authorities should also be encouraged to re-examine their preference for Section 8 and consider adding a preference for persons experiencing long-term homelessness, if they have not already done so.

Maximize Utilization Of Project-Based Section 8 Assistance:

Project-based assistance is Section 8 rental assistance that attaches to a unit of housing as opposed to traveling with a tenant. Project-based assistance is an effective tool in providing operating cost subsidies for supportive housing.

Local housing authorities should be encouraged to project-base the maximum allowable amount of Section 8 assistance. A number of local housing authorities have been very responsive to the needs of the residents of supportive housing for rental assistance. Currently no housing authority has converted the 20% maximum vouchers to project-based assistance. HUD regulations should be reassessed in light of the need to provide ongoing rental assistance for persons experiencing long-term homelessness. Federal, state and local officials, and funding partners should work together to address this gap in operating cost subsidies.

Maximize HUD McKinney-Vento Funding for Supportive Housing:

Provide technical assistance to new permanent supportive housing developments within each Continuum of Care region to ensure access to the full amount of federal homeless assistance funding.[13] Strategically use McKinney Vento operating and service funds to serve persons experiencing long-term homelessness that may not be eligible for state-funded supportive housing.

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[13] The State of Minnesota could have obtained an estimated additional $3.4 million in McKinney-Vento funding in 2003.

Re-entry Housing:

The Department of Corrections will undertake increased efforts to address the issue of re-entry housing for offenders in transition from incarceration to the community, possibly including: temporary board and care, ¾ way houses, halfway houses, and increases to the emergency fund. Offenders who meet the Department of Corrections risk criteria for housing services and who experienced long-term homelessness prior to incarceration will be eligible to receive assistance in these efforts. The Department of Corrections will provide data regarding offenders who have experienced long-term homelessness who receive assistance in these efforts. The Department of Corrections will consult with the Department of Human Services and the Minnesota Housing Finance Agency in regard to the Corrections re-entry housing efforts through the interagency decision-making process established by this initiative.

Licensing of Supportive Housing:

Some types of licensing or registration of supportive housing may assist in accessing additional funding.

6.3.3.3. Service Cost Strategies

Service cost strategies address previously discussed funding gaps by identifying ways to maximize the use of existing DHS programs and federal match where available. Since service funding gaps cannot be addressed solely with existing resources, a number of funding priorities are also delineated if new resources are made available in the future.

After a review of Minnesota's Medicaid programs, the Department of Human Services has determined that every effort has been made to make them as broad and flexible as is permissible under current federal law. Federal and state programs and policies, including discharge practices, should be reviewed continually for opportunities to improve services and provide increased flexibility and choice for persons experiencing long-term homelessness.

Provide Flexible Funding:

New resources are needed for those services not currently eligible for funding under existing programs or for unanticipated costs. DHS will contribute funding on an annual basis, beginning in 2004, to a pool of flexible funding to be created for housing with support projects applying to the MHFA Super RFP process. Funding could be used for one-time costs, to help leverage other service funding resources, or to support housing tenancy support services needed by persons experiencing long-term homelessness.

- One resource for this fund is mental health client service funds now used for housing subsidies. MHFA has agreed to provide funds from its own resources, on a temporary basis, to increase the funds available under the Bridges program so that the amount of funding for housing subsidies for persons with a mental illness remains stable while service funding increases. The long-term funding of this increase to the Bridges program will need to be addressed in the future.

- Emergency Shelter is an important part of the continuum of care for persons experiencing homelessness. At present, Group Residential Housing (GRH) is a source of funds to pay for services for persons in shelters. DHS proposes to make GRH funding more flexible so that it could also be used for to pay for supportive housing services. The purpose of this change would be to better serve persons experiencing long-term homelessness who are now reliant on shelters, but who would be better served by supportive housing. Approximately $600,000 per year could be used in this more flexible fashion. There is a reasonable expectation that, as the supply of supportive housing for persons experiencing long-term homelessness is increased, the demand for emergency shelter space will be reduced.

- Minnesota has been a leader in providing transitional housing, which is a form of supportive housing (generally shorter-term). DHS currently operates a program that provides funding for transitional housing, but these funds are limited by statute to programs with 24-month residency limits. In order to serve the needs persons experiencing homelessness who need longer-term support, DHS proposes to change the Transitional Housing Program so that programs that provide support beyond 24 months would be eligible for up to 10% of this funding pool or $300,000. This change, as well as the proposal to make GRH funding more flexible, may have the potential of leveraging federal funding by facilitating the use of waivers.

- Legislation for the GRH and Transitional Housing Program changes may be necessary. The challenge with increasing flexibility in these programs is to avoid adding to the problem of homelessness with these changes.

Target New Funding:

If additional funding is made available, it could be targeted to persons who are not currently receiving the level or type of services that they need, due to inadequate funding. For example, programs such as Assertive Community Treatment, Targeted Case Management, ARMHS or MA waivers could provide the appropriate intensity of services for persons who have a severe mental illness so that they can maintain stability.

Increase Availability Of Technical Assistance:

Provide information on service funding resources and other DHS programs and work with housing developers or providers interested in serving persons experiencing long-term homelessness.

Coordinate with Rule 36 Restructuring and Mental Health Initiatives:

As part of the restructuring of adult mental health residential services, DHS is currently working with multi-county planning groups to enhance the capacity of some of these facilities to provide more intensive, short-term treatment, to convert a percentage of current funding to a range of permanent supportive housing options and to develop ACT teams. Persons who have

experienced long-term homelessness may benefit from improved access to intensive community-based services. DHS will consider the needs of persons experiencing long-term homelessness as the restructuring of this program progresses.

Chemical Dependency Case Management Option:

A new service option will soon be available for persons with chemical dependency who could benefit from case management or service coordination. The new treatment service licensing rule, which is scheduled to be implemented on September 1, 2004, adds case management as a service that can be provided by licensed chemical dependency treatment providers. This should allow counties and tribes to contract with providers and pay for case management for individuals who are eligible for the Consolidated Chemical Dependency Treatment Fund. These services could follow an individual into a variety of housing settings. The Chemical Health Division of DHS uses federal Substance Abuse Treatment and Prevention block grant money to fund case management services for chronically chemically dependent individuals. Provision of this service is based on a Request for Proposals and is dependent on available funding and the quality of proposals received by the Chemical Health Division.

Redirect State Funding In PATH Projects To Other MH Service Models:

DHS proposes to use state funding in PATH projects to maximize federal reimbursement. In order to access additional federal reimbursement for those individuals who are Medical Assistance (MA) eligible, State funds could be used as the match for MA programs such as Assertive Community Treatment (ACT), Adult Rehab Mental Health Services (ARMHS) and Targeted Case Management. Currently there are eight counties across the state receiving Project for Assistance in Transition from Homelessness (PATH) funds that serve homeless people who have a serious mental illness or concurring mental illness and substance abuse.

Work With Existing DHS Workgroup On Case Management Reform:

The workgroup will be asked to address issues specific to persons experiencing long-term homelessness. This group is to report to the legislature in 2005. In redesigning these services, the needs of persons experiencing long-term homelessness must be kept in mind as well as how supportive housing can assist with the delivery of case management services.

Work with DEED on Employment Support Services for Persons with Mental Illness:

Encourage supportive work programs for persons with mental illness experiencing long-term homelessness as a component of supportive services in the future.

Partner With Counties To Develop Capacity:

Counties are both a funding source and a deliverer of services, and as such, have a critical role in addressing long-term homelessness. Counties should continue to be involved in the development and implementation of strategies to achieve the goal. Consideration must be given to county budgets when program changes are contemplated that require funding for the non-federal share of program costs.

Discharge Planning:

Develop and implement policies for the discharge of persons from publicly funded institutions or systems of care to prevent persons being discharged from immediately becoming homeless. These institutions and systems of care include health care facilities, foster care or other youth facilities, and corrections programs and institutions.[14]

Support Federal Ending Long-Term Homelessness Services Initiative (ELHSI):

The initiative creates a new federal program that would provide individuals and families who experience long-term homelessness with the full range of services they need to stay off the streets. If funded, this program could alleviate some of the difficulty faced by providers of housing with supports services. The Congressional delegation has been encouraged to support this initiative.

Metropolitan Area Regional Planning:

The state agencies will support the work of the counties in the Twin Cities metropolitan area in developing collaborative policies on long-term homelessness issues between counties.

Technical Assistance:

Increased efforts should be made to provide technical assistance to nonprofit organizations and others in areas of the state with a limited capacity to develop supportive housing.

6.4. Interagency decision-making process and a plan to fund supportive housing.

See business plan at Section 7.

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[14] In order to prevent discharge from resulting in homelessness, the State begins the process of discharge planning when a person enters an institution, not when he or she is ready to be released; ensures that all other services needed and all available entitlements are secured prior to discharge; and that all stakeholders are included in the discharge planning process. Prior to discharge, an assistance plan is established for persons who receive treatment for mental illness, mental retardation or chemical dependency in a regional treatment center, for youth in foster care programs, and for offenders released from a correctional facility. The plan provides case management services, assistance in finding housing, employment, adequate medical and psychiatric treatment, and aid in the readjustment to the community.

7. Recommendations and Next Steps: A Business Plan to End Long-Term Homelessness by 2010

The plan must include an estimate of the statewide need for supportive housing, an estimate of necessary resources to implement the plan, and alternative timetables for implementation of the plan. It will propose changes in laws and regulations that impede the effective delivery and coordination of services for the targeted population in affordable housing.

This section provides the principal recommendations and business plan of the Working Group based on the information, analysis and discussions that have been part of the Working Group process. A detailed description of the major assumptions upon which the business and financial plan is based is set forth in the section of the report titled "Business Plan" assumptions following the conclusion at section 8.

7.1. Vision and Goal.

The vision of the Working Group is to end long-term homelessness for all individuals, youth, and families with children in the state of Minnesota by the end of 2010. As a result, the goal is to making housing and service options that allows persons who have experienced long-term homelessness to be successfully housed over the long-term. As this vision and goal are pursued, it is important to not lose focus on the needs of the broader homeless population and those who are at risk of homelessness. The broader homeless situation should be improved, not worsened, as a result of proceeding to implement these recommendations.

7.2. The Need: Provide Housing with Support Service Opportunities to 4,000 Additional Households.

Based on the 2003 homelessness survey of the Wilder Foundation, Minnesota should plan to provide supportive housing to an additional 4,000 long-term homeless households by 2010. This would accommodate some growth in the population pf persons experiencing long-term homelessness over the seven-year period. It will be important, of course, to update the plan and be prepared to pursue other necessary strategies based on the 2006 Wilder survey and other available data. For example, it is anticipated that providing significant additional housing with support opportunities will free up shelter and transitional housing space for persons experiencing homelessness on a temporary basis. If this does not occur and there is a demonstrated shortage of temporary housing opportunities for persons experiencing homelessness, separate strategies to address this issue should be pursued. In addition, it is necessary that existing housing opportunities with support services for persons experiencing homelessness be maintained so that existing units are not lost.

7.3. The Strategy: Cost Effective Reforms for Providing Housing and Support Services.

The evidence reviewed by the Working Group demonstrates that permanent supportive housing works. Outcomes for persons experiencing long-term homelessness are enhanced, and the costs of crisis services are reduced. Providing housing with adequate supports to 4,000 households is a major challenge, financially, and to the capacity of our housing and social service delivery

systems. To maximize the amount of supportive housing available, the Working Group reviewed strategies to provide supportive housing more cost-effectively by utilizing strategies including:

- controlling development costs by using innovative designs, alternative materials, and limiting transaction costs;
- maximizing the use of the private, competitive rental market to avoid the costs of new construction;
- carefully scrutinizing support service levels to focus on those that relate directly to being successfully housed over the long-term; and
- requiring persons experiencing long-term homelessness to pay a portion of their rent from available sources and use financial incentives to minimize the amount of state support necessary.

7.4. The Financing Plan: Initial State Leadership to Leverage Other Resources.

The following table summarizes the financing plan, which estimates a total approximate cost of $540 million over seven years. It is important to note that this financing plan is a unique effort to estimate over time the costs and potential sources for providing housing and support services from multiple funding sources each of which have different allowable uses and eligibility criteria. As a result, the plan provides an estimated order of magnitude, not precision, for the costs and potential sources. This plan will require continued updating as implementation proceeds.

Financing Plan Estimate (2004 - 2010)
(in millions)

Sources		Costs/Uses	
Identified Sources			
State General Obligation Bonds ($16.2 million in 2002; $20 million in 2004; remainder in 2006 and 2008)	$ 90	New construction (500 units)	$ 85
Minnesota Housing Finance Agency State Appropriated Programs Agency Resources	$ 90	Acquisition and rehabilitation (1,500 units)	$125
Private Tax Credit Equity (MHFA allocation)	$ 60	New units integrated into mixed-income developments (400 units)	$ 50
Department of Human Services	$120	Rental/operating assistance (1,600 units for available units in the rental market -$40 million; remainder to support other new units identified above - $60 million)	$100
Remaining Sources: Federal Government, Local Government, Philanthropic/Nonprofit, State (Departments of Human Services, Corrections, and MHFA)	$180	Housing Support/Community Living Services/Income Supplements	$180
Total	**$ 540**	**Total**	**$ 540**

Key points related to the financing plan include:

- *Phase-in*. The dollar figures represent the additional resources necessary to house and serve an estimated 4,000 long-term homeless households based on an estimated schedule for providing the housing and support services over the seven-year period.
- *Identified Sources*. The "identified" sources represent those that can be reasonably anticipated based on existing funding levels and with minor changes to some programs. They are, however, not guaranteed. The identified sources are general obligation bonds, funds from the state appropriated Housing Trust Fund, MHFA resources from the Agency's bond funds, and service funds allocated by the Department of Human Services. Department of Human Services funding is not available in a "lump sum" or "pool" as individual determinations of eligibility must be made; however, approximately $10 million has been identified initially for use as part of a flexible service fund.
- *Remaining Sources*. By identifying and attempting to quantify the "remaining sources", it is clear that state government cannot finance this plan alone. Filling the gaps requires at least two strategies. First, leveraging state resources to obtain federal, local, and philanthropic resources. These sectors have contributed to past and ongoing efforts for persons experiencing long-term homelessness and there is reason to believe they may continue and enhance their efforts, particularly if the state provides continued leadership. Second, addressing the identified service funding gaps requires exploring opportunities to increase the use of "mainstream" services as defined earlier, and targeting resources to the needs of persons experiencing long-term homelessness. To the extent additional state resources are necessary but unavailable, the ability to achieve the goal, or the timetable within which it can be achieved, will be affected.
- *Ongoing Costs*. After 2010 there will be ongoing costs for rental assistance and for support services. Reducing or eliminating these costs to the state would require successful "mainstreaming" of most support service costs and for the federal government to fulfill its role of providing rental assistance. A very imprecise estimate of these costs by 2010 is $88 million, annually. To the extent such funding is necessary and unavailable in 2010, the housing would become part of the affordable housing supply primarily for those other than persons experiencing long-term homelessness.
- *Savings and Benefits*. These figures do not include an estimate of the reduced costs to counties, other local units, and the state of reduced use of "crisis" services by persons experiencing long-term homelessness. Nor do they account for the benefits associated with the better outcomes that should be achieved by persons experiencing long-term homelessness such as increased employability.

7.5. <u>The Implementation Plan: Establish Accountability and be Proactive.</u>

The Working Group process has resulted in a wealth of knowledge and a committed group of stakeholders. An essential element of implementing the business plan will be to take advantage of and build on this knowledge and to continue to involve stakeholders. The business plan should be implemented, in general, as follows:

- *Continued Interagency Cooperation.* The Departments of Human Services, Corrections, and the Housing Finance Agency should enhance and institutionalize their joint efforts to proactively solicit and fund supportive housing for persons experiencing long-term homelessness. The existing "super RFP" process of the MHFA should be utilized, but there should be flexibility so that funds are available on a pipeline basis as well. Priority for funding should include proposals that:
  - serve long-term homeless families and children;
  - have project-based rental assistance committed; and
  - will leverage other funds including CDBD, HOME, and tax credits.

  In addition, it will be important that projects to be funded have a service funding plan that is approved by the Department of Human Services and the county in which the project is to be located.
- *Develop the System for Supportive Housing*. The state agencies also should continue their work to develop creative funding strategies that allow a more natural "system" to develop to provide for the development of supportive housing. It will be critical to involve the federal government, counties and other local governments, and nonprofit funders as partners in addressing funding and funding system issues. A key part of this system should include a database on housing with support service opportunities, a one-stop shop, to avoid unnecessary duplication and so that persons experiencing long-term homelessness can be easily and efficiently housed in an appropriate setting.
- *Evaluation*. Rigorous evaluation and search for best practices should be integrated into the implementation process. The data necessary to plan, measure and evaluate successful outcomes will be collected every three years by the Wilder Statewide Study of People Without Permanent Shelter. The Department of Human Services, Department of Corrections, and the Minnesota Housing Finance Agency, with the assistance of stakeholders, should also contribute key information. Additionally, all state or federal funded housing providers that target persons experiencing homelessness including emergency shelters, domestic violence shelters, and transitional and supportive housing programs will participate in Minnesota's Homeless Management Information System (HMIS).[15]
- *Stakeholder participation and capacity building*. A broadly representative advisory body like the Working Group should be established to assist in implementation of the business plan and track progress. Persons who have or are experiencing homelessness should be included. In addition, it will be important to

[15] HMIS is an internet-based system that will provide standardized and timely information to improve access to housing and services and strengthen our efforts to end homelessness. Data on homelessness including unduplicated counts, use of services, and the effectiveness of the local homeless assistance system will be collected. HMIS may track the success of outcomes of persons experiencing long-term homelessness who enter supportive housing and whether the same persons ever return to shelters.

work with developers, local governments, and service providers to develop and maintain the capacity to implement the plan and assist in addressing siting and similar issues.

- *A long-term homeless director without new bureaucracy*. A director for ending long-term homelessness should be engaged, using existing resources, to coordinate implementation of the business plan. The director should report to the Commissioners of Human Services, Housing Finance, and Corrections. In addition, and also within existing resources, the Department of Human Services intends to offer technical assistance for service planning for housing with support service projects.

8. Conclusion: An Opportunity to Succeed

The Working Group has sought to develop a plan that addresses a complex social issue in a businesslike way. Proceeding to implement the plan offers significant benefits and few risks. The benefits will accrue to persons experiencing long-term homelessness in increased productivity and qualify of life, and to the rest of Minnesota in reduced crisis service costs and in knowing that the needs of some of our most vulnerable citizens are being addressed. The risk of proceeding is confronting obstacles that we fail to overcome, not achieving the goal, and being held publicly accountable. Even if this occurs, a bold, ambitious effort would have been undertaken that will create affordable housing that can be made available to others, and services would have been provided to those who need them.

Establishing goals that improve quality of life, developing implementation plans, aligning resources, and being held accountable—for success or failure—are essential principles of good public governance. The Working Group on long-term homelessness advocates putting these principles to work for individuals, youth, and families with children experiencing long-term homelessness, and calls on the "many hands" that are necessary to proceed and risk success.

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ENDING LONG-TERM HOMELESSNESS IN MINNESOTA REPORT SUPPLEMENT

This is a supplement to the report from the Working Group on Long-Term Homelessness, the purpose of which is to set forth the assumptions upon which key elements of the business and financing plan are based. These assumptions were arrived at based on extensive analyses of data from the Wilder survey; cost and other information from existing housing with support service projects; and meetings, interviews and surveys involving many Working Group members, stakeholders, and other knowledgeable persons. These assumptions will be continually tested against new data and actual experience, and refined and adjusted accordingly.

The supplement has three elements. First, the table setting forth the financing plan is set forth again for reference purposes. Second, the assumptions related to the "sources" are set forth. Third, the assumptions related to the costs and uses are set forth. There is some overlap relating to the assumptions for sources and costs/uses. Where this overlap occurs, an effort was made to cross-reference in order to avoid unnecessary duplication.

Financing Plan Estimate (2004 - 2010)
(in millions)

Sources		Costs/Uses	
Identified Sources		New construction (500 units)	$ 85
State General Obligation Bonds ($16.2 million in 2002; $20 million in 2004; remainder in 2006 and 2008)	$ 90	Acquisition and rehabilitation (1,500 units)	$125
Minnesota Housing Finance Agency State Appropriated Programs and Agency Resources	$ 90	New units integrated into mixed-income developments (400 units)	$ 50
Private Tax Credit Equity (MHFA allocation)	$ 60	Rental/operating assistance (1,600 units for available units in the rental market -$40 million; remainder to support other new units identified above - $60 million)	$100
Department of Human Services	$120		
Remaining Sources: Federal Government Local Government Philanthropic/Nonprofit State (Departments of Human Services, Corrections, and MHFA)	$180	Housing Support/Community Living Services/Income Supplements	$180
Total	**$ 540**	**Total**	**$ 540**

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Assumptions On Sources Of Funding

1. Capital Bonding:

Assumption: $90 million of general obligation bonds over 7 years.

Rationale: State general obligation bonds are a valuable resource and an appropriate use of bond proceeds, which will be used to construct capital facilities that will last 30 years or more. General obligation bond funds must be used for projects that are owned by a public entity, such as a local unit of government, and there are limits to reimbursable costs. This requires a willing local government owner, which may in turn lease the project to a nonprofit housing and service provider.

General obligation bonding accounts for $90 million of the anticipated $260 million capital costs of the plan, or just over one-third. In 2002, the legislature appropriated $16.2 million of capital bonding for projects that will primarily serve homeless veterans to be located in St. Cloud and Minneapolis. The plan anticipates a modest increase from the 2002 appropriation in 2004 to $20 million. This amount has been recommended by the Governor as part of his capital budget. The plan anticipates additional capital appropriations of $25 million in 2006 and $30 million in 2008.

2. MHFA Resources:

Assumption: $90 million of State appropriations and Agency resources

Rationale: This consists of three sources. The first is the Housing Trust Fund at $25 million. This is a part of a biennial appropriation to the Minnesota Housing Finance Agency ($8.6 million FY 04-05), which is used to provide rental and operating assistance to very low-income persons. It is also used as a source of capital funding. It is anticipated that a significant amount of Housing Trust Fund proceeds will be necessary to maintain existing supportive housing. The Housing Trust Fund proceeds in the plan are for new units and related rental assistance and housing support services. Appropriation increases of $2 million each year are anticipated for the Housing Trust Fund in 2005, 2007, and 2009. If these additional appropriations are not forthcoming, there will be a shortfall in the financing plan or the resources would come from other housing programs.

The second is the Preservation Affordable Rental Investment Funds (PARIF), another appropriated resource ($18.5 million for FY 04-05). It is anticipated that up to $10 million of PARIF resources can be used as part of the financing plan over the seven-year period to the extent that these funds are not needed for the preservation of federally assisted housing.

The third is non-appropriated "Agency" resources, which account for $50 million of the plan. Agency resources are those that can be periodically released from MHFA bond funds. This represents a significant commitment of the Agency, and can be a one-time commitment only as there is no anticipated return on investment for these funds. Foregoing any return of investment has an impact on the Agency's ability to invest in other affordable housing over the long-term.

The Agency is reviewing strategies to minimize the impact on other affordable housing programs as a result of a one-time use of funds for this purpose.

3. Private Tax Credit Equity:

Assumption: $60 million of tax credit equity.

Rationale: The Low-Income Housing Tax Credit (LIHTC) program created in 1986 and made permanent in 1993, is an indirect federal subsidy used to finance the construction and rehabilitation of low-income affordable rental housing. Washington lawmakers created this as an incentive for private developers and investors to provide more low-income housing. Typically, affordable rental housing projects do not generate sufficient profit to warrant the investment.

The LIHTC gives investors a dollar-for-dollar reduction in their federal tax liability in exchange for providing financing to develop affordable rental housing. Investors' equity contribution subsidizes low-income housing development, thus allowing some units to rent at below-market rates. In return, investors receive tax credits paid in annual allotments, generally over 10 years.

It is proposed that 25% of the approximately $5.412 million in tax credits allocated annually by the MHFA will be set aside for permanent supportive housing starting in 2005. It is anticipated that $1.353 million ($5.4 x .25) in tax credits which are received by investors over ten years, will generate approximately $10 million in equity per year assuming current market prices of seventy-four cents per tax credit dollar per year times ten years. ($1.353 million x 10 x .74= $10,000,000).

4. DHS Sources and Uses/Costs:

This is the assumption for all DHS sources and uses/costs because the concepts are so inter-related in this context.

Assumption: DHS will contribute $120 million, from all sources, to the costs of providing necessary services and rent contributions. An estimated $180 million is the cost for service and income supplements - $150 million for services, and $25-30 million for income supplements.

Rationale: In order to determine the total funding amount available from DHS service and income supplement sources for individuals and families experiencing long-term homelessness, it was first necessary to estimate their need for services, the cost of those services, and the percentage of the need that could be covered by existing DHS programs at current levels of funding. The value of income available for rent and any new or redirected sources of DHS funding were also added to the total amount of DHS program resources to be made available.

There is no definitive research on the level of service needs over the long-term for households who have experienced long-term homelessness. It is recognized that the level of service needs will fluctuate over time for most households. The fluctuation in service needs over time is taken into account by the use of average costs of services, rather than trying to make assumptions about how long any household might need a particular level of service. There is consensus

among stakeholders and Working Group members that some form of housing tenancy supports will need to be provided to all households for an extended period of time.

Recent data from the Supportive Housing and Managed Care pilot shows a 15% reduction in the average cost of services to families from FY 2002 to FY 2003; this may be some evidence of the extent of the change in service level needs as families progress. This pilot is serving among the very hardest to serve of the homeless population. However, long-term data is not yet available from the pilot.

Fifty percent (50%) of the persons included in the Wilder Statewide self-report that they have a mental illness or a chemical dependency, or both. Other research suggests that the percentage is probably much higher. This assumption leads to an assumption of a need for intensive services.

DHS staff estimated that 50% of the total costs of necessary services ($150 million) would be able to be covered by existing state and federal programs at current funding levels. This means that there is $75 million from its service programs alone that is available or could be available to pay for services for the long term-homeless with minor changes to some programs. This funding is not available in a lump sum or a pool, as each program has individual eligibility requirements and special efforts may be necessary to assure that persons experiencing long-term homelessness become eligible for the programs.

The value of certain income supplement programs is also estimated for purposes of the business plan. Data from the actual contributions of households to rent in a variety of affordable rental settings was provided by the MHFA. It is estimated that $25 - 30 million in income supplements would be used by this population to pay toward rent in housing with supports settings.

- $10 million in flexible, targeted funds from GRH and Transitional Housing: DHS could redirect existing funding in two programs, Transitional Housing and the GRH program to the extent possible to meet the need for a flexible fund for service costs. It is expected that a total of $10 million over the seven-year period of the Business Plan could be made available. Neither of the proposals described below costs additional state money nor should they reduce the number of people served under the existing programs. They have the potential of leveraging federal funding which would mean additional resources may be made available as a result of this proposal. The proposals expand the use of these funding sources so individuals experiencing long-term homelessness in these programs that need supportive housing have more options. An amendment to GRH and Transitional housing statutes will be needed. The amendment would limit the use of this funding to settings created under the Business Plan and bonding proposals. The flexible funding could be part of the Super RFP process for these projects.

    - GRH funding that is currently only available and used for some of persons experiencing long term homelessness in shelters for services would be made available for use in supportive housing developed under the Governor's Business Plan and bonding proposal. Approximately $600,000 per year could be used in this more flexible fashion.

- Transitional housing funding, $300,000 per year (approximately 10%) of existing state funding would be used for transitional housing operating and service costs for housing with support projects for the long-term homeless clients they serve. Funds would continue to be used for operating or service costs in the new settings.

- $10 million in Mental Health Service funding refinancing - BRIDGES and PATH proposals: An additional $10 million for mental health services would be made available primarily by the MHFA's assumption of rental subsidy costs through the Bridges programs so that DHS Mental Health Initiative funding could be used solely for services.

  - Bridges mental health client service funding under the Adult Mental Health Initiatives can now be used for housing subsidies. The MHFA has agreed to provide funds from its own agency resources, on a temporary basis, to increase the funds available under the Bridges rental subsidy program so that the amount of funding for housing subsidies for persons with a mental illness remains stable while service funding increases. The amount of funding that would be picked up by the MHFA in the Bridges program is expected to be $1.33 million per year for the seven years of the Business Plan. The long-term funding of this increase to the Bridges program will need to be addressed in the future.

  - DHS proposes to use state funding in PATH projects to maximize federal reimbursement. In order to access additional federal reimbursement for those individuals who are Medical Assistance (MA) eligible, State funds could be used as the match for MA programs such as Assertive Community Treatment (ACT), Adult Rehab Mental Health Services (ARMHS) and Targeted Case Management. Currently there are eight counties across the state receiving Project for Assistance in Transition from Homelessness (PATH) funds that serve homeless people who have a serious mental illness or concurring mental illness and substance abuse. The federal share of the PATH program in 2004 is $517,000 and the State required match is $172,334. The State contributes $287,667 above the match, which can be used for the MA match.

The estimated cost of $180 million is for housing support, community living, and income supplement costs. It is based on the Wilder data assumptions about the number and type of households used in the business plan. This service cost assumption was based on the following calculations:

- Costs of $10,000 per year per individual and $15,000 per year per family for services were used. These numbers were based on information submitted from current supportive housing providers to the Working Group. The services costs are based on estimates from current supportive housing providers. The Supportive Housing and Managed Care pilot estimates average costs for families of $16,660, excluding an average of 22% for housing costs. In addition, the Wilder Roof

Project and Project Quest (Hearth Connection) estimate on the range of service costs at the highest level of intensity to be between $10,061 and $16,142. The lower number for singles is consistent with Hearth Connections' estimates. The assumption uses an amount close to, but not at the top of the range. The fact that persons experiencing long-term homelessness are a hard-to-serve population who are experiencing multiple challenges was also considered.

- The phase-in assumptions of the capital portion of the business plan were also applied to the service costs. All of these calculations created an estimate of $150 million that would be needed for services for persons experiencing long-term homelessness for the duration of the business plan.
- $25 million is estimated for the costs of providing income supplements that help defray operating costs.
- The estimates do not include an inflation factor.
- No attempt has been made to offset the costs by anticipated savings, but savings in crisis services are expected.
- The estimated total is not all new costs, since an estimated 66.6% of homeless households surveyed reported receiving income from MFIP or GA, employment services from MFIP, any kind of medical care through a regular medical benefit or insurance program, or reported being covered by MA or GAMC.
- The costs of health care, chemical dependency treatment, and mental health care are not reflected in these estimates.

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5. Remaining Sources:

Assumption: $180 million

Rationale: The remaining sources are of four types: 1) other state sources, including the MHFA, DHS, and DOC as they may become available. As the plan proceeds, there may be additional resources identified from these sources; 2) the federal government. This would be primarily for rental assistance and service funding as detailed elsewhere in this report, but also for capital funding from HUD; 3) local government. Many local governments contribute to capital or service funding for housing and support services in-kind, cash and cost avoidance. Although the current fiscal situation makes providing such funding difficult, many local governments, particular counties, recognize the cost-effectiveness of supportive housing in reducing crisis costs which are a significant burden on counties as well; 4) philanthropic sources. Minnesota has been fortunate to benefit from foundations that have made a priority of investing in affordable housing, including The McKnight and the Charles K. Blandin Foundations. It will be important to maintain existing commitments and expand them to a broader base of foundations that may want to invest in an innovative plan to address the long-term homelessness issue.

Assumptions on Cost/Uses

1. The Number of Households to be served.

Assumption: At least 4,000 households will need to be served over the next 6 years.

Rationale: The assumption is based on information from the Wilder Research Center Statewide Survey of Homeless Persons, conducted in October 2003 on the number of persons currently experiencing long-term homelessness; an adjustment is made to this data to account for additional persons who may experience long-term homelessness at some point over the course of the next six years.

- Based on the 2003 one-night count, the Wilder Research Center estimates that over the course of a year there were no fewer than 3,288 persons who experienced long-term homelessness, including 454 children.
- The number of households estimated over the course of the year to experience long-term homelessness is 2,834.

The estimate is based on the single-count of persons experiencing long-term homelessness who are in emergency shelters, battered women's shelters, other emergency arrangements and places not intended for habitation and the count of those in transitional housing who have chemical dependency, mental illness, and/or chronic health conditions for which they have not received recent care. Including this subset of persons in transitional housing in the estimate of the number of persons experiencing long-term homelessness is reasonable because persons who needs, but are not receiving, treatment for these health issues are unlikely to be able to make the transition to unsupported housing within 24 months without supportive services.

The 2003 Statewide Survey was able to provide a count of persons who met the Working Group's definition of persons experiencing long-term homelessness. The estimates provided to the Working Group by Wilder based on the 2000 Statewide Survey used a different definition and included everyone in transitional housing. The method used in the 2003 estimates is the more conservative method.

A 40% increase above the number of long-term homeless households estimated in 2003 is assumed. Between 1997 and 2003, the total number of persons experiencing homelessness increased by approximately 40%. The increase occurred primarily between 1997 and 2000; between 2000 and 2003, the count remained essentially flat. Several factors led us to assume an increase.

- First, the assumption attempts to recognize that, despite our best efforts, over the next six years, new people will experience long-term homelessness. It is expected that there will be some turnover in the permanent supportive housing; however, it is assumed that the turnover rate in permanent supportive housing will be less than the incremental increase in the number of persons experiencing long-term homelessness. There is no reliable way to measure the turnover in supportive housing at this point since this is a relatively new industry in Minnesota, particularly for projects serving the hardest to serve – the long-term homeless.

- Second, recent economic forecasts show that payroll employment remains stubbornly below end-of-recession levels. Full-time work was half as common in 2003 as in 2000 among persons experiencing homelessness. Slow growth in the labor force may impact the extent of homelessness.
- Third, the Wilder Research Center acknowledges that there is no reliable methodology for using "cross-sectional data" to produce annual population estimates. Their annual estimates are described as conservative.
- Finally, the Wilder Research Center concurs that 4,000 households is a reasonable planning estimate since it is a number above the most conservative estimates and below the most inclusive estimates.

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2. Types of Households to be Served.

Assumption: Two-thirds of the households experiencing long-term homelessness are single adults or unaccompanied youth. The remaining one-third of the households is assumed to be families with children.

Rationale: According to the 2003 Statewide Survey:

- 90% of the households meeting the definition of long-term homeless were households composed of single adults or unaccompanied youth;
- If all transitional housing residents who meet the definition of long-term homeless, regardless of current health status or need, are considered 80% of those households were single adults or unaccompanied youth;
- One-third of the households in transitional housing, who meet the definition of long-term homeless, were households with children.

About 10% more children were homeless in October 2000 as compared to October 2003. The drop in the number of homeless children may be due to the reclassification of one large facility.

3. Size of Households to be Served.

Assumption: Families to be served will predominately consist of one adult and two to three children.

Rationale:

- The Wilder survey found that the average number of children with a parent meeting the definition of long-term homeless was 2 children.
- This compares to the average family size in MHFA's Housing Trust Fund Rental Assistance portfolio of: 2.26 children.

- The average MFIP family is 3 persons; 68% of the MFIP caseload has 1 or 2 children.
- Including only long-term homeless persons in emergency settings or those in transitional housing who are not receiving care for a major problem, 97% of those in emergency settings and 87% of those in transitional housing reported that they needed housing with two bedrooms or less.

4. Housing Type and Mix: New Construction and Acquisition/Rehabilitation vs. Rental Assistance.

Assumption: Sixty percent of the housing units needed to meet the goal (2,400 units) will be provided through new construction or acquisition and rehabilitation and the remaining 40% of the need (1,600 units) will be met through rental assistance in existing housing.

Rationale: Available resources are insufficient to build our way out of the problem. The plan promotes utilization of existing rental housing that is well located and suitable for the targeted population. The current environment in which vacancy rates are somewhat higher than ideal lends itself to making use of existing housing. There is a role for the private sector to play in meeting the goal of ending long-term homelessness and that role is to make existing units available to persons who have experienced long-term homelessness, provided that the necessary supports, including rental assistance are in place.

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5. Housing Type and Mix: Sole Purpose vs. Scattered-Site.

Assumption: One-half of the housing opportunities (2,000 units) will be sole purpose/ single site and one-half (2,000) will be mixed-income/scattered-site/clustered site.

Rationale: This approach implements one of the principles adopted by the Working Group that housing choices should be maximized and that these units should be flexible options so that the individual housing needs are met.

A. Sole Purpose / Single Site (2,000 units):

Sole purpose/single site buildings are buildings in which all of the units are supportive housing. These sole purpose buildings could be a variety of models from harm reduction/safe havens, to single room occupancy building, to large family housing. Sole purpose buildings are recommended because:

- Residents benefit from peer examples whom they encounter on a daily basis.
- Residents who share similar histories of homelessness can easily develop a sense of community.
- Sole purpose buildings allow support services to be delivered very efficiently.

B. Scattered-site / Clustered Site (1,600 units):

Several considerations lead to the assumption that a significant portion of the needed units should be provided in scattered sites.

- Consumers and advocates for persons experiencing homelessness as well as direct service providers encouraged the integration of supportive housing into the larger community.
- The transition to general occupancy housing when support services are no longer needed can be easier if a resident has lived in a community that is not exclusively supportive housing. Living in a scattered-site setting avoids the disruption of having to move when a resident is ready to graduate from housing with supports.
- Scattered sites lessen many of a neighborhood's objections to having supportive housing units located in their neighborhood. The difficulties confronted by providers of housing with supports in attempting to site a development must be considered. Dispersing the housing with supports throughout a community makes the housing less visible and alleviates concerns about a concentration of units in a neighborhood.

The private sector can play a role in helping to meet the goal of ending long-term homelessness through the provision of housing in scattered sites.

C. Mixed-income (400 units):

One strategy for implementing the scattered-site component of the business plan is to include some units of housing with supports in new construction, mixed-income developments. Most likely these would be developments in which the MHFA is assisting with some affordable units. A few supportive housing units (probably no more than 10% of the total) could be included in the mix.

The MHFA conducted a small, informal survey of developers/management companies with whom it has considerable experience to gauge their receptivity to including some supportive housing units in their housing developments. While the response was mildly receptive to the notion, acceptance hinged on crucial conditions, including a guarantee that needed services would be provided. Until more success can be demonstrated with including supportive housing units in mixed-income developments, the assumption of 400 mixed-income units is aggressive.

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6. Housing Type and Mix: New Construction vs. Acquisition/Rehabilitation.

Assumption: Seventy-five (75%) of the units (1,500 units) in sole purpose developments will be provided through acquisition and rehabilitation; only 25% (500 units) in sole/single purpose buildings plus another 400 units in mixed-income developments will be provided through new construction.

Rationale: This 75/25 split between acquisition/rehabilitation and new construction for sole purpose building reflects the Agency's emphasis on achieving the goal with the least expensive, but highest quality product. Acquisition/rehabilitation is a far less expensive means of producing supportive housing than new construction and will enable us to meet the identified housing needs with the funds that realistically will be available for this effort.

This emphasis on acquisition/ rehabilitation is one of the reform elements of the business plan. In addition to cost considerations, siting issues that result in delays and additional expenses lead to acquisition/rehabilitation as the major means of producing supportive housing units. It is recognized that there may be relocation and attendant relocation costs in many instances. Projects that involve minimal relocation will be preferred. The problem of adding to the ranks of persons who are at risk of becoming homeless should not be exacerbated by these activities.

In the most recent funding rounds through MHFA, approximately one-half of the funded requests for supportive housing were for acquisition/rehabilitation; the other half were for new construction projects.

The rental housing market has softened significantly in the last two years as reflected in the change in vacancy rates from 2.2% in 2000 to 6.7% in 2003. Vacancy rates in higher-end buildings are especially high. Opportunities exist to acquire and complete modest rehabilitation of well-located, decent housing at a very reasonable cost. The market conditions are now such that a strategy emphasizing acquisition/rehabilitation is not only reasonable and prudent, it is a smart business decision.

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7. Housing Type and Mix: Rental Assistance.

Assumption: Virtually all of the households experiencing long-term homelessness will need some level of rental assistance, either project-based (2,400) or tenant-based (1,600), for a period of time.

Rationale: The costs of operating a rental-housing unit, and particularly a supportive housing unit, exceed the ability to pay of most persons and families experiencing long-term homelessness. The following chart sets forth average incomes from the most common sources of income and the amount available for monthly rent at 30% and 50% of income.

Income Source	Amount (Monthly)	30% of Monthly Income	50% of Monthly Income
Average Income Wilder Survey Metropolitan Area	$513	$154	$256.50
Average Income Wilder Survey Greater Minnesota	$494	148	$247
MFIP (1 parent, 2 children)	$532	$160	$266
SSI (Single adult)	$564	$169	$282

The majority of persons experiencing homelessness do not currently have access to rental assistance. The Wilder Survey reported that 40% of those surveyed were on a waiting list for Section 8 or some other type of housing assistance. Nearly 48% of those on a waiting list in the metro area and 74% of those in Greater Minnesota had been on the waiting list for 6 months or less. Of those surveyed in the metropolitan area, 33% could not get on a waiting list because the list was closed. (See *Statewide Survey*, Tables 38 and 39.) Only 3.9% of those surveyed in the metropolitan area and 5.7% of those surveyed in Greater Minnesota reported having a housing voucher in the last two years that they could not use because it was revoked or expired or no landlord would accept it. (See *Statewide Survey*, Table 40)

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8. Amount of Rental Assistance.

Assumption: Single adults will need, on average, monthly rental assistance of $378 and families with children will need, on average, monthly rental assistance of $851.

Rationale: The actual operating costs for supportive housing provide guidance as to the amount of rental assistance that will be needed. Below is a chart of the operating costs for a variety of supportive housing developments in the metro area.

Operating Costs Identified for Supportive Housing

Development Location	Type of Housing and Units	Costs are based on:	Unit Count	Total Annual Operating Costs **	Total Operating Costs Per Unit Month	Annual Taxes	Gross Rent	Average Tenant Portion Paid
Minneapolis	Rehab -Family Apartment	Actual	17	$131,300	$644	$ 300	1BR = 784 2BR = 1003 3BR = 1071	1BR = 21 2BR = 256 3BR =129
St. Paul	Rehab -Family Apartment	Actual	31	224,630	604	18,475	1BR = 650 2BR = 750	1BR = 273 2BR = 177
Minneapolis	New Family Townhouse	Actual	24	$303,791	1,055	43,858	2BR = 1003 3BR = 1356 4 BR = 1537	2BR = 31 3BR = 112 4 BR = 172
St. Paul	New Family Townhouse	402	25	307,768	1,026	43,000	2BR = 948 3BR = 1282 4BR = 1453	2BR = 60 3BR = 121 4BR = 91
Minneapolis	New Family Townhouse	402	20	205,213	855	21,000	2BR = 862 3BR = 1166 4BR = 1321 5BR = 1519	2BR = 275 3BR = 179 4BR = 116 5BR = 75
Minneapolis	New Family Townhouse	Budget	14	113,225	674	3,800	EFF = 296 1BR = 353 2BR = 416 3BR = 500 4BR = 574	EFF = 164 1BR = 76 2BR = 285 3BR = 46 4BR = 122
Average Family Per Unit Per Month: **$810**								
St. Paul	Single Adult Efficiency	Actual	76	301,228	330	3,882	236	SRO =236
St. Paul	Single Adult Efficiency	Actual	70	338,968	404	11,095	247	SRO = 247
St. Paul	Rehab Single Room Occupancy	402	71	434,391	510	1,400	Information Not Available	Information Not Available
Minneapolis	Rehab -Youth Efficiency	Actual	30	210,978	586	19,940	EFF = 446 1BR = 106	EFF = 94 1BR = 71
Minneapolis	Rehab -Single Adult Efficiency	Budget	61	431,744	590	20,000	609	SRO = 173
St. Paul-*Proposed*	New Single Room Occupancy	402	71	422,020	495	15,000	Information Not Available	Information Not Available
Average Single Room Occupancy Per Unit Per Month**:** **$486**								

** Annual Operating Costs include taxes, insurance and annual reserves deposits, and also front desk cost if paid from operating.

Another indicator of the amount of rental assistance needed is the fair market rents (FMRs) established by the U.S. Department of Housing and Urban Development. Below is a chart with 2004 FMRs in selected areas, for selected apartment sizes.

Location	**FMR - 0 Bedroom**	**FMR - 2 Bedroom**	**FMR - 3 Bedroom**
Twin Cities Metro	$578	$951	$1,286
Duluth	$302	$499	$666
Rochester	$389	$714	$986
Kandiyohi County	$350	$537	$673
Moorhead	$385	$603	$832
St. Cloud	$349	$535	$674

Due to the small sample size and lack of long-term operating history, the business plan uses an amount higher than the average estimate of the cost of rental assistance/operating support to avoid deficits in the financial plan. The plan anticipates rental assistance administrative expense reimbursement consistent with the federal Section 8 voucher program.

Based on data from existing supportive housing developments, the average monthly contribution toward rent by a single person is $200 and by a household with children is $100. The $200 per month contribution by a single person is also supported by an analysis of the Bridges program participants. These amounts reduce the level of needed rental assistance or operating subsidies.

The estimated cost of providing rental assistance over the next seven years is $100 million. The estimated annual cost for 4,000 households is $33 million.

The business plan incorporates two reform measures relating to rental assistance. It is recommended that the rental assistance be structured to incorporate an incentive to move from the state-funded rental assistance to Section 8. This incentive most likely will take the form of requiring a larger tenant contribution towards the rent – more than 30% of the tenant's income. The federal program will be more attractive to households once they have earned income.

The plan also recommends that a policy be implemented that incents supportive housing providers to maximize the number of households that are served with a given amount of rental assistance. Therefore, the plan contemplates giving priority to requests for rental assistance funds that will serve households at the lowest monthly cost. Consideration will be given to setting a maximum monthly payment for rental assistance, adjusted for family size and location.

9. Length of Rental Assistance.

Assumption: The state-funded rental assistance is temporary.

Rationale: State-funded rental assistance will end after 6 years. The expectation is that, in time, there will be sufficient non-state resources, primarily from a variety of federal sources that will address ongoing operating cost needs. This could occur though increased resources such as Section 8 vouchers for persons experiencing long-term homelessness, utilizing other existing resources such as Shelter Plus Care. Even Minnesota, with its history of providing state

funding for housing, should not be expected to assume this role and fund a major ongoing program. Without this federal assistance, long-term homelessness will reappear shortly after the state-funded rental assistance ends. The assumption regarding the temporary nature of the state-funded rental assistance may be the most aggressive assumption contained in the business plan.

As it relates to Section 8 vouchers, current waiting lists at HRAs and PHAs across the state range from 1 month to 4 years. The waiting list time does not reflect the time that a household has to wait until a waiting list is opened; in the metro area this can add up to 3 years to the time it would take to obtain a Section 8 voucher.

At the current funding levels for the Section 8 program, the local HRAs and PHAs cannot be expected to be able meet the rental assistance needs identified in this plan. A number of the large HRAs and PHAs are approaching the limits on the amount of Section 8 assistance they may project-base. Many have over-committed their Section 8 vouchers and may be forced to rescind commitments to households who are seeking housing now or fail to renew previously issued vouchers.

The plan includes an assumption that local HRAs and PHAs will be willing to project-base Section 8 assistance in supportive housing units when more voucher funding is made available. Many HRAs and PHAs have already demonstrated a willingness to do so. A reexamination of preferences may be appropriate as more federal assistance becomes available and the end of state-funded rental assistance approaches.

Finally, the plan assumes that private landlords will participate in efforts to meet the goal. Assuming that the needed rental assistance is available, private landlords must be willing to accept as tenants individuals and families who do not have a recent rental history and who may very well have blemished rental histories, if the state is to meet its goal. The plan envisions (and budgets for) housing tenancy support services being available to every household in need of services. These housing support services may replicate the work done by the Wilder Roof project and St. Stephens Church in helping homeless households find a landlord willing to accept them as tenants and acting as a resource for the landlord when problems arise. The plan assumes that with certain safeguards in place, landlords will be partners in achieving the goal.

In sum, the commitment of the federal government, local landlords, and the local PHAs and HRAs is essential for this critical element of the financial plan to work.

10. Development Cost Estimates.

Assumption: Development costs will average:

Type of Unit/ Construction Type	Per Unit Cost
Family – New Construction	$185,000
Family – Acquisition/ Rehabilitation	$90,000
Families – Mixed-Income Construction	$140,000
Singles – New Construction	$120,000
Singles – Acquisition/Rehabilitation	$60,000
Singles – Mixed-Income	$95,000

Rationale: In making assumptions about the costs of developing various types of supportive housing units, actual experience in recent years was examined. The assumptions are neither the highest amounts nor the lowest; but instead represent amounts believed to be sufficient to produce quality housing.

Supportive Housing Summary

Location	Number of Units	% of Non-Housing Space	TDC $	TDC $ Per unit
Family - New Construction				
Minneapolis	20	38.54%	$ 5,850,519	$ 292,526
Maplewood	13	18.08%	$ 3,373,866	$ 259,528
Minneapolis	12	1.28%	$ 2,636,017	$ 219,668
St. Paul	5	21.44%	$ 1,181,600	$ 236,320
Brooklyn Park	4	20.28%	$ 572,338	$ 143,085
Mankato	8	0.00%	$ 805,990	$ 100,749
St. Paul	26	8.46%	$ 7,068,786	$ 271,876
Total in category	**88**	**17.42%**	**$ 21,489,116**	**$ 244,195**
Per Unit				
Family - Rehab and Expansion				
Maplewood	35	10.74%	$ 4,532,878	$ 129,511
Minneapolis	39	24.94%	$ 4,482,127	$ 114,926
St. Paul	44	12.40%	$ 5,313,445	$ 120,760
Minneapolis	24	0.00%	$ 2,315,000	$ 96,458
Total in category	**142**	**15.49%**	**$ 16,643,450**	**$ 117,207**
Per Unit				
Family - Rehab				
Minneapolis	15	17.40%	$ 255,520	$ 17,035
St. Louis Park	20	6.93%	$ 705,000	$ 35,250
St. Paul	12	10.26%	$ 718,665	$ 59,889
St. Paul	18	25.00%	$ 2,100,000	$ 116,667
Total in category	**65**	**15.43%**	**$ 3,779,185**	**$ 58,141**
Per Unit				
Family - Acquisition/Rehab				
Duluth	6	0.00%	$ 1,112,871	$ 185,479
Robbinsdale	30	17.82%	$ 2,750,000	$ 91,667
St. Louis Park	20	0.00%	$ 1,687,349	$ 84,367
Mankato	8	5.59%	$ 885,613	$ 110,702
Total in category	**64**	**7.19%**	**$ 6,435,833**	**$ 100,560**
Per Unit				

Supportive Housing Summary (continued)

Location	Number of Units	% of Non-Housing Space	TDC $	TDC $ Per unit
Singles - New Construction				
Bloomington	21	38.57%	$ 2,366,208	$ 112,677
Minneapolis	31	14.19%	$ 6,337,217	$ 204,426
Apple Valley	36	2.84%	$ 4,316,950	$ 119,915
Minneapolis	26	49.62%	$ 5,317,486	$ 204,519
Minneapolis	12	0.00%	$ 927,175	$ 77,265
Mounds View	19	40.16%	$ 2,152,200	$ 113,274
Cloquet	5	0.00%	$ 911,800	$ 182,360
Rosville	22	44.02%	$ 2,499,500	$ 113,614
St. Paul	12	17.43%	$ 2,894,171	$ 241,181
Minneapolis	96	20.00%	$ 8,866,277	$ 92,357
St. Louis Park	7	8.73%	$ 1,047,626	$ 149,661
Total in category	**287**	**25.96%**	**$ 37,636,610**	**$ 131,138**
Per Unit				
Singles - New Construction and Rehab				
Minneapolis	39	0.00%	$ 6,223,315	$ 159,572
Total in category	**39**	**0.00%**	**$ 6,223,315**	**$ 159,572**
Per Unit				
Singles - Rehab				
Minneapolis	22	0.00%	$ 377,503	$ 17,159
Grand Rapids	16	12.33%	$ 103,467	$ 6,467
St. Paul	151	55.45%	$ 3,500,000	$ 23,179
Duluth	18	13.76%	$ 214,399	$ 11,911
St. Paul	70	50.55%	$ 1,682,692	$ 24,038
Total in category	**277**	**47.72%**	**$ 5,878,061**	**$ 21,220**
Per Unit				
Singles - Acquisition/Rehab				
Minneapolis	5	0.00%	$ 193,234	$ 38,647
Anoka	4	0.00%	$ 221,900	$ 55,475
Total in category	**9**	**0.00%**	**$ 415,134**	**$ 46,126**
Per Unit				

Originally, lower per unit development costs were proposed. In response to well-reasoned comments about the unrealistic nature of the proposed costs, the target was raised for family new construction.

The plan recognizes that projects will come in with costs both above and below the target. Factors such as site concerns, community mandates, and common space requirements will impact the likelihood that a project can be delivered at these target amounts. The plan does not preclude innovations in housing models and welcomes innovations in construction techniques and materials that produce costs savings. Like all of the other assumptions, the cost assumptions will be compared to actual experience and revised accordingly.

Program or common space costs are included in the data from which the target costs were derived. Criteria should be developed to guide decisions about the need for, the size of, the convertibility of program space, and costs of program space. Closer scrutiny of program space is a reflection of the policy of seeking reasonable and appropriate reductions in all aspects of the costs of producing supportive housing.

The assumptions reflect the emphasis on reducing the cost of developing supportive housing. This policy will be implemented by setting targets for costs and rewarding those applicants who produce a quality product that costs less than the target amount.

11. Inflation.

Assumption: All housing related costs will increase 5% each year.

Rationale: 5% per annum inflationary adjustment is reasonable in light of data on recent experience. Between 1999 and 2003, the Consumer Price Index for rent for primary residence increased by 19%. For the same period of time, the Producer Price Index for input (materials) for multi-unit residential construction increased by 2%.

12. Phase-In.

Assumption: By the end of seven years, all of the estimated 4,000 households experiencing long-term homelessness will have housing opportunities and access to necessary support services.

Rationale: It is impossible to provide all of the needed housing and support services overnight. Housing developments that are selected for funding will be ready for occupancy approximately two years later. The phase-in is planned as follows:

Year	Percent of Households Served
2004	5%
2005	15%
2006	25%
2007	40%
2008	60%
2009	80%
2010	100%

By 2010, at least 4,000 households will be served.

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APPENDIX

ENDING LONG-TERM HOMELESSNESS IN MINNESOTA

Report and Business Plan of the Working Group on Long-Term Homelessness

Submitted by

Minnesota Department of Human Services
Minnesota Department of Corrections
Minnesota Housing Finance Agency

Prepared for

The Minnesota Legislature

March 2004

APPENDIX

Funding Catalogs

Catalog of All DHS Capital, Operating and Services (Public) Funding

Work Group on Supportive Housing for Persons Experiencing Chronic Homelessness

Program Name		CAPITAL	OPERATING		SERVICES									
			Rental Assistance	Deposit	Housing Search & Counseling	Accessibility Modifications	Independent Living Skills: One-time Training	Independent Living Skills: Ongoing Support	Family Counseling & Training	Transportation	Employment Services	Psychiatric/ Mental Health Services	CD Treatment/ Relapse Prevention	Other
Income Supplements														
DHS	General Assistance (GA) State Funding-basic income assistance program[1]	N	Y-at recipient's discretion	N (see EGA)										
DHS	Emergency General Assistance (EGA) State Funding[2]	N	Y-only in emergency situations	Y-only in emergency situations										

[1] **Minnesota General Assistance (GA)**

Purpose Provides a modest state cash grant to persons who have short term injuries or disabilities, who are usually in the application process for SSI, and who have extreme financial need. Intended for ongoing shelter, utility, food and personal needs expenses at the di[s]cretion of the recipient.

Global Funding Forecasted. 10,200 people served in FY 02

Individual Funding $203/month singles; $260/ month couples; $72/month as personal needs allowance to residents of various facilities

Eligibility Program participants must fit at least one of the 15 categories of eligibility specified in state statutes. Eligibility categories are primarily defined in terms of disability and/or unemployability. Most applicants and recipients are required to apply for benefits from federally funded disability programs for which they may qualify, such as Retirement, Survivors, and Disability Insurance or Supplemental Security Income. In addition, the person or couple must have income and resources less than program limits. The resource limit for all units is $1000. After subtracting certain income disregards, a single person must have net income less than $203 per month, and a couple must have net income less than $260 per month.

[2] **Emergency General Assistance (EGA)**

Purpose Provides a modest state funded, one-time emergency cash supplement primarily to GA recipients or to persons who have short term illness or disability and would normally (in non-emergency situations) be ineligible for GA due to their personal income and/or resources.

Global Funding Capped allocation

Individual Funding No maximum amount of money per person however, individuals may only use EGA once per 12 month period

Eligibility GA income limits, or short-term illness or disability emergency.

Information http://www.dhs.state.mn.us/ecs/program/general.htm

[3] **Minnesota Supplemental Aid (MSA)**
Purpose provides a modest state cash supplement primarily to persons who receive SSI or, in limited situations, to persons who would be eligible for SSI except for their excess personal income. May be used for ongoing shelter and utility expenses at the discretion of the recipient. Subject to federal Maintenance of Effort requirements
Global Funding In FY 02, an average of 27,600 people a month received MSA. No cap on the number of individuals who may use the program
Funding stream is forecasted
Individual Funding Supplement is $81 per month (may vary depending on circumstances) for a monthly total of $633 when SSI is included. MSA may also be used to provide a personal needs allowance ($72 monthly) to residents of various facilities.
Eligibility SSI eligible –Age 65 or over, aged, blind disabled. Assets of $2000 or less if individual; $3000 or less couple. Disability for non-SSI recipients is determined by the State Medical Review Team.
Information http://www.dhs.state.mn.us/ecs/program/msa.htm

[4] **Emergency Minnesota Supplemental Aid (EMSA)**
Purpose Provides a modest state-funded, one time (within a 12 month period) emergency cash supplement primarily to persons who receive SSI or, in limited situations, to persons would be eligible for SSI except for their excess personal income.
Global Funding Funding stream is a capped allocation-all assistance is subject to the availability of funds. There is no cap on the number of individuals who may use the program.
Individual Funding There is no maximum amount of money per person however, individuals may only use EMSA once per 12 month period**.**
Eligibility SSI eligible
Information http://www.dhs.state.mn.us/ecs/program/msa.htm

[5] **Minnesota Supplemental Aid (MSA) - Shelter Needy**
Purpose Provides an additional cash supplement to MSA recipients who are being discharged from state institutions. It is intended to facilitate the transition back into the community by providing a higher level of assistance for ongoing shelter and utility expenses than normally available to MSA recipients.
Global Funding Funding stream is forecasted in MSA total
Individual Funding $135 per month for a monthly total of $768 when SSI and the usual MSA grant are combined.
Eligibility To be eligible for the allowance, an applicant must meet all of the following requirements:

- eligible for MSA,
- relocating to the community from an institution
- under the age of 65.
- determined to be shelter-needy because total shelter costs exceed 40% of the client's gross income before application of this allowance.
- must apply for subsidized housing. Once the client has been approved for and receives subsidized housing, the client is no longer eligible for the supplement

Information http://www.dhs.state.mn.us/ecs/program/msa.htm

[6] **Supplemental Social Security Income (SSI)**
Purpose SSI is a Federal income supplement program funded by general tax revenues (not Social Security taxes). Designed to help aged, blind, and disabled people, who have little or no income. It provides cash to meet basic needs for food, clothing, and shelter. Any person who receives a benefit from SSI is categorically eligible for MA (Minnesota's Medicaid Program) without a spenddown.
Global Funding Federal funding. State may provide supplements-see MSA.

Individual Funding Federal benefit is currently $ 574/month
Eligibility To get SSI, you must be age 65 or older or blind or disabled. Children as well as adults can get benefits because of blindness. Disabled means you have a physical or mental problem that keeps you from working and is expected to last at least a year or to result in death. Children as well as adults can get benefits because of disability. When deciding if a child is disabled, Social Security looks at how his or her disability affects everyday life. For more information about benefits for children, contact any Social Security office to ask for the booklet, *Benefits For Children With Disabilities* (Publication No. 05-10026).
Information http://www.ssa.gov/notices/supplemental-security-income/
See also: Social Security Disability To qualify for these benefits, you must first have worked in jobs covered by Social Security. http://www.ssa.gov/dibplan/index.htm

[7] **Group Residential Housing (GRH)**
Purpose Provides an income supplement to eligible persons to pay for rent and food in specified licensed or registered settings. The supplement is paid directly to providers on the behalf of clients.
Global Funding In FY 02, there were over 4,800 GRH settings serving approximately individuals 13,500 monthly. Funding stream is forecasted. There is no cap on the number of individuals who may use the program. 100% state funded
Individual Funding The base payment is $680 per month. This amount may be supplemented for additional room and board costs or service costs in limited situations.
Eligibility If a person is eligible for GRH, he or she is eligible for Medical Assistance without a spenddown.
Information http://www.dhs.state.mn.us/CFS/Programs/CommLivingSup/GRHInfo.htm

[8] **GRH Metro Demonstration Program**
Purpose Created by the Legislature in 1995 to develop more cost-effective housing solutions for people who cope with mental illness, chemical dependency or HIV/AIDS who were either homeless or at-risk of becoming so. The Demonstration Program was designed and coordinated by the Corporation for Supportive Housing and currently operates in three counties.
Global Funding Up to $2.2 million in state funding to be used for operating support and service subsidies for up to 190 supportive housing unit. Funding is included as part of GRH forecast.
Individual Funding Provides Section 8 type of rental subsidy where individual pay no more than 30% of income for rent
Eligibility Eligible for GRH and MI, CD, or HIV *and* homeless or at-risk of homelessness
Information Staff Contact- 296-6004

[9] **Supportive Housing and Managed Care Pilot**
Purpose Is located in Blue Earth and Ramsey counties and managed by the Hearth Connection, a non profit agency. The Pilot provides affordable housing and other supports necessary for homeless people to lead healthier lives in the community. DHS contracts with the two counties who have in turn contracted with Hearth Connection to manage and administer the Pilot. Hearth Connection contracts with primary provider organizations responsible for direct service provision for a particular area and population group.
Global Funding State funded. Current level of funding is $2 million/yr. to end in FY 2005
Eligibility The Pilot targets very hard to serve single adults and families who are homeless or at risk of homelessness and who have multiple barriers similar to the participants of the GRH Demonstration Program. Current number of participants: 217 from 53 families that includes 154 children located in Ramsey and Blue Earth counties.
Information http://www.dhs.state.mn.us/CFS/Programs/CommLivingSup/default.htm

[10] **Emergency Food and Shelter Program (EFSP)**
Purpose Funds are used for the purchase of food and shelter to supplement and extend local emergency resources. The DHS Office of Economic Opportunity staffs the set-aside committee, which determines the local allocations for EFSP.
Global Funding EFSP funds are administered by the Federal Emergency Management Agency (FEMA) and are allocated to counties by formula. Local jurisdictions disburse funds to agencies that provide emergency services.
Information http://www.dhs.state.mn.us/CFS/OEO/EFSP.htm

[11] **Emergency Services Program (ESP)**
Purpose Funds are used to provide emergency shelter and to assist homeless persons in attaining essential services.
Global Funding Funds are awarded biannually to local providers through a competitive application process. In FY 01, nearly 2,000 homeless households received shelter and 28,000 received supportive services funded by ESP. State funded.
Eligibility Individuals are homeless and do not have resources to afford their own housing**.**
Information http://www.dhs.state.mn.us/CFS/OEO/ESP.htm

[12] **Emergency Shelter Grants Program (ESGP)**
Purpose Funds are provided to shelters, transitional housing programs, and emergency service providers for operating costs, essential services, and prevention activities. These services are provided to families and individuals who are homeless.
Global Funding Federally funded. The Department of Housing and Urban Development (HUD) allocates ESGP funds to the Department of Human Services which awards funds to local agencies through a competitive application process on a biennial basis. In FY 01, ESGP funds were provided to a network of agencies that served 6,131 households throughout MN.
Eligibility Individuals are homeless or at imminent risk of losing their housing and do not have resources to afford their own housing.
Information http://www.dhs.state.mn.us/CFS/OEO/esgp.htm

[13] **Rural Housing Assistance and Stability Program (RHASP)**
Purpose Program provides supportive services to homeless families and individuals to help them secure permanent housing, increase their household income and become increasingly involved in their communities.
Global Funding The RHASP program is funded through the federal Department of Housing and Urban Development's Supportive Housing Program. Services are available in most of the non-metro counties in Minnesota.
Individual Funding In 2001, the program provided a total of 1,134 individuals with first month's rent, damage deposit, transportation, relocation assistance and application fees to stabilize permanent housing
Eligibility Individuals are homeless and do not have resources to afford their own housing**.**
Information http://www.dhs.state.mn.us/CFS/OEO/rhasp.htm

[14] **Transitional Housing Program (THP)**
Purpose Funds providers of housing and supportive services to homeless individuals and families. Programs include congregate facilities or scattered-site transitional housing. Funds may be used for the operating, administrative, and supportive service costs of providing transitional housing
Global Funding State funded
Individual Funding Funds are awarded to local providers through a competitive application process. In FY 01, over 2,500 households received housing with support services through THP.

Eligibility Individuals are homeless and do not have resources to afford their own housing**.**
Information http://www.dhs.state.mn.us/CFS/OEO/thp.htm

[15] **Bridges**
Purpose Program provides rental assistance for households in which at least one adult member has a serious and persistent mental illness. This program links housing with social services through a partnership between a local housing agency and a social service agency.
Individual Funding Provides rental assistance The rental assistance is intended to stabilize the household in the community until a Section 8 certificate voucher becomes available**.**
Eligibility is limited to households with incomes below 50% area median income in which at least one adult member has a serious and persistent mental illness.
Information http://www.mhfa.state.mn.us/multifamily/multifamily_homeless.htm

[16] **Community Support Services for Adults with Serious and Persistent Mental Illness (SPMI) (Adult Rule 78)**
Purpose Grants are awarded to counties for community support services. These grants include a separate allocation which is based on the amount each county formerly received as the state share of MA case management, adjusted by the number of people now being served by each county.
Global Funding Effective 7/1/99, counties became responsible for the non-federal share of MA case management, but they can use this "former state share" grant to meet part of that responsibility. 100% state funds No cap, although funds may be limited to rental payments only if funds are likely to not cover the fiscal year. In CY 01, approximately 350 individuals were served.

[17] **Crisis Housing**
Purpose Provides financial assistance to hospitalized clients needing help to pay for their housing. These funds are used only when other funds, such as SSI, are not available. Funds are accessed by case manager or provider, not given directly to consumer**.**
Eligibility People need to be in inpatient care for up to 90 days and have no other help to pay for housing costs. No maximum amount of money available per person.
Information http://www.mhponline.org/Sidebar/crisishousing2.htm

[18] **Mental Health Initiative/Integrated Fund**
Purpose Supports local planning and development to expand community-based services to develop alternative service delivery models to reduce reliance on facility-based care. The Adult Mental Health Initiatives, are helping thousands of Minnesotans with serious and persistent mental illness to live, work and recreate in the community. Through the initiatives, local mental health authorities have designed community-based delivery systems to: provide an expanded array of services for consumers to select; improve access and coordination of services without cost shifting; integrate state facilities and human resources into the community mental health system, and use funding streams and reimbursements creatively. The initiatives range from single-county efforts in the metro area to partnerships involving up to 18 counties. Each initiative is tailored to local needs. The initiatives include a variety of services and supports, including but not limited to the following: expanded crisis services, housing and housing supports, supported employment, and Assertive Community Treatment teams providing intensive case management.
Global Funding No cap on funding. Availability is constrained by amount of funding available

See also: **Offenders with mental illness** A new initiative will provide alternative placements and treatment in the community for convicted offenders with mental illness who are being considered for a prison sentence. Courts will have authority to determine when this option would be consistent with public safety and the needs of the individual.

[19] Projects for Assistance in Transition from Homelessness (PATH)

Purpose Funds from the DHHS (Center for Mental Health Services) to the State, are awarded to 8 counties to provide outreach, engagement and mainstreaming for homeless persons with a serious mental illness.
Global Funding Grants to counties are made in combination with Rule 78 Community Support funds. In FY 2002, approximately 6,993 individuals were served
Eligibility A homeless person by State definition who is believed to have a serious mental illness by PATH staff**.**

[20] Restructure of Rule 36 Residential Treatment Facilities

Purpose This effort is currently in the planning phases with implementation projected to be 7/04. A portion of the current Rule 36's will convert to an intensive residential treatment facility with an average length of stay of 90 days. Funding for remaining Rule 36 facilities will be used to develop a range of permanent housing options partly supported by $2 million in state Rule 36 grant funds or for the development of Assertive Community Treatment (ACT) teams. The intensive residential and ACT teams will receive MA reimbursement for persons who are MA eligible. The non federal share of both will be allocated from the current Rule 36 grant funds to counties**.**

[21] Medical Assistance-General Information

Purpose More than 400,000 Minnesotans receive health care coverage through Medical Assistance (MA) — Minnesota's Medicaid program — the largest of the state's health care programs. MA provides necessary medical services for low-income families, children, pregnant women, and people who are elderly (65 or older) or have disabilities.
MA programs include "State Plan" and "Waiver" programs. The federal Centers for Medicare and Medicaid Services (CMS) administers Medicaid nationwide, providing funding, approving state plans, and ensuring compliance with federal regulations.
Global Funding In Minnesota, the Department of Human Services (DHS) oversees the Medicaid (Medical Assistance) program, administered locally by counties and funded with $4.1 billion a year in total federal and state funds. Medicaid is the largest single source of federal funding in Minnesota's budget.
Individual Funding Total average monthly enrollment in FY 2002 was 397,849.
Eligibility Must meet income and asset limits; Must be Minnesota resident. Must be U.S. citizen or "qualified" noncitizen
Income limits
There are many categories with different income standards. Examples of net income limits are:

Effective through 6/30/04		Yearly	Monthly
Adults with children	Family of two	$12,120	$1,010
	Family of four	$18,408	$1,534
Pregnant women	Family of two	$33,336	$2,778
	Family of four	$50,604	$4,217
Infants under age 2	Family of two	$33,936	$2,828
	Family of four	$51,528	$4,294
People 65 or older, people who are blind, people who have a disability	Family of one	$8,988	$749
	Family of two	$12,120	$1,010

Applicants who make more than MA income limits may still qualify if they have enough medical bills to meet a "spend down" (similar to an insurance deductible), in which their medical bills exceed the difference between their income and the MA standard.

Asset limits

Children (under 21) and pregnant women – None
People 65 or older, people who are blind, people who have disabilities
$3,000 for a single person
$6,000 for a household of two, plus $200 for each additional household member
Families with children
$10,000 for a household of one
$20,000 for a household of two

Information **http://www.dhs.state.mn.us/HealthCare/asstprog/mmap.htm**

[21] MA Targeted Case Management (TCM)

Purpose Provides grants to counties that can be used to pay the county share of MA case management or for expanded mental health services. The amount is adjusted annually based on the number of clients served by each county. Certified counties receive Medical Assistance (MA) reimbursement for case management activities for children who are at risk of or experiencing maltreatment or out-of-home placement or are in need of protection and services. All counties in Minnesota are participating in Child Welfare-TCM. Legislation allows for the extension of the program to contracted staff and to tribal social services. Consumer has choice of whether to accept service or not.
Global Funding Federal and State funding.
Information Mental health targeted case management (MH-TCM) is a mental health service in accordance with Minnesota Rules, part 9505.0323. Medical Assistance reimburses mental health targeted case management provided to eligible persons with a serious and persistent mental illness or to children with a severe emotional disturbance. Case manager qualifications and responsibilities are defined in the Comprehensive Mental Health Acts for Adults and Children, Minnesota Statutes, section 245.461 through section 245.4861 and 245.487 through 245.4887, respectively.

[22] MA Rehabilitation Option

Purpose Under MA state plan that allows for greater flexibility in how and by whom rehabilitation services can be provided. The two service groupings are: adult rehabilitative mental health services (ARMHS) and crisis response services. Rehabilitation services are direct treatment services. The Rehab option does not reimburse providers for providing Medicaid rehabilitation services to persons with mental retardation.
Global Funding No cap on the number of eligible persons who may access funding. Funding is forecasted.
Individual Funding Pays for direct treatment services.
Eligibility Eligible recipient is an MA eligible individual who is age 18 or older
is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed; has substantial disability and functional impairment in three or more areas, so that self-sufficiency is markedly reduced; and
has had a recent diagnostic assessment by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals
Information http://www.dhs.state.mn.us/Contcare/mentalhealth/amhrs.htm http://www.dhs.state.mn.us/Provider/manual/chapter16.htm

[23] **Alternative Care (AC)**
Purpose Program provides funding for home and community-based services to persons age 65 and older who are in need of assistance with chronic care needs to remain in a community setting.
Global Funding State funded service program for elderly but not MA Waiver. The number served is limited by the program allocation available within the state's fiscal year. In FY 02, approximately 12,193 people were served.
Individual Funding The maximum amount of money available per person is determined on a monthly basis according to the case mix assigned during the assessment of client needs and strengths.
Eligibility A person age 65 and older who is assessed through the Long-Term Care Consultation (LTCC) process is eligible for AC funding when the following are true:
1) The person is in need of nursing facility level of care and admission is recommended,
2) The person's income and assets would be inadequate to fund a nursing facility stay for more than 180 days, 3)The person chooses to receive community services instead of nursing facility services. 4) No other funding source is available for the community services
Information http://www.dhs.state.mn.us/newsroom/Facts/AltCareProgram.htm

[24] **Community Alternative Care (CAC) (MA Waiver)**
Purpose To provide home and community-based services necessary as an alternative to institutionalization that promote the optimal health, independence, safety and integration of a person who is chronically ill or medically fragile and who would otherwise require the level of care provided in a hospital.
Global Funding In FY 02, approximately 139 people were served. Up to 170 individuals may use the waiver. Funding stream is forecasted. Federal and state funded**.**
Individual Funding The monthly dollar cap is based on the diagnosis and the DRG grouping at the current time. (This will change with the aggregate methodology implementation.)
Eligibility for the CAC Waiver is determined through a screening process. To be eligible for the CAC Waiver, a person must meet all these criteria:

- Be a Medical Assistance recipient or be eligible for MA
- Require the level of care provided in a hospital
- Be under the age of 65 years at the time of application
- Choose care in the community instead of a hospital
- Be certified as disabled by the Social Security Administration or the State Medical Review Team
- Have a Community Support Plan, which includes assurances of the health and safety for the person

Information http://www.dhs.state.mn.us/Contcare/disability/cacwaiver.htm

[25] **Community Alternatives for Disabled Individuals (CADI) (MA Waiver)**
Purpose Provides funding for home and community-based services for children and adults under age 65 who would otherwise require the level of care provided in a nursing facility.
Global Funding In FY 02, approximately 6,151 people were served.
Legislation this year put a limit on growth over the next two years Current cap on number served - 10/1/02-9/30/03 = 9,511 individuals. Cap on number served - 10/1/03-9/30/04 = 10,721 individuals, however federal authority is being sought to increase those numbers because of unprecedented growth. Funding stream is forecasted. Federal and state funded.
Individual Funding Dependent on individual case mix, however there is a request to exceed process, and next year there will be an aggregate funding allocation to counties similar to MR/RC waiver.
Eligibility for the CADI Waiver is determined through a screening process. To be eligible for the CADI Waiver, a person must meet the following criteria:

- Be a Medical Assistance recipient or be eligible for MA
- Be under the age of 65 years at the time of application

- Be determined to likely require the level of care provided to individuals in a nursing facility
- Choose care and services in the community instead of a nursing facility
- Be certified disabled by the State Medical Review Team or by the Social Security Administration

Information http://www.dhs.state.mn.us/Contcare/disability/cadiwaiver.htm http://www.dhs.state.mn.us/provider/manual/chapter26.htm

[26] **Elderly Waiver (EW) (MA Waiver)**

Purpose Provides funding for home and community-based services for adults age 65 and older who, through a community assessment, are determined to need the level of care provided in a nursing facility.

Global Funding In FY 02, approximately 11,912 individuals were serve. Up to 15,000 may use the waiver (7/03-6/04) Funding stream is forecasted. Federal and state funded.

Individual Funding The amount of money available per person varies based on each individual's dependencies**:**

Elderly Waiver	
Case Mix	Monthly Cap as of 7/1/2003
A	$1,963
B	$2,233
C	$2,620
D	$2,707
E	$2,985
F	$3,076
G	$3,174
H	$3,581
I	$3,675
J	$3,917
K	$4,565

Eligibility Recipient must eligible for MA, 65 years of age or older and need nursing home level of care as determined by the Long-Term Care Consultation process

Information http://www.dhs.state.mn.us/newsroom/Facts/EWfs.htm http://www.dhs.state.mn.us/provider/manual/chapter26.htm

[27] **Mental Retardation/Related Conditions (MR/RC) (MA Waiver)**

Purpose Waiver provides funding for home and community-based services for children and adults with mental retardation or related conditions as an alternative to intermediate care facility for persons with mental retardation or related conditions (ICF/MR) placement.

Global Funding Federal and state funding. Up to 16,715 individuals may use the waiver
(7/03-6/04) Approximately 14,814 individuals are currently on the waiver. Funding stream is forecasted.

Individual Funding Maximum Amount of Money per Person

The MR/RC waiver has an aggregate budget methodology. Counties receive a calendar year budget amount based on paid claims for services for people on the MR/RC waiver, for the previous fiscal year, with adjustments. If a person enters the waiver in a brand new allocation (either authorized by the legislature through funding increases, or because of the decertification of an

ICF/MR bed), resources are added to the county budget based on the "profile" of the person. The profile is determined based on the screening document assessment information on the person's medical and behavioral functioning. For FY 04, the daily resource amounts are:
Profile I = $197.20 Profile II = $166.53 Profile III = $141.15 Profile IV = $117.53
Eligibility for the MR/RC Waiver is determined through a screening process. To be eligible for the MR/RC Waiver, a person must meet the following criteria:
1) Be a Medical Assistance recipient or be eligible for MA, 2) have mental retardation or a related condition, 3) require the level of care provided to individuals in an ICF/MR, 4) make an informed choice requesting home and community-based services instead of ICF/MR services
Information http://edocs.dhs.state.mn.us/lfserver/Legacy/MS-2015-ENG
http://www.dhs.state.mn.us/Contcare/disability/mrrcwaiver.htm
http://www.dhs.state.mn.us/provider/manual/chapter26.htm

[28] **Traumatic Brain Injury (TBI) (MA Waiver)**
Purpose Provides funding for home and community-based services for children and adults under age 65 who have an acquired or traumatic brain injury.
Global Funding In FY 02, approximately 639 individuals were served
Current cap on number served - 4/1/03 – 3/31/04 = 1,306 individuals. The 2003 Legislature capped growth at 150 new clients per year for the biennium. Funding stream is forecasted. Federal and state funded
Individual Funding Dependent on individual case mix or neurobehavioral hospital per diem, however there is a request to exceed process, and next year there will be an aggregate funding allocation to counties similar to MR/RC waiver.
Eligibility for the TBI Waiver is determined through a screening process. To be eligible for the TBI Waiver a person must meet all criteria**:**
Be a Medical Assistance recipient or be eligible for MA

- Have a diagnosis of traumatic or acquired brain injury or an acquired or degenerative disease diagnosis where cognitive impairment is present
- Experience significant/severe behavioral and cognitive problems related to the injury
- Be under the age of 65 years at the time of application
- Be certified as disabled by the State Medical Review Team or by the Social Security Administration
- Be determined to need the level of care available in a nursing facility (NF) or neurobehavioral (NB) hospital
- Choose services in the community instead of services in a nursing facility or neurobehavioral hospital
- Be assessed at Level IV or above on the Rancho Los Amigos Levels of Cognitive Functioning Scale

Information http://www.dhs.state.mn.us/Contcare/disability/tbiwaiver.htm
http://www.dhs.state.mn.us/provider/manual/chapter26.htm

[29] **General Assistance Medical Care (GAMC)**
Purpose State program provides coverage for health care services including preventive care, hospitalization, mental health and chemical dependency services, prescription drugs and dental care.
Global Funding State funding. Forecasted program.
Individual Funding There are two levels of covered services. Covered health care services under the comprehensive benefit package include doctor visits, hospitalization, prescriptions, eye exams, eye glasses, dental care and more. Hospitalization only coverage provides inpatient hospital coverage, including physicians' services during hospitalization**.**
Eligibility Low-income adults, ages 21-64, who have no dependent children and who do not qualify for federal health care programs, live in Minnesota for at least 30 days and intend to stay, be a U.S. citizen or "qualified" non-citizen. Income limits vary depending on family size and benefit level. The asset limit is $1,000 for comprehensive coverage. The asset limit for hospitalization only coverage is $15,000 for one and $20,000 for two or more. To qualify, you must not be eligible for Medical Assistance**.**

Information http://www.dhs.state.mn.us/HealthCare/programs/gamc.htm

[30] **Consolidated Chemical Dependency Treatment Fund (CCDTF)**
Purpose Funds treatment of eligible people who have been assessed to be in need of treatment for chemical abuse or dependency. Services are provided to anyone who is found by an assessment to be in need of care and is financially eligible, unless the needed services are to be provided by a managed care organization under which the person is enrolled.
Global Funding Funding stream is forecast. There is no cap on the number of individuals who may use the program**.**
Individual Funding Approximately 18,500 individuals are served annually**.**

Eligibility Eligible clients (Tier 1) includes those who are enrolled in Medical Assistance (MA), General Assistance Medical Care (GAMC), receive **Minnesota** Supplemental Assistance (MSA), or meet the MA, GAMC, or MSA income limits
Information http://www.dhs.state.mn.us/Contcare/chemicalhealth/programservice.htm

[31] **HIV/AIDS Grants**
Purpose Provide a menu of services specifically for HIV-infected people to prevent or delay enrollment in the MA or GAMC programs.
Global Funding In FY 00, HIV/AIDs program helped 981 people with case management services. Federal and State funding
Individual Funding Pays for Dental, Drug Reimbursement, Insurance premium, Nutrition assistance.
Eligibility Service people living with HIV who have income under 300% of the federal poverty guideline and cash assets under $25,000.
Information http://www.dhs.state.mn.us/Contcare/hiv/mnhivprograms.htm

[32] **Childrens' Mental Health**
Purpose A variety of initiatives assist children, families and communities through DHS' Children's Mental Health Division, who work closely with county and collaborative partners to deliver a continuum of mental health services to children and families. Children's mental health collaboratives address the needs of children with SED and EBD and children at risk of these conditions. Partners in collaboratives include representatives or staff from at least one county, one school district, juvenile corrections and a local mental health entity or provider. Local children's mental health collaboratives are designed to ensure appropriate responses whenever a family comes in contact with the system. The wraparound process is a core planning process that replaces categorical approaches to improving the lives of children and families who have complex needs and are served by many agencies. A child and family team develops individualized, culturally competent mental health care plans. These involve informal and formal supports that are centered on the unique needs, strengths, values, norms and preferences of children, families and communities.
Information http://www.dhs.state.mn.us/newsroom/facts/CMH_collab.htm

[33] **Consumer Support Grants**
Purpose To assist people with functional limitations and their families in directly purchasing and securing supports needed to live as independently and productively as possible in the community. Consumer Support Grants enable consumers to receive support grant as an alternative to home care services benefits they received through MA, the AC program or the Family Support Grants.
Global Funding Consumer Support Grants are administered through the counties. In FY 02, approximately 208 people were served. Currently state funded.
Individual Funding Recipients receive a grant amount less than or equal to the state share of the amount of certain long-term care services they have received under other programs
Eligibility Those eligible to receive MA, AC or Family Support Grants
Information http://www.dhs.state.mn.us/Contcare/disability/conssupportgrant.htm

	Program Name	CAPITAL	OPERATING		SERVICES									
DHS	Minnesota Supplemental Aid (MSA)[3] State Funding-SSI eligibility	N	Y-at recipient's discretion	N (see EMSA)										
DHS	Emergency Minnesota Supplemental Aid (EMSA)[4] State Funding-SSI eligibility	N	Y-only in emergency situations	Y-only in emergency situations										
DHS	Minnesota Supplemental Aid Shelter Needy[5]-<65 to move out of NF, Hospital, ICF	N	Y	N (see EMSA)										
	Supplemental Social Security SSI[6] Federal funding (see also state supplements-MSA)	Income support program for aged, disabled-	Income may be used for all categories											Federal standards for eligibility- Very low income- few assets.
Community Living Supports														
DHS	Group Residential Housing (GRH)[7] similar to SSI eligib.- State Funding		Y	N	N	N	N	N	N	N	N		N	
DHS	GRH Metro Demo Program[8] GRH eligibility-at risk of homelessness State Funding		Y	Y	Y	N	Y	Y	Y	N	N		Y	Services may be covered under other state program i.e. MFIP
DHS	Supportive Housing Managed Care Pilot[9]-GRH eligibility and at risk of homelessness State Funding		Y	Y	Y	N		Y	Y		N		Y	
Office of Economic Opportunity														
DHS	Emergency Food and Shelter Program[10]	N	N	Y	N	N	N	N	N	N	N	N	N	Food shelf, motel voucher
DHS	Emergency Services Program[11]	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	

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[34] **MFIP Consolidated Fund**
Purpose Grants allocated to counties for flexible uses that must include Emergency Assistance and can include employment and training services and the provision of case management for eligible MFIP recipients. Product of 2003 Legislative session. Funding for numerous separate programs is consolidated and accountability for outcomes is increased. Counties will have more flexibility to continue successful approaches to support MFIP families going to work.
Global Funding Funding will be allocated to counties and tribes based on historic State Fiscal Year 2002 spending.
Individual Funding Will vary by county

Eligibility MFIP Eligibility
Information http://www.dhs.state.mn.us/newsroom/Facts/2003session/2003welfareReform.htm

	Program Name	CAPITAL	OPERATING		SERVICES									
DHS	Emergency Shelter Grants Program[12]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
DHS	RHASP[13]	N	N	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	
DHS	Transitional Housing Program[14]	N	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	
Mental Health														
DHS-MHFA	Bridges[15] State funding		Y	Y										Housing support provided by DHS -
DHS	Community Support Services for Adults with SPMI (Rule 78)[16] State Funding				Y			Y						Non-MA eligibles Also benefit & crisis assist
DHS	Crisis Housing[17] for Adults with SPMI who are in institutional care up to 90 days and no other source of funding State Funding		Y – up to 3 months rent											Also mortgage payment for and utilities payments up to 3 months
DHS	Mental Health Initiative/ Integrated Fund (Son of Bridges)[18] In or at risk of RTC hosp. State funding	Y	Y	Y Rest of MHI/Integrated Funds	Y $3.2 M state funds = Total	Y	Y	Y		Y	Y	Y		Funding is limited and fixed In CY 2002 = 52 counties and $1,339,708 in housing
DHS	Projects for Assistance in Transition from Homelessness (PATH)[19] Federal and State funding	Y – Housing renovation, expansion, and repairs; Planning of housing; assistance; services	Y – One time rental payments to prevent eviction	Y – Security deposits	Y – Technical assistance in applying for housing assistance, Improving the coordination of housing							Y-Outreach - connecting to Mainstream MH service		Limited to 8 counties -Supportive and supervisory services for residential settings; -Screening and diagnostic treatment services; -Habilitation and rehabilitation services; -Community mental health services; -Alcohol or drug treatment services; -Training; -Case management
DHS	Restructure of Rule 36 Residential Treatment Facilities[20] Federal and State funding	Y Development of Housing	Y	Y		Y		Y				Y		Also housing development $ and Assertive Community Treatment teams
	Medical Assistance													
DHS	MA Targeted Case Management[21] Eligibility SPMI, MA eligible													County administered-covers non-fed. share of

	Program Name	CAPITAL	OPERATING		SERVICES									
	Consumer has choice of whether to accept or not													MA
DHS	MA Rehabilitation Option ARMHS[22] SMI Federal and State Funding				Y			Y			Y-not direct job coaching	Y		MA eligible SMI w/ 3 or more funct.limit
DHS	MA Rehabilitation Option Crisis Response[22] SMI											Y		
	HCBS Waivers + Waivers from Fed. MA requirements-Approx. 50-50 Fed/State Funding													
DHS	Alternative Care Program[23] State Funded program- piggyback on Elderly Waiver				Y-through case management	Y	Y-limited basis in certain counties	Y-limited basis in certain counties	Y-caregiver training and professional case management	Y-limited to AC type service and supportive services access	N			
DHS	CAC waiver[24]													
DHS	CADI waiver[25]				N	Y	Y	Y	Y	Y	Y			
DHS	Elderly waiver[26]				N	Y	N	N	Y	Y	N			
DHS	MR/RC waiver[27]				Y-through housing access coordination	Y-to home and vehicle	N	Y-DT&H, in-home family support, supported living	Y-caregiver training & ed consumer training & ed	Y	Y-supported employment			
DHS	TBI waiver[28]				N	Y	Y	Y	Y	Y	Y			
DHS	GAMC[29]													
Chemical Health														
DHS	Consolidated Chemical Dependency Treatment Fund[30]				N	N	Y	N	Y	N	Y			
HIV/AIDS														
DHS	HIV/AIDS grants and services[31]													

Program Name		CAPITAL	OPERATING		SERVICES									
Other														
DHS	Children's Funding[32]													
DHS	Consumer Support Grants[33]													
DHS	MFIP Consolidated Fund[34]													
Veterans														

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MINNESOTA HOUSING FINANCE AGENCY - CAPITAL, OPERATING AND SERVICES FUNDING ANALYSIS

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
MHFA Housing Trust Fund	Capital, Operating and Rental Assistance funding with a funding priority for supportive housing and housing that serves homeless.	General Fund State Appropriations FY 2004-2005 $8,610,000 MHFA	Incomes must not exceed 60% AMI, 75% of program funds for incomes that must not exceed 30% metro AMI statewide. (2003 statewide area median income is $65,100).	Provides 0% interest deferred loans.	Provides grants for unique operating costs and revenue shortfalls (operating deficits). Also, provides project-based and tenant based rental assistance program funding. Rental subsidy levels can be structured with either deep and shallow subsides (30% of tenant's income for rent or a capped amount).	Not applicable – prohibited by statute.	Limited resources, operating funding still an ongoing issue, often need Section 8 to fully cover operating funding. Capital - often need Section 8 to make the rents affordable to the most vulnerable populations Operating- Short term grants (10 years), not available for the life of the loan Rental Assistance – 1. Tenant based -program funding, works well because its scattered site housing and tenants have housing choice. ***(continued on next page)***	MHFA has the ability to allocate the funds among any of the three activities as funding priorities change.

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
MHFA Housing Trust Fund ***(continued)***							2. Projected based -Short term grant does not work well because MHFA does not have the resources to commit to project based development funding for 30 years.	
Low-Income Housing Tax Credits	The Housing Tax Credit (HTC) Program offers a ten-year reduction in tax liability to owners and investors in eligible affordable rental housing units.	FY 2004-2005 $8.8 million approximately; including over $5 million to MHFA and over $4 million to Suballocators. The Federal Tax Reform Act of 1986 Section 42 of the Internal Revenue Code Minnesota Statute 462A221 to 225	Residential Rental proposals where at least 50% of the units have rents affordable to households with incomes at 60% AMI or less; or 20% of the units have rents affordable to households with incomes at 50% AMI or less.	Housing units produced as a result of new construction, substantial rehabilitation, or acquisition with substantial rehabilitation. Program space can be considered part of basis, (not to exceed 20% of total basis) and use of that space by non-residents is permitted, as long as users' income is 60% or less of AMI.	Not an eligible use.	Not an eligible use.	Limited resources, supportive housing projects are competing with other affordable housing projects that need less additional resources. If Transitional Housing, residents must meet McKinney Act definition of homeless.	Developments proposing to set aside units for "households with special needs" or building SRO units will receive funding priority. A set aside for supportive housing for long term homeless is possible but first the MN HTC Statute and Qualified Allocation Plan (QAP) must be changed to allow chronically homeless as a targeted population under selection requirements. A priority for long-term homeless would require QAP change but not statutory change.

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Section 8 Housing Assistance Payments	Tenant pays 30% of income for rent and HUD pays the difference. Tenant based or project based.	FFY 2004-2005 $136,000,000 MHFA for project based assistance. PHAs and HRAs directly receive Section 8 funds for tenant based or project based vouchers. HUD 24 CFR Part 982	Incomes below 50% AMI or contracts before 1981 30% of units must have incomes below 50% AMI. Must be fair market rent.		Provides project-based and tenant based rental assistance. Tenant pays 30% of income for rent. PHA applies for tenant based housing choice vouchers. A PHA can use up to 20 percent of its housing choice vouchers for project based vouchers, funds are obligated under the annual contributions contract (ACC).	Recently HUD has allowed tenant service coordinator expenses to be paid out of the operating budget. Rents may be increased under operating cost adjustment factor (OCAF) contracts to fund service coordination. Not all developments have OCAF rent increases.	Rent subsidies through Section 8 assistance is the key to covering operating costs in supportive housing MHFA project based units can not be diverted At one point in time, federal Section 8 preferences gave priority for occupancy by homeless or households at risk of becoming homeless.	Create a set aside within current MHFA project based units for future supportive housing units or consider using a select number of smaller project based family developments as permanent supportive housing sites. PHAs/HRAs could project base tenant based vouchers for supportive housing units?

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Family Homeless Prevention and Assistance Program (FHPAP)	Housing and support services designed to stabilize people in their existing homes, shorten the amount of time that people stay in emergency shelters, and assist people with securing transitional or permanent affordable housing to eliminate repeated episodes of homelessness. MHFA	General Fund State Appropriations FY 2004-2005 $7,430,000 MHFA	Eligible Applicant: A county or group of contiguous counties jointly acting together or a non-profit organization with sponsoring resolutions from each county board within its operating jurisdiction. Projects must be designed to stabilize households in existing housing, shorten shelter stay, and assist households to secure permanent housing.	Not allowable under current state statute.	Funds can be used to provide up to 24 months of rent assistance.	Funds can be used for any type of support services to help households maintain stable housing.	Program intent is to provide a systems change response to effectively use community resources to prevent homelessness and to rapidly re-house and stabilize households that have become homeless. Local projects target funds to serve the greatest number of households at the lowest cost in the shortest length of time to achieve effective outcomes. Using funds for Permanent Supportive Housing would decrease the ability to serve a large number of households.	Local projects could choose to direct funds to support services and rent assistance costs for permanent supportive housing. And/or a specified amount of funds could be set aside for specific projects (but with 2 year limitations for rent assistance).
Bridges	Rental assistance for persons with mental illness until a Section 8 certificate becomes available.	FY 2004-2005 $3,276,000 MHFA 982 households served in FY 2001-2002	Incomes below 50% AMI and one adult member with a serious and persistent mental illness.	NA	Provides tenant based and could provide project based rental assistance. Tenant pays 30% of income for rent.	Prohibited by MN statute, requires service linkage to DHS/county mental health services.	Limited resources.	If more resources, could expand. Program is administered through housing authorities in partnership with Adult Mental Health Initiatives.

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Housing Opportunities For Persons with AIDS (HOPWA)	HOPWA funds may be used for a wide range of housing, social services, program planning, and development.	2003 Formula Allocation Minneapolis EMA $839,000 Minnesota $109,000 Funding priorities are set by the MN HIV Housing Coalition.		Acquisition, rehabilitation, or new construction of community residences or SRO housing units.	Costs for facility operations and rental assistance.	Health care and mental health services, chemical dependency treatment, nutritional services, case management, assistance with daily living, and other supportive services.	HOPWA rental assistance is currently maximized and in use. All units funded with HOPWA must be occupied by a family or person living with HIV/AIDS.	
Tribal Indian Housing	Mortgage loans, home improvement financing and rental assistance opportunities to American Indian people through out the state.	General Fund State Appropriations May be used for homeownership loans. FY 2004-2005 $2,210,000	Minnesota Chippewa Tribe, Sioux communities, Red Lake band of Chippewa Indians.		Rental subsidies		Tribes could choose to change priorities to operating or for homeless prevention and housing tenancy support services.	
Urban Indian Housing	Homeownership and rental housing opportunities for low and moderate-income American Indians residing in urban areas.	General Fund State Appropriations FY 2004-2005 $360,000	American Indians in cities of 50,000 with an American Indian population in excess of 1000.		Rental subsidies.	Funding available for special assistance program components of projects that address specifically identified needs of American Indians.	Could choose to change priorities to operating or for homeless prevention and housing tenancy support services through the application process and the Council of Urban Indians.	

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
HOME Rental Rehabilitation Program	Deferred loans to rehabilitate privately owned rental property.	FY 2004-2005 $10.3 million MHFA FY 2004-2005 $12.8 million For the 6 Entitlement Communities - cities and counties. MHFA is the funder, delivering assistance through a network of local governments and nonprofit organizations in areas that do not receive a HOME allocation directly from HUD.	Nonprofits, individuals, corporations, partnerships. 90% of tenants must not have incomes exceeding 60% AMI, adjusted for family size. Other rent and occupancy restrictions apply if the project has 5 or more units.	0% loans of $100,000 or less, forgiven after 5-year affordability compliance. Requires a 25% owner match. 0% deferred loans of $100,000 or more require no owner match, but must be repaid at first mortgage maturity or earlier transfer of title. Maximum loan is $14,000 per unit.	No	No	No	
HOME (Activities that are eligible under HOME but that MHFA does not fund).	HOME (Activities that are eligible under HOME but that MHFA does not fund).	May be used to support the acquisition, new construction, reconstruction, or rehabilitation of non-luxury housing, for tenant-based rental assistance, and to support CHDOs.	Approximately $10 million received per year, allocated among HOME Rental Rehabilitation, Minnesota Urban Rural Homesteading, and CHDO Operating Funds programs, and MHFA administrative expenses.	Nonprofits, individuals, corporations, partnerships. 90% of tenants must not have incomes exceeding 60% AMI, adjusted for family size. Other rent and occupancy restrictions apply if the project has 5 or more units.	May be grants, loans, deferred loans, interest subsidies, equity investments, loan guarantees.	HOME may be used to pay a portion of the operating expenses of CHDOs that own, sponsor, or develop housing that is funded with CHDO set-aside dollars.	No	

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Multifamily Endowment Fund	MHFA Endowment Fund used for Flexible Financing for Capital Costs to complete the gap in development projects once underwriting is complete and the Contingency Fund.	MHFA Endowment Fund expenditures and repayments are redetermined for new activities every two years.	No income or rent limits.	Can be used for gap financing in conjunction with Agency amortizing first mortgages	May be used for one time rent subsidies.	May be used to fund tenant service coordination.	Flexible, limited funding source. Balance at this time is $11 million. Used primarily to support first mortgage program that in turn generates funds to support operations of the Agency plus provide funding for future loan activity from interest earnings on amortizing first mortgages.	May be used for anything the Agency statute and board authorizes. Use of this resource for purposes other than supporting amortizing loan activity would result in fewer new affordable units being produced, higher rents on new units, and reduction in future sources of operating funds and loan activity.
HUD McKinney- Vento Homeless Assistance Funds								
Supportive Housing Program (SHP)	Innovative supportive housing, permanent housing for disabled persons, and safe havens developed to allow homeless persons to live as independently as possible.	FY 2003 SHP/SPC $13,746,333 potential pro-rata share, plus bonus funding FY 2002 SHP/SPC $16,189,105 HUD McKinney-Vento Homeless Assistance Funds Subtitle C of Title IV of the McKinney-Vento Homeless Assistance Act, 24 CFR part 583	Must serve people who are homeless.	Acquisition, rehabilitation, new construction. Requires 50% match.	Operating Costs - requires cash contribution of 25% of the total operating costs. Safe havens limit overnight occupancy to 25.	Supportive Services - requires cash contribution of 20% of total supportive service costs. Supportive services only provider may not also provide the housing.	Resources are limited and competitive, only a couple new projects can be funded each year. In Ramsey and Hennepin Counties renewal project funding needs may not be met. Funding may be on a 1-2 year basis, making it difficult to access other ongoing funding.	Planning capacity to obtain funding in Greater MN could be improved. Prioritize for safe havens or CD?

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Shelter Plus Care (SPC)	Rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded outside the program	**FY 2003 SHP/SPC $13,746,333 potential pro-rata share, plus bonus funding** **FY 2002 SHP/SPC $16,189,105** HUD McKinney-Vento Homeless Assistance Funds Subtitle F of Title IV of the McKinney-Vento Homeless Assistance Act, 24 CFR part 582	Must serve people who are homeless and disabled. Government or PHA must apply.		Tenant, sponsor, project or SRO based rental assistance Rental assistance must be matched dollar for dollar with support services		Resources are limited. Compete with permanent Supportive Housing Program projects.	Support service funding match could be MA?
Section 8 SRO Moderate Rehabilitation Program	Rental assistance on behalf of homeless individuals in connection with moderate rehab. Units for occupancy by one person, may contain food preparation or sanitary facilities.	Funding is available for SRO Mod Rehab. HUD McKinney-Vento Homeless Assistance Funds Section 411 of the McKinney-Vento Homeless Assistance Act, 24 CFR part 882	**Must serve people who are homeless.** **Non-profit organizations and PHAs must apply.**		SRO housing rental assistance. Rental assistance covers operating expenses including debt services for rehabilitation financing but resources outside of the program pay for rehab.			

MINNESOTA DEPARTMENT OF EMPLOYMENT AND ECONOMIC DEVELOPMENT- CAPITAL, OPERATING AND SERVICES FUNDING ANALYSIS

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Extended Employment - Basic Funding	Provides funding for supported and center-based employment to persons with severe disabilities through a network of 30 community rehabilitation programs. Supported employment provides ongoing support for persons working in the larger community in a variety of employment settings.	State General Fund $11,510,00 MN Stat. §268A.13 - .§268A.15	Individuals with severe disabilities enrolled in one of 30 community rehabilitation programs.	N/A	Staff and non-personnel expenses.	Services are provided by community rehabilitation programs (CRPs). CRPs provide services that are necessary to maintain or advance the worker's employment including job skill training at the work site; behavior management, job-related self-advocacy skills training; communication skills training; ***(continued on next page)***		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Extended Employment - Basic Funding ***(continued)***	Center-based employment provides ongoing support for persons who work in manufacturing, services, and retail enterprises operated by the community rehabilitation program					independent living skills training; training in job seeking skills; career planning, job development; job placement; rehabilitation technology, job redesign, or environmental adaptations; disability awareness training for the worker, the worker's employer, supervisor or co-workers, and other services to increase the worker's inclusion at the work site; job-related safety training; facilitation of natural supports at the work site; transitional employment services; other services needed to maintain or advance the employment of these workers.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Extended Employment-Coordinated Employability Projects	This program provides employment supports to persons with serious and persistent mental illness (SPMI) who secure employment through 23 Coordinated Employability Projects. These projects are a collaborative effort with the Mental Health Division of the Department of Human Services, which provide valued workers to Minnesota employers. Assist individuals with SPMI to find employment. Provide on-going supports to maintain employment. Support employers who have workers with SPMI. (continued on next page)	State General Fund $1,180,000 MN Stats. Section 268A.13 to 268A.15	Individuals with serious and persistent mental illness enrolled in one of Coordinated Employability Projects.	N/A	Cost of 1.0 FTE to provide contract management, training, program management, program evaluation and data analysis.	Services that are necessary to find, maintain or advance the worker's employment. These supports are a rehabilitation intervention in which providers work with individuals who have attained jobs to help them stay attached to the labor force Services include: job skill training; behavior management; job-related self-advocacy skills training; communication skills training; training in job seeking skills; career planning, job development, or job placement; job-related safety training; transitional employment services.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Extended Employment-Coordinated Employability Projects ***(continued)***	Make employment for individuals with SPMI available throughout the state. Coordinate services with county and state human services programs. Reduce the need for hospitalization and other services.							

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Food Support Employment and Training Program	The Food Support and Training Program (FSET) is designed to provide food support recipients who do not receive other case assistance with services that will result in employment and self-sufficiency. The program is jointly administered with the Minnesota Department of Human Services.	$3, 200,000 to $3,500,000 40% from the State) U.S. Code, Title 7, Chap. 51, Sec. 2015(d) and MN Stats. Sec. 256.051	The program serves adults between the ages of 18-55 from non-public assistance food support households. In return for monthly food support, participants must comply with work requirements.	N/A	Administration of the program including planning, budgeting, evaluation, accounting, financial management, statistical systems and related data processing, indirect costs.	FSET services include an individual assessment of work-related strengths and barriers and an Employment Plan designed to help participants obtain or upgrade the skills necessary to gain viable employment. Job training may include General Equivalency Diploma (GED), English as a Second Language (ESL), high school diploma or short-term vocational training. Support services are provided on an individual basis for job search and Start Work needs. Participation in work or work activities is required each month that the participant receives food support. FSET services are administered statewide by counties, usually through service providers such as Workforce Centers, community action agencies and county employment and training providers.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Job Service Program	Provide businesses and workers with services and information to build and maintain a world-class workforce. Increase the number of employers placing job orders. Increase the number of job orders filled. Increase the number of workshops provided to jobseekers. Increase the number of job seekers who enter employment. Increase the amount of individualized assistance given to targeted populations, R.I. claimants, and veterans. Increase the number of individuals and employers using self-service (Internet-based services).	$12,100,000 U.S. Department of Labor	General public	N/A	All program expenses. There are no training or support activities in this program.	Taking job orders from employers (providing a labor exchange). Providing employer seminars with respect to employment issues. Providing labor market information to employers and job seekers. Recruiting and screening job seekers on behalf of employers. Help job seekers to identify their skills and market themselves efficiently to employers who need their skills.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Minnesota Family Investment Act - Employment Services	The purpose of the Minnesota Family Investment Act (MFIP) is to provide support for families that helps them move from welfare to unsubsidized employment	U.S. Department of Health and Human Services and State of Minnesota U.S. Code, Title 42, Sec. 603 and MN Stats. Sec. 256J to 256J.73	The program's serves families currently on welfare. For most welfare recipients, participation in employment programs is mandatory and benefits are limited to 60 months in a lifetime.			All participants receive an assessment and a job search support/employment plan which outlines mutually agreeable steps necessary to become self-sufficient. The program expects participants to take responsibility for supporting their families within time limits or their benefits will be reduced. Participants are always better off working duet to financial incentives; they remain eligible for an incentive until they earn up to 120 percent of the poverty level. Childcare and medical services are also available to help participant's transition off welfare, into work. MFIP-ES operates in all 87 counties in Minnesota and on eleven Indian Reservations. Employment services providers vary throughout the state and include Minnesota Workforce Center Partners, community action agencies, educational agencies, county agencies, and other non-profit entities.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Minnesota Opportunities Industrialization Centers	The motivation, training, retraining, placement, and support of the economically disadvantaged, to reduce unemployment and raise the income potential of the unemployed and underemployed. underemployed. Deliver employment and training services to the economically disadvantaged. To equip those who need jobs with the skills to do the work. Offer selected skills training where there is a high market demand. Develop new OICs, and ensure organizational coordination, unity and accountability with all OICs. ***(continued on next page)***	$8,061,000 U.S. Department of Labor, Employment & Training Administration	Unemployed and underemployed, economically disadvantaged youth (16-21) and adults (21 and older).	N/A	Wages, fringes and taxes; financial services; liability insurance, travel, meetings, planning, office supplies, audit, staff development, postage, equipment purchases, printing, copying, dues and membership.	Services include outreach/recruitment; counseling; remedial education; motivational and pre-vocational training; skills training; job development and placement. Under special projects, also serve youth, older workers, refugees, and ex-offenders. Local OICs offer instruction appropriate for the job-specific skills needed by the local community served. Minnesota OICs offer selected skills training where there is a high market demand such as: nursing assistant, business and office, manufacturing, carpentry, computer skills, casino management. Operate programs for special needs projects such as school-to-work, welfare-to-work, Youth Build, internships, ESL and refugee training, Youth Entrepreneurship, and institutional offender training.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Minnesota Opportunities Industrialization Centers ***(continued)***	Facilitate the development of quality outcomes through adherence with standards, and the evaluation of programs and services. Diversify sources for increasing the fund and resource bases. Develop a statewide OIC interagency communication and interaction network.							
Minnesota Youth Program	The Minnesota Youth Program is a state-funded program providing work experience and academic enrichment activities to economically disadvantaged and at-risk youth between the ages of 14-21 in all 87 counties.	$4,154,000 State General Fund MN Stats. Sec. 268.56 to 268.561	Economically disadvantaged at-risk youth between the ages of 14-21.	N/A	Wages, fringes and taxes; financial services; liability insurance, travel, meetings, planning, office supplies, audit, staff development, postage, equipment purchases, printing, copying, dues and membership.	The Minnesota Youth Program operates through local Workforce Councils and is available in all 87 counties. The needs of youth are assessed and used as the basis of designing individualized service strategies. Work experience, basic skills training, work-based learning, career counseling, personal counseling, life skills training, mentoring, and peer support groups are available as well as support services such as transportation and child care.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Minnesota Youthbuild	The purpose of the Minnesota Youthbuild Program is to assist at-risk youth in making a successful transition to the work world. The program is designed to provide affordable housing to low income families and individuals. Twelve organizations, located throughout the state, currently participate in the Minnesota Youthbuild Program.	$644,053 State General Fund MN Stats. Sec. 268.361 to 268.367	Youth between the ages of 16-24, that are high school dropouts and potential dropouts; youth at risk of involvement with the juvenile justice system; chemically dependent and disabled youth; homeless youth; teen parents; and public assistance recipients. The program also serves low-income and homeless families and individuals in need of affordable housing.	N/A	Wages, fringes and taxes; financial services; liability insurance, travel, meetings, planning, office supplies, audit, staff development, postage, equipment purchases, printing, copying, dues and membership.	Services include construction skills training, work experience, job readiness training, leadership development, and basic academic skills.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Senior Community Service Employment	The program exists to provide training and practical community service employment opportunities for people age 55 and older; to enable them to transition into unsubsidized employment. Provide part-time employment opportunities in community service positions. Training to place older workers into unsubsidized employment (a minimum of 20 % must be placed into unsubsidized employment). ***(continued on next page)***	$2,100,000 U.S. Department of Labor	Unemployed, underemployed, and economically disadvantaged individuals 55 and over.	N/A	Management and direction of a program project, reports on program evaluation, MIS, accounting, bonding, and audits.	Outreach and assessment to develop individual service strategy plan. Counseling to assist enrollees in areas such as health, nutrition, social security and Medicare benefits, and retirement law. Support services including work shoes, eye glasses, physical examinations, workers compensation, unemployment compensation. Subsidized employment opportunities with community service organizations at wages no less than the State or Federal minimum wage. Subsidized employment with private sector employers in growth industries. Transportation may be paid for if transportation from other sources is unavailable.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Senior Community Service Employment ***(continued)***	Outreach to economically disadvantaged older workers who are detached from families, community, and other support services. Direct training with employers in growth industries and jobs reflecting the use of new technological skills.							

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Small Cities Development Program	The Small Cities Development Program provides decent housing, a suitable living environment and expanding economic opportunities, principally for persons of low-and-moderate income. Proposed projects must meet one of three national objectives: Benefit to low-and-moderate income persons; Elimination of slum and blight conditions; or Elimination of an urgent threat to public health or safety.	U.S. Department of Housing and Urban Development	Cities and townships with populations under 50,000 and counties with populations under 200,000. Indian tribal governments, which can receive funds directly from HUD, are ineligible for this program.	Yes, limited.		Housing Grants- Small Cities Development Program (SCDP) funds are granted to a local government which, in turn, loans funds for the purpose of rehabilitating local housing stock. Loans may be used for owner-occupied, rental, single-family or multiple family housing rehabilitation. Loan agreements may allow for deferred payments or immediate monthly payments. Interest rates may vary, and loan repayments are retained by grantees for the purposes of making additional rehabilitation loans. SCDP funds may also be used to assist new housing construction projects. Funds may also be used for land acquisition, site improvements, infrastructure or housing unit construction. In all cases, housing funds must benefit low-and - moderate income persons. In addition, Comprehensive Grant projects can be awarded. ***(continued on next page)***		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Small Cities Development Program ***(continued)***						These Comprehensive projects frequently include housing and public facility activities, economic development activities. These economic development activities include loans from the grant recipient to businesses for building renovations/construction, purchase equipment, or working capital. The most common economic development activity is rehabilitation of local commercial districts.		
Veterans Services Program	Enable Minnesota veterans to achieve economic security by facilitating quality career related services.	$3,500,000 U.S. Department of Labor U.S. Code, Title 38,	Any individual that has served more than 180 consecutive days on active duty (not for Reserve or National Guard Training), served on active duty and released because of a service connected illness or injury. (Does not have to meet the 181- day rule.), in the National Guard or Reserves and was called to active duty during a war or in a campaign or expedition for which a campaign badge is authorized.	N/A	Administration of the program including planning, budgeting, evaluation, accounting, financial management, statistical systems and related data processing, indirect costs.	Job ready assessment, job preparation assistance, and job placement assistance are provided by the Disabled Veteran Outreach Program (DVOP) and Local Veterans Employment Representative (LVER) staff. DVOP and LVER staff are located at Workforce Centers throughout the state.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Vocational Rehabilitation Program (Rehab. Services)	Assist Minnesotans with disabilities to reach their goals for working and living in the community. Achieve improved employment outcomes that respond to consumer needs. Collaboration to implement the Minnesota Workforce Center System and Workforce Investment Act of 1998. Productive coalitions with workforce investment partners, program stakeholders that include consumers, employers, disability advocacy organizations, schools, and social service agencies.	$37,100,000 U.S. Department of Education and State General Fund match	Applicants will be found eligible for VR services when there is evidence that they a) have a physical or mental impairment which constitutes or results in a substantial impediment to employment; and b) require VR services to either prepare for, secure, retain, or regain employment consistent with their strengths, resources, priorities, concerns, abilities, capabilities and informed choice. All individuals will be presumed to be able to benefit from VR services in terms of an employment outcome unless there is clear and convincing evidence to the contrary due to the severity of the disability	N/A	Administration of the program including planning, budgeting, evaluation, accounting, financial management, statistical systems and related data processing, indirect costs.	Assessment to determine vocational rehabilitation needs. Vocational evaluation and work adjustment training. Rehabilitation counseling and guidance. Job coaching, OJT, specific skill and post secondary training, job placement and post-employment services. Referral to other programs and services. Independent living skills training to support an employment goal. Auxiliary aids and services, rehabilitation/assistive technology; durable medical equipment; and personal assistance services. Physical and mental restoration. Purchase of occupational licenses, tools, equipment, and initial stocks and supplies. Transportation.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Welfare to Work Program	The Welfare to Work Program provides job placement and post-placement services that promote individual and family self sufficiency. The program's goal is to place hard-to-serve welfare recipients in unsubsidized jobs and help them stay employed. Primary customers include long-term recipients of the Minnesota Family Investment Program (MFIP).	U.S. Department of Labor, Employment & Training Administration	Welfare to Work is specific federal funding targeted to individuals considered at risk of long-term public assistance dependence. Participants must have either been on assistance for a total of 30 months or be within 12 months of reaching the five-year limit or have exhausted their time limit. Eligibility may also include MFIP recipients at risk of long-term public assistance dependency, former foster children now 18-24, or custodial parents with income below the poverty level. Certain non-custodial parents may also be eligible. Seventy percent of the state's allocation must serve long-term recipients or non-custodial parents.	N/A	Administration of the program including planning, budgeting, evaluation, accounting, financial management, statistical systems and related data processing, indirect costs.	Services include job search and retention skills training, wage subsidy, training and work experience. Support services may include child care, temporary housing, transportation and mentoring designed to help participants transition to work. Local Workforce Investment Boards work closely with MFIP programs to coordinate services at locations throughout the state.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Workforce Investment Act - Adult	The WIA Title 1B Adult Program provides employment and training assistance to adults to increase their employment, retention, earnings, and occupational skill attainment.	$7,500, 000 (approx.) U.S. Department of Labor Workforce Investment Act of 1998	Adults seeking greater participation in the labor force.	N/A	Administration of the program including planning, budgeting, evaluation, accounting, financial management, statistical systems and related data processing, indirect costs.	Services available to assist job seekers include preliminary assessment of skill levels, aptitudes, and abilities; support services; occupational training; on-the-job training; job search assistance; placement assistance; and career counseling. Information is also available on a full array of employment-related services, including information about local education and training service providers, labor market information, job vacancies, and skills necessary for in-demand jobs. Sixteen local Workforce Service (WSA) Areas select the menu of services and the providers who deliver the services.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Workforce Investment Act - Youth	The WIA Title 1B Youth Program provides year-round employment and training services to economically disadvantaged youth in all 87 counties.	$7,615,382 U.S. Department of Labor Workforce Investment Act of 1998	Participants between the ages of 14-21, who are economically disadvantaged and are one or more of the following: basic skills deficient, pregnant or parenting, homeless, a runaway, foster child, or a youth who needs additional assistance to complete an educational program or to secure and hold employment.	N/A	Administration of the program including planning, budgeting, evaluation, accounting, financial management, statistical systems and related data processing, indirect costs.	The program operates throughout Minnesota through the local WSA /Workforce Councils. Local Youth Councils select youth service providers and provide program oversight. Services include assessment, work experience, basic skills training, mentoring, follow-up, supportive services as needed, and leadership skills training to help youth develop as citizens and leaders. Specific services are based on an individualized assessment of each youth.		

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Extended Employment- Basic Funding	Provides funding for supported and center-based employment to persons with severe disabilities through a network of 30 community rehabilitation programs. Supported employment provides ongoing support for persons working in the larger community in a variety of employment settings. Center-based employment provides ongoing support for persons who work in manufacturing, services, and retail enterprises operated by the community rehabilitation program	State General Fund $11,510,00 MN Stats. Section 268A.13 to 268A.15	Individuals with severe disabilities enrolled in one of 30 community rehabilitation programs.	N/A	Staff and non-personnel expenses.	Services are provided by community rehabilitation programs (CRPs). CRPs provide services that are necessary to maintain or advance the worker's employment. Services include job skill training at the work site; behavior management, job-related self-advocacy skills training; communication skills training; independent living skills training; training in job seeking skills; career planning, job development; job placement; rehabilitation technology, job redesign, or environmental adaptations; disability awareness training for the worker, the worker's employer, supervisor or co-workers, and other services to increase the worker's inclusion at the work site; job-related safety training; facilitation of natural supports at the work site; transitional employment services; other services needed to maintain or advance the employment of these workers.		

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MINNESOTA DEPARTMENT OF CORRECTIONS - CAPITAL, OPERATING AND SERVICES FUNDING ANALYSIS

PROGRAM NAME	DESCRIPTION	FUNDING SPECIFICS	ELIGIBILITY	CAPITAL	OPERATING Rental Subsidies	SERVICES	ASSESSMENT	OPPORTUNITY
Ancillary Services	This fund is used to contract with halfway houses. It provides for placements for high-risk offenders at the time of their release from incarceration.	$961,000.00 annual. In years prior to 2002 this account usually received supplemental funds of approximately $1,000,000.00 from the institution division. This supplement is no longer available due to per diem reduction efforts by the previous DOC administration and budget cuts imposed by the 2003 legislature.	High-risk offenders.		This funding level provides a two-month placement for approximately 265 high-risk offenders per year.		This funding is meeting a critical public safety need and it would be counterproductive to divert these funds to address chronic homelessness.	
Emergency Housing Fund	This fund is used to provide first month rent or security deposit for high-risk sex offenders who are at risk of homelessness during transition from incarceration to community.	$50,000.00 annual	High-risk sex offenders.		This funding is intended to address the need for housing immediately upon release in order to be able to provide corrections supervision in the community.		This funding is dedicated to high-risk sex offenders.	

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SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 1: Identify Key Characteristics of Chronic Homeless

MEETING SUMMARY

July 17, 2003

Welcome and Member Introductions

Commissioner Goodno, Commissioner Fabian and Commissioner Marx welcomed the members of the working group.

Commissioner Goodno thanked Working Group Members for their commitment to an issue that is a priority for the governor. He stated that supportive housing is an issue we need to deal with, we need to recognize that a lot of prior work has been done, but that this will not be an easy process with one solution. To serve people with multiple barriers, the different agencies must work together to move forward in trying to address solutions.

Commissioner Fabian expressed that this is an excellent opportunity to review the supportive housing work already done, bring recommendations together and move forward.

Commissioner Marx thanked Working Group Members for their willingness to participate in developing a business plan to reduce long-term homelessness as the legislature has called on us to do. He stated that the scope of problem is manageable. We can't solve all problems with this group, we are not trying to address the entire homeless situation, but we will be able to focus on individuals and families that experience long-term homelessness, their characteristics and their needs, to develop a system that will support them. We will identify the right issues to achieve success.

Members also made introductions.

Working Group Orientation

Commissioner Marx reviewed the legislation and the expected goals and outcomes of the Working Group to "propose a formal, interagency decision-making process and a plan to fund supportive housing proposals" in order to reduce the number of Minnesota individuals and families that experience long-term homelessness, reduce system costs and improve social outcomes. This first meeting will focus on identifying the key characteristics of people chronically experiencing homelessness; the second meeting on models of supportive housing, best practices, and available resources; the third on gaps in resources and barriers to filling the gaps in capital, operating, and services funding; the fourth on the interagency decision making process; and the fifth on the criteria, plan and timetable for funding. The Working Group will review the report to the legislature that is due by February 14, 2004.

Janel Bush, Department of Human Services, summarized previous supportive housing efforts.

Review of County-State Supportive Housing Working Group

Ramsey County Commissioner Sue Haigh and Hennepin County Commissioner Gail Dorfman summarized supportive housing work done by counties. Commissioner Haigh related information on the group of county-state officials convened last year on supportive housing. The group issued a policy statement including a brief overview of the problem and defining supportive housing. Commissioner Haigh stated that supportive housing is important in reducing costs for public systems, improving outcomes, reducing out of home placement costs, increasing effectiveness of services provided, and achieving the ultimate goals of housing stability for families and individuals. One of the key issues is how to develop way to pay for coordinated services, how to have financing plan for services developed at same time capital plan is developed.

Review of Proposed Characteristics

Commissioner Marx directed Working Group Members to the principle purpose of the meeting: to identify key characteristics of persons experiencing chronic homelessness, focusing on long-term homeless, not on the entire homeless population. Cherie Shoquist reviewed the document "Key Characteristics of Persons Experiencing Chronic Homelessness." In addition to looking at other federal, state, local policies, agency staff consulted the 2001 Wilder Study on homeless, and held in-depth discussions with stakeholders, shelter and street outreach service providers, the Coalition for the Homeless, Metro-wide Engagement on Shelter and Housing, the Corporation for Supportive Housing, and others. The most prevalent characteristics are chemical and mental health problems. We will request data accurately reflecting the characteristics defined by this group in new Wilder Survey, which will take place this fall. Preliminarily, Wilder estimated that between 2800 and 3600 individuals are chronically homeless each year.

Working Consensus on the Target Population

The Working Group discussed the target population. Working Group Members stated that it is important to consider other characteristics in addition to mental illness and chemical dependency, due the fact that not all mental illness or chemical dependency is reported or diagnosed and to alleviate concerns that people who experience long-term homelessness without mental illness or chemical dependency will not be able to access housing and services. The term "lacking a permanent place to live" was suggested to better define homelessness because it is difficult to document the absence of housing status.

The Working Group identified the target population as: "An individual or adult family member with: mental illness, chemical dependency, or co-occurring mental illness and chemical dependency; chronic health conditions (including HIV/AIDS); domestic violence, abuse or neglect; cognitive limitations; or criminal history who has either lacked a permanent place to live continuously for a year or more, or has lacked a permanent place to live at least four times in the past three years, or prior to any incarceration or institutionalization.

Solicit Criteria and Ideas for Models to Consider

Mari Moen, Corporation for Supportive Housing, agreed to put together a document on settings and models and Jennifer Ho, Hearth Connections, agreed to review services best practices in preparation for the next meeting. Several members and stakeholders agreed to join them. Commissioner Marx thanked members for participating.

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Laws of Minnesota, 2003, Chapter 128, Article 15, section 9.

WORKING GROUP ON SUPPORTIVE HOUSING FOR LONG-TERM HOMELESSNESS

The commissioners of the department of human services, trade and economic development, the Minnesota housing finance agency, and the department of corrections shall convene a working group to develop and implement strategies to foster the development of supportive housing options in order to:

(1) reduce the number of Minnesota individuals and families that experience long-term homelessness;

(2) reduce the inappropriate use of emergency health care, shelter, chemical dependency, corrections and similar services; and

(3) increase the employability, self-sufficiency, and other social outcomes for individuals and families experiencing long-term homelessness.

The working group must include metropolitan area and greater Minnesota representatives of:

(1) counties;
(2) housing authorities;
(3) non-profit organizations knowledgeable about supportive housing;
(4) non-profit organizations experienced in the provision of services to the homeless;
(5) developers and other business interests;
(6) philanthropic organizations; and
(7) other representatives identified as necessary to the development of the plan, including other government agencies.

The working group shall:

(1) determine the key characteristics of individuals and families experiencing long-term homelessness for whom affordable housing with links to support services is needed;

(2) identify a variety of supportive housing models that address the different needs of individuals and families experiencing long-term homelessness;

(2) determine the existing resources that may fund these models for families and individuals who are experiencing long-term homelessness;

(4) identify the gaps in capital, operating, and service funding that affect the ability to develop supportive housing models;

(5) propose a formal, interagency decision-making process and a plan to fund supportive housing proposals based on the agreed-upon criteria, with the goal of maximizing access to funding for the capital, operating and service costs of supportive housing proposals either scattered site or project based;

(6) identify and recommend models to coordinate mainstream resources and services, i.e., resources and services available to the general population, or more specifically, low-income populations, that can be utilized to assist individuals and families experiencing homelessness, so that housing and homelessness supports can me maximized, and

(7) identify and recommend remediation actions to remove barriers individuals and families experiencing homelessness face when attempting to access mainstream resources and services.

The plan must include an estimate of the statewide need for supportive housing, an estimate of necessary resources to implement the plan, and alternative timetables for implementation of the plan and propose changes in laws and regulations that impede the effective delivery and coordination of services for the targeted population in affordable housing.

The commissioners must report on the status of efforts by the working group to improve the effectiveness of the delivery and coordination of services and access to housing for individuals and families experiencing long-term homelessness and recommend next steps to the appropriate committees of the legislature by February 15, 2004.

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WILDER RESEARCH CENTER

SUMMARY

Homeless adults and children in Minnesota

On the night of October 26, 2000, over 500 interviewers surveyed 2,480 of Minnesota's homeless adults and youth, including a representative sample of those receiving shelter and transitional housing services, plus 468 people in unsheltered locations.

A series of complete reports on the study are available at www.wilder.org/research

More are homeless. On any given night, an estimated 8,600 people are homeless in Minnesota. This is nearly 2.5 times the estimate made in October 1991. The estimate is based on:

- 7,121 homeless men, women, unaccompanied youth, and children who were staying in Minnesota's shelters and transitional housing programs on the night of October 26, 2000
- 51 who were in detox facilities on the same night
- An estimated additional 1,424 in unsheltered locations

More are working. In nine years the proportion of homeless adults working full- or part-time has more than doubled from 19 percent in 1991 to 41 percent in 2000. The proportion working full-time has more than tripled from 7.5 percent to 26 percent. Over one-quarter of all homeless adults now report their main source of income is from steady employment. However, 68 percent earn less than $10 an hour, and 39 percent earn less than $8 an hour. To afford an average one-bedroom apartment in the Twin Cities area ($664 in 2000) would require an hourly wage of about $12.70.

More are people of color. While the overall racial composition of Minnesota's adult population is about 94 percent white, the homeless adult population is 34 percent white, 47 percent African American, 11 percent American Indian, 1 percent Asian, and 8 percent other (including mixed race). People of color now make up 66 percent of homeless adults, up from 59 percent in 1991. Youth of color are also disproportionately represented among the homeless, though not to the same extent.

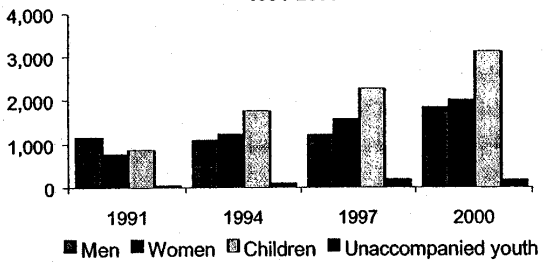
More are children. Homeless children today outnumber Minnesota's entire homeless population in 1991. On the night of the survey, 3,122 children were in shelters, transitional housing, or on the streets with their parents. In 2000, one-third of all homeless adults - 10 percent of men and 66 percent of women - had at least one child under 18 with them. These homeless children are at significant risk of serious health, emotional, and behavioral problems. School-age children are also at higher risk for school problems or repeating a grade, and more parents report these problems in 2000 than in 1997.

More are mentally ill. Thirty-seven percent of homeless adults have serious mental illness, up from 32 percent in 1997, which was also an increase from 1994. Other aspects of health remained fairly steady. Over one-third reported that they needed to see a doctor for a physical health problem, and 30 percent for an emotional or mental health problem, and more than half had dental problems that needed attention. 19 percent had been diagnosed with alcohol abuse disorder, and 13 percent with drug abuse disorder, both slightly down from 1997. Childhood sexual abuse (24%) and physical abuse (33%) are about as common among homeless adults as in 1997, but the prevalence among homeless youth has grown to 28 percent for sexual abuse and 47 percent for physical abuse.

How many people are homeless in Minnesota?

On the night of October 26, 2000, Minnesota's 188 shelters and transitional housing programs were providing a temporary place to stay for 7,121 homeless men, women, unaccompanied youth, and children. An additional 51 homeless people were staying in detox facilities. Using conservative estimates based on studies done elsewhere of the harder-to-find homeless, another 1,424 people were staying in places not meant for human habitation (such as in cars, under bridges, and in abandoned buildings), and another 12,733 were "doubling up" temporarily with family or friends. The total estimated number of people homeless or precariously housed in Minnesota on this night, or any other recent night, is 21,329.

Homeless people in Minnesota shelters, 1991-2000



***Source:** Wilder Research Center; data provided by shelter service providers across the state.*

Since the statewide homeless survey was first conducted in October 1991, the total number of homeless people receiving shelter has grown by 149 percent — or more than doubled. The number of homeless children in 2000 is more than the total for people of all ages nine years ago. While the total state population grew (from 1989 to 1999) by about 12 percent, the number of men receiving shelter services has grown (from 1991 to 2000) by 58 percent, the number of sheltered women has grown by 157 percent, and the number of children in emergency and transitional housing has increased by 257 percent.

Most of this increase has been in people using transitional housing. Emergency shelters served 44 percent more people in 2000 than in 1991 and battered women's shelters served 73 percent more, while transitional housing services increased by 366 percent, or more than quadrupled.

It may fairly be asked whether the growth in the number of sheltered homeless people simply reflects a growth in the capacity of the system to serve them. Perhaps the actual number of homeless people stayed the same over the 1990s, while more shelter providers reached a higher and higher proportion of them. However, shelter census reports collected quarterly by the state show that the number of homeless people turned away for lack of capacity grew faster than shelter capacity. The evidence indicates that the total number of homeless in the state has increased at least as fast as the estimates in this study.

	Nov. 1991	Nov. 1994	Nov. 1997	Nov. 2000
Shelter capacity per night	3,168	5,017	5,559	7,544
Turnaways per night	201	676	467	1,025
Turnaways as % of capacity	6.3%	13.5%	8.4%	13.6%

***Source:** Wilder Research Center calculations, based on data from Department of Children, Families & Learning.*

Who is homeless in Minnesota?

- ✓ **Average age: 40 for men, 32 for women, 15 to 16 for youth.**
- ✓ **Minorities are greatly and increasingly over-represented.**
- ✓ **Most are not newcomers to Minnesota.**

Homeless adults (age 18 and older) had an average age of 36 (40 for men, 32 for women). People age 55 and over made up 5 percent of the homeless adult population. The oldest person interviewed was 80. Unaccompanied youth (age 17 and younger) had an average age of 15.7; the youngest was 10. Compared to 1997, youth were about the same age in 2000, and homeless adults were slightly older.

Both adults and youth were approximately evenly split between men and women. Among adults, men predominated in emergency shelters and in non-sheltered locations, and women were the majority in transitional housing and battered women's shelters. The gender gap narrowed somewhat in 2000.

Racial and cultural minorities were more likely than whites to be homeless. The table below shows the racial distribution of surveyed adults and youth, and the 1999 (most recent available) estimates for the total Minnesota population in the same age ranges.

Compared to 1997, the 2000 adult homeless population was more concentrated among minority group members, while the youth population was slightly more white.

Twenty-four percent of homeless adults had less than a high school education, and 48 percent had completed high school or a GED but no more. 28 percent had some amount of post-secondary education. These figures show a rise in education level from 1997, when 30 percent had not completed high school or a GED.

Sixteen percent of homeless adults, and 31 percent of adult men, were veterans, up from 13 percent and 26 percent in 1997.

Seventy-two percent of homeless adults had lived in Minnesota for the past three years or more. Of those who had lived in Minnesota for two years or less, 32 percent had lived in Minnesota before. These figures are unchanged from 1997.

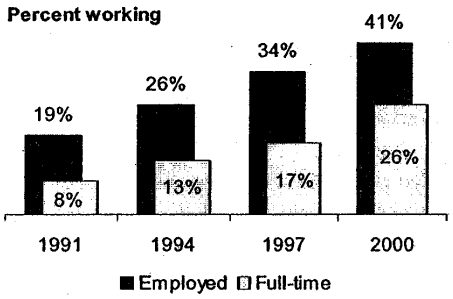
Homeless adults, Oct. 2000	Minnesota adults, 1999		Homeless youth (age 10-17), Oct. 2000	Minnesota youth (age 10-17), 1999
46.7%	2.6%	African American	24.9%	4.0%
10.5%	0.9%	American Indian	20.0%	1.9%
0.9%	2.1%	Asian/Pacific Islander	0.5%	4.1%
34.3%	94.4%	White	46.3%	90.0%
7.6%	--	Other, including mixed race	8.3%	--
6.5%	1.7%	Hispanic or Latino origin (may be of any racial group)	6.6%	2.5%

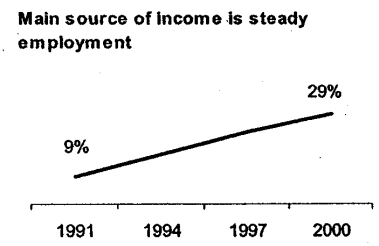
Sources: *Homeless data from Wilder Research Center; 1999 population estimates from the State Demographic Center at Minnesota Planning. (Data on mixed race is not available for the general population.)*

Employment and income

- ✓ **Employment continues to grow sharply.**
- ✓ **26% are working full time.**
- ✓ **Wage rates and monthly incomes remain low.**
- ✓ **Housing affordability is a growing factor in homelessness.**

Forty-one percent of adults were employed, and 26 percent were employed full time. 29 percent of adults reported steady employment as their main source of income. All of these are significantly higher than in 1997, when 34 percent were working (17% full time) and 23 percent had a steady job as their primary source of income. These figures have risen steadily since 1991, when only 19 percent were working (8% full time).





Of those who were working, 39 percent were earning less than $8 per hour, and 68 percent were earning less than $10 per hour. Most (57%) had been in their primary job for at least three months.

The average monthly income of all homeless adults, from all sources, was $622. One-third had incomes above $700 per month. Adjusting for inflation, incomes in 2000 were very similar to 1997.

Asked to name the biggest barriers or problems to getting a job now, unemployed homeless adults focused first on lack of transportation (25%, up from 21% in 1997), physical health (24%, up from 19%), and lack of housing (22%, up from 12%). Among parents, the top barrier was inability to find or afford child care (41%).

Housing affordability

As this survey illustrates, homelessness involves many factors beyond the purely financial. However, the gap between wages and housing costs plays an increasing role in Minnesota homelessness.

This gap was highlighted in a January 2001 report by the Office of the Legislative Auditor. The report stated that average rents in the Twin Cities area increased 34 percent between 1990 and 1999, while the median household income of renters grew by only 9 percent. Rents rose most sharply in the last few years, and the rental market is projected to become even tighter during the decade to come.

The Legislative Auditor's report estimated that the average rent in the Twin Cities area was $664 for a one-bedroom apartment and $815 for a two-bedroom apartment in 2000.

The commonly accepted definition of housing affordability is no more than 30 percent of income for low-income households because, above this amount, not enough money remains to weather financial setbacks.

More than 10 percent of working homeless adults earn less than $6.00 per hour. At this pay rate, even two full-time workers in the same household would pay 32 percent of their income for a typical one-bedroom apartment, or 39 percent for a two-bedroom apartment. A single adult would spend 48 percent of income for a typical efficiency apartment, at $504 monthly rent.

Over one-third of Minnesota's working homeless adults earn $6.00 to $7.70 per hour. A full-time worker in this pay range could afford a monthly rent of $312 to $400. A typical one-bedroom apartment in the Twin Cities metropolitan area would take 50 to 64 percent of their income.

About one-third of working homeless adults earn $7.70 to $9.60 per hour, making rents of $400 to $500 affordable. The average one-bedroom apartment would cost 40 to 50 percent of the monthly income of a full-time worker in this range.

More than 20 percent of working homeless are earning $9.60 to $12.00 per hour. In this range, they could afford $500 to $625 per month for housing, which is still less than the average rent for a one-bedroom apartment.

A significant proportion of homeless adults report problems with credit, evictions, or bad rental history, and over half say the lack of affordable housing is a barrier to getting housing. If a person is evicted, the resulting unlawful detainer remains in their record for years, and makes it almost impossible to compete with other renters in a tight housing market. In this way, high rents and low vacancy rates often combine with low wages to create a cycle that is difficult to break.

Housing history and reasons for homelessness

- ✓ **60% of adults are homeless for the first time.**
- ✓ **Half have been homeless for 6 months or less.**
- ✓ **Many were abused or institutionalized as children.**
- ✓ **41% of homeless adults were released from an institution, homeless program, or treatment center in the past year, and 49% of those had no stable place to go.**
- ✓ **A growing proportion of homeless youth have a history of sexual or physical abuse.**
- ✓ **Reports of "survival sex," in exchange for basic necessities, are becoming more common among homeless youth.**

Among adults, 60 percent were experiencing homelessness for the first time. Half had been without regular housing for six months or less, although 16 percent had been homeless for three years or longer. 56 percent of youth reported being in their first experience of homelessness. Half had been homeless for three months or less, and 12 percent had been homeless for one year or longer.

Compared to 1997, slightly more adults had been homeless before. The current homeless episode was somewhat longer in 2000. For youth, about the same proportion were homeless for the first time in 2000, and the average length of time for which they had been homeless was somewhat shorter than in 1997.

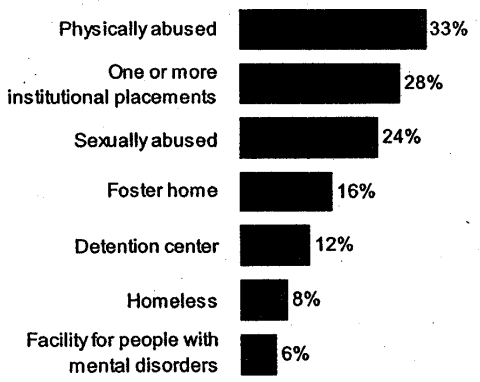
The main reasons adults said they left their last housing included a mix of economic and personal reasons. The main reasons cited were:

evicted (33%); unable to afford rent (23%); abuse (18%); other relationship problem (28%); drinking or drug problem (21%); substandard or unsafe housing (15%); and violence in the neighborhood (14%).

Nineteen percent of homeless youth left home because of abuse, and over half (55%) because of other relationship problems. Their main reasons for not returning home were: at least one adult in the household won't tolerate their being around (50%); adults in the household don't attend to their basic needs (30%); alcohol or drug use by a parent or other household member (30%); the danger of physical abuse (24%); not enough space for everyone (21%).

Many homeless adults had troubled childhoods. Twenty-eight percent had at least one kind of institutional placement as a child, and at least 8 percent had been homeless as a child. The most common institutional placements were foster homes (16%), detention centers (12%), and facilities for people with mental disorders (6%). Other traumatic childhood experiences included childhood physical abuse (25% of men, 40% of women) and childhood sexual abuse (12% men, 37% women). All of these rates were almost exactly the same as in 1997 except for childhood physical abuse of men, which was down from 28 percent to 25 percent.

Traumatic childhood experiences of homeless adults



Among youth, the prevalence of physical abuse rose from 1997 to 2000, from 32 percent to 40 percent for males and from 43 percent to 53 percent for females. Similarly, the number reporting sexual abuse rose from 6 percent to 14 percent for males and from 37 percent to 41 percent for females. More homeless youth also said they had engaged in "survival sex" (in exchange for shelter, clothing, food, or other necessities) — that proportion rose from 10 percent in 1997 to 15 percent in 2000. Fewer youth in 2000 were parents (8%, down from 17% in 1997).

Forty-four percent of adults had lived in some kind of institution or treatment facility as an adult. Forty-one percent had been released from an institution or from a housing facility or program in the past year. Of these, 49 percent reported that they did not have a stable place to live when they left.

Financial factors were by far the most common current barrier to housing cited by homeless adults. Over half (54%) of all homeless people identify "There is no housing I can afford" as a main reason preventing them from getting housing now. Other major barriers include credit problems (31% overall, 45% of parents), no local rental history (20% overall, 13% of parents), a criminal background (21% overall, 8% of parents), court eviction or bad rental history (24% overall, 31% of parents), and the cost of application fees (18% overall, 24% of parents).

Families with children

- ✓ **One-third of homeless adults (10% of men and 66% of women) have children with them.**
- ✓ **An increasing percentage of homeless parents report their children have learning and school problems.**
- ✓ **Serious physical, emotional and behavioral problems are much more common among homeless children than among Minnesota children in general.**

On the night of the survey, 3,122 children under age 18 were in shelters, transitional housing, or on the streets with their parents.

Thirty-four percent of homeless adults (10% of men and 66% of women) had children age 17 or younger with them. This is about the same proportion as in 1997. Parents were more likely to be served in battered women's shelters or transitional housing, where they made up 56 percent and 45 percent of the households, than in emergency shelters (23%) or on the streets (9%).

On average, parents had 2 to 3 children with them. The average age of children was 7 (up slightly from 1997), and one-third were age 4 or younger. About half (53%) of families had been homeless for six months or less, while 29 percent had been homeless for a year or longer.

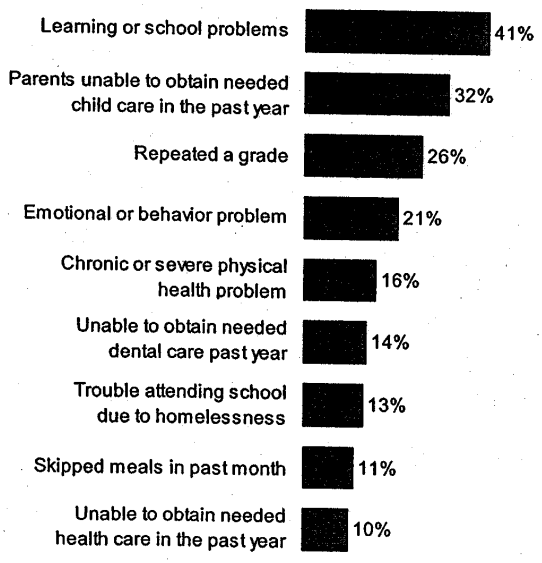
Nine unaccompanied youth had children of their own with them (4.5% of all homeless youth surveyed, down from 12% in 1997).

Homeless parents reported that their children faced a variety of problems. Sixteen percent reported having a child with a serious health problem, and 21 percent a child with a serious emotional or behavior problem.

Of parents with school-age children, 41 percent had a child with learning or school problems (up from 36% in 1997). Twenty-six percent had a child who had repeated at least one grade (up from 20% in 1997). Thirteen percent had a child who had trouble going to school because of their housing situation, the same proportion as in 1997.

During the previous 12 months, 10 percent of parents had been unable to obtain needed health care for their children, 14 percent had been unable to obtain needed dental care, and 32 percent had been unable to obtain needed child care. During just the past month, 11 percent reported their children had skipped meals because there wasn't enough money to buy food.

Problems of homeless children



Fewer homeless parents reported being unable to obtain child care (down from 46% in 1997 to 32% in 2000).

Among the homeless, parents are more likely than single adults to be people of color. They are less likely to have been homeless for over a year, less likely to have had recent drug or alcohol treatment or a serious mental health diagnosis, and less likely to have a high school education. They are equally likely to have been living in Minnesota for at least two years, or to be working full-time.

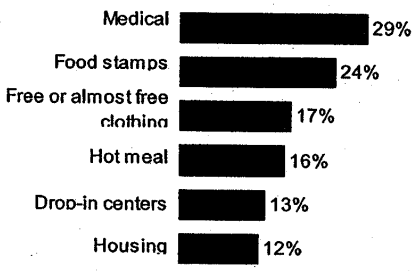
Services used and services needed

- ✓ **Homeless adults mainly report receiving basic survival services for health care, food, and clothing.**
- ✓ **The main service needs they report are for longer-term issues — help finding jobs and financial assistance.**
- ✓ **Transportation appears to be a more serious problem than in the past.**
- ✓ **For homeless youth, the greatest reported needs are for a job, school or training, and financial assistance. Food also appears to be a growing need.**

Nearly all the services most frequently used by homeless adults address immediate and basic needs (medical, food, clothing). The most commonly reported services used in the previous month: publicly funded medical benefits of various types (59%), Food Stamps (41%), clothing shelves (40%), hot meal programs (31%), drop-in centers (25%), food shelves (24%), and transportation assistance (21%). Notable changes (of more than three percentage points either way) since 1997: Food Stamps (up from 38% to 41%), and hot meal programs (up from 27% to 31%).

Of all the services they had received in the past month, adults reported the following as the most helpful: Medical Assistance (29%), Food Stamps (24%), free or almost free clothing shelves (17%), hot meal programs (16%), drop-in centers (13%), and housing assistance (12%).

Most helpful services received by adults



The services homeless youth received were quite different. The most commonly mentioned kinds were drop-in centers (35%), outreach services (35%), Medical Assistance (29%), hot meal programs (20%), transportation assistance (20%), food shelves (18%), free or almost free clothing shelves (18%), Food Stamps (18%), and job assistance (18%).

Youth said that the most helpful services were drop-in centers, cited by 38 percent (up from 23% in 1997), outreach services, cited by 31 percent (not asked in 1997), and Medical Assistance (cited by 25%, the same as in 1997). Youth also reported getting more help in 2000 from food shelves and hot meal programs. Job training was considered one of the most helpful services by only 4 percent in 2000, down from 13 percent in 1997.

Respondents were asked about their main needs, aside from housing. Adults most frequently

mentioned a job (36%), financial assistance (20%), transportation (18%), school or training (11%), and medical care (11%). Fourteen percent of parents mentioned child care. These are similar to 1997 figures, with a four percentage point rise in transportation needs and a three percentage point drop in school or training needs.

Youth most often mentioned a job (35%), school or training (30%), financial assistance (26%), food (16%), and clothing (13%). The only notable change from 1997 was an increase in the mention of food, up from 12 percent to 16 percent.

Twenty-four percent of adults, and 63 percent of families, were receiving MFIP (welfare) benefits at the time of the survey. Seventy-four percent of families had received MFIP during the past 12 months. Of these, 31 percent had been sanctioned. In comparison, figures from the Minnesota Department of Human Services show that 25 percent of the general MFIP population were sanctioned over the course of a comparable 12-month period. Twenty-eight percent of homeless MFIP recipients were exempt from work requirements at the time of the interview, compared with 12 percent of the general MFIP population at any given time.

Physical and mental health

- ✓ **35% of homeless adults say they need professional care for a physical health problem. Over half need dental work.**
- ✓ **37% visited an emergency room in the past 6 months, an average of 2.5 times.**
- ✓ **38% have a diagnosed mental illness, up from 32% in 1997.**
- ✓ **15% have a "dual diagnosis" of mental illness and alcohol or drug disorder.**
- ✓ **32% consider themselves alcoholic or chemically dependent.**

On the day of the survey, 35 percent of homeless adults said they needed to see a health professional for a physical health problem, 30 percent for an emotional or mental health problem, and 13 percent for an alcohol or drug problem. Fifty-four percent needed to see a dentist. These rates are close to those reported in 1997.

Half (51%) had received care for at least one illness during the previous 12 months, and 37 percent had received care in an emergency room during the previous six months. People who had used the emergency room averaged 2.5 visits during this period.

Twenty-eight percent reported various barriers that kept them from getting needed health care. The main barriers reported were no money (33%) and no insurance (28%).

Mental illness affects a growing proportion of homeless Minnesotans. Thirty-eight percent (up from 32% in 1997) had been told by a doctor or nurse, within the past two years, that they had schizophrenia, manic-depression, some other type of delusional disorder, major depression, anti-social personality disorder, or post-traumatic stress disorder. Twenty-nine percent had received outpatient care for mental health problems at some time in their lives, and 18 percent had previously lived in a facility for people with mental health problems.

Fifteen percent had a dual diagnosis of at least one mental illness and a drug or alcohol disorder. Nineteen percent had been diagnosed with alcohol abuse disorder, and 13 percent with drug abuse disorder (both very close to 1997 levels). Thirty-two percent consider themselves alcoholic or chemically dependent, about the same as in 1997. Thirty-eight percent had been in a drug or alcohol treatment facility, 19 percent within the past two years. Thirty-one percent had ever been in an alcohol or drug outpatient treatment program.

Of the 5 percent of homeless adults whose most recent institutional experience had been a drug or alcohol treatment facility, just over half (51%) had had no stable place to live when they left the facility, although 70 percent had been offered follow-up or aftercare.

For slightly fewer than 2 percent of homeless adults, the most recent institutional stay was in a mental hospital, and 45 percent of those had been released without a stable place to stay. Just over half (52%) had been offered follow-up or aftercare.

Technical notes

This report presents findings from a survey of homeless people conducted by Wilder Research Center, with the help of more than 500 trained volunteers, on October 26, 2000. Fifty-three percent of the known adult population of homeless shelters and transitional housing programs participated in this survey.

Because long-term homeless individuals have a greater chance of being homeless on any given survey date than do people who are homeless for only a brief time, they appear more numerous in a single-night count than they would over the course of a year. The results describe those who are homeless at any given time, some of their experiences prior to losing their housing, and the kinds of help they might need.

The findings are representative of the total sheltered population of the state, and of the non-sheltered individuals who were contacted. They do not represent the unknown number of non-sheltered homeless who could not be located, nor do they represent those at imminent risk of losing housing or those who are doubled up with friends or family.

After interviewing a random sample of sheltered adults, interviews were weighted to reflect the known population of 3,820 sheltered adults across the state on the date of the survey. The 381 interviews with non-sheltered homeless adults were not weighted because the total non-sheltered population is not known. The total weighted adult sample size is therefore the 3,820 weighted sheltered adults plus the 381 unweighted non-sheltered adults, or 4,201. The sample of 209 unaccompanied youth is unweighted because, as with the non-sheltered adults, the total population is not known. (A full description of weighting methodology can be found in the full report at www.wilder.org/research)

Definitions

This study uses a definition of homelessness closely based on the one established by Congress for programs operated by the U.S. Department of Housing and Urban Development:

A **homeless individual** is anyone who (1) lacks a fixed, regular, and adequate nighttime residence or (2) has a primary nighttime residence that is a supervised, publicly or privately operated temporary living accommodation, including emergency shelters, transitional housing, battered women's shelters; or any place not meant for human habitation.

The two categories of people included in the federal definition but not included in this survey are: (1) those at risk of immediate eviction and (2) those recently homeless but now in supportive housing that is not time-limited.

Homeless youth, in this study, are those who currently have no parental, substitute, foster, or institutional home to which they can safely go. They are unaccompanied by an adult and have spent at least one night either in a formal emergency shelter, improvised shelter, doubled-up, or on the street.

"Street" homelessness (non-sheltered): Wilder Research Center worked with street outreach workers throughout the state to locate people in non-sheltered locations including hot meal sites, drop-in centers, encampments, and other outdoor locations. Non-sheltered persons stay in cars, abandoned buildings, tents or makeshift shelters, or hallways of apartment buildings. They may also spend the night in places open 24 hours a day or on a bus or train. Some go back and forth between non-sheltered sites and emergency shelters on different nights.

	Emergency shelters	Battered women's shelters	Transitional housing
Access	• Walk in or referred by a social service agency • If space is limited, may be selected by lottery	• Walk in or referred by an agency or advocate	• Walk in or referred by a social service agency or shelter program
Services	• Safe sleeping space • Most open only evenings and overnight; rarely available for people who work nights and sleep days • Some sites provide other services like hot meals, health care, employment and/or housing information, and connections to other services	• Safe refuge for women and their children when fleeing an abusive situation • Legal advocacy and moral support for women while they work on a longer-term solution to their situation	• Housing and support services • Must be willing to work with a case manager to set family and housing stability goals to prevent future homelessness • Most are family-focused, but some serve other specific populations such as veterans, single adults, or persons with special needs
Length of stay	• Up to 30 days	• Until safe housing can be arranged; usually up to 30 days	• Up to 24 months

For more information about the study, contact Greg Owen at 651-647-4612 or Ellen Shelton at 651-637-2470.

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August 2001

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Hennepin County

An Equal Opportunity Employer

Summary of Key Research Findings To Date on Cost-Effectiveness of Supportive Housing for Families April 2003

Supportive housing provides affordable housing with on-site case management and other supportive services intended to stabilize residents who have experienced chronic homelessness and other issues, such as substance abuse, and promote their self-sufficiency. Two supportive housing projects funded in part by the Hennepin County Children, Family and Adult Services Department (CFASD) are Portland Village, with 24 apartment units located in Minneapolis, and Perspectives, with 52 units located in St. Louis Park. The department is evaluating these projects to determine whether supportive housing reduces county-funded crisis services in child protection, out-of-home placement, and substance abuse treatment.

The analysis looks at social services purchased by CFASD beginning in the six months before and six months after families moved into supportive housing to address the questions: *does supportive housing reduce residents' use of high cost crisis services, and does overall service usage show a shift towards long-term stability?* Recognizing that six months is a relatively short time to evaluate change in this target population, we are continuing to track service usage and costs. The key findings below combine the results of 18 families from Portland Village and 25 from Perspectives who remained housed there for at least six months from the beginning of our studies in 2002:

Key Findings

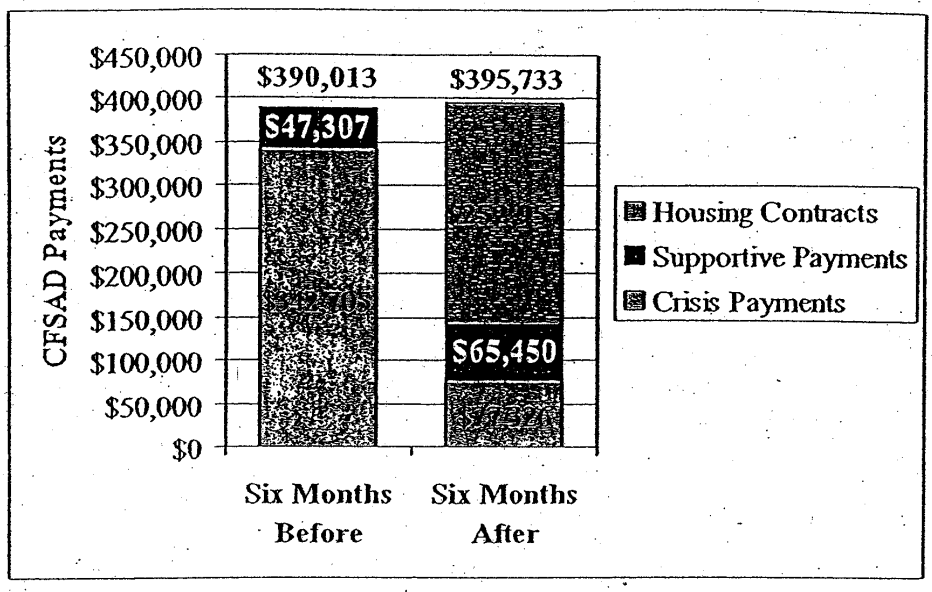
- Crisis costs declined by an average of $6,200 per family, primarily because of reduced chemical health treatment and children's days in foster care.

- There was a significant shift in CFASD funding from crisis services to supportive/preventive services (mostly CFASD's cost for the supportive housing contracts). The total amount CFASD spent was nearly the same, but before families moved into supportive housing, 88% of funds purchased crisis services. After families moved into supportive housing, 22% were spent on crisis services. See Figure 1 on page 2.

- At this point in the study, supportive housing for chronically homeless families is essentially cost-neutral to the department—the contracts pay for themselves. Over the long term, as successful families achieve self-sufficiency and move into independent housing, CFASD would eventually save money from all types of CFASD interventions. This analysis will be available in a subsequent report.

- This analysis is limited to services and payments made by the Children, Family and Adult Services Department and does not count services provided by other Hennepin County departments (e.g., Community Corrections, Economic Assistance). The reduction in CFASD crisis services indirectly indicates that total potential savings in human services are underestimated.

Figure 1, Combined CFASD Payments for 43 Families Remaining Housed at Portland Village and Perspectives Supportive Housing



Study Population and Methods

Forty-three out of 67 families housed at the beginning of the study periods (December 2001-January 2002 for Portland Village and July-August 2002 for Perspectives) continued to live in supportive housing for at least six months. The findings in this summary focus on this population. The evaluation also has findings on the eight families who left because they achieved stability and moved into other permanent housing, and on the 16 families who left due to relapse. Technical reports on both Portland Village and Perspectives research can be found on CFASD's Internet site: http://www.co.hennepin.mn.us/cfasd/welcome.html in the bottom right portion of the web page. The full reports also include results for all 67 families on social work cases opened, employee hours recorded in time reporting, and number of occurrences and days children lived in foster care.

For more information on data analyzed in this summary, contact:

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mark.herzfeld@co.hennepin.mn.us

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hearth connection

Hearth Connection is changing how Minnesotans address long-term homelessness. Working with a broad range of partners, Hearth Connection will show that it is possible to help people break the cycle of homelessness, improve their health and self-reliance, in a way that is more cost effective for government.

- **Partnering with State government,** the Minnesota Legislature has committed funds to a Minnesota Department of Human Services demonstration project called the Supportive Housing and Managed Care Pilot.

- **Ramsey and Blue Earth Counties are active in all aspects of project:** planning; administration; service coordination; financing; and evaluation.

- **Building on the knowledge of community social service agencies** to use and develop best practices for mental health, chemical dependency, housing, parenting and child development

- **Partnering with participants** from homelessness to housing and health, recruiting people with the most challenging circumstances, and including consumers in the overall effort

- **Working with CSH** to build supportive housing communities and linking participant-focused support with a broad array of housing models

- **Independent Evaluation by the National Center on Family Homelessness** measuring improvements in participants' lives, reductions in use of costly government programs, monitoring systemic changes in participant experiences, agency activities, interagency cooperation, financing, and service integration

- **Investment of all Minnesota health plans** to work together to improve health.

The Supportive Housing and Managed Care Pilot combines the following:

- Supportive housing
- Comprehensive support from a primary provider
- Intentional participant-level service coordination through support teams
- Intentional system-level service coordination among agencies involved
- An independent, comprehensive evaluation

Here is how it works. Existing homeless service providers, along with mental health and chemical dependency case management programs, identify potential participants. They describe the project to potential participants. If people are interested, these workers assist in completing an application. Eligible participants are assigned to a primary provider. 53 families and 80 single adults participate today.

The primary provider might contact the worker who helped with the referral to facilitate an introduction and initial meeting. It may take one or many encounters before an individual or family chooses to participate.

The primary provider helps participants identify, gain access to and move into housing. Primary providers maximize participant choice in housing, helping participants to select units that meet their stated preferences. Hearth Connection, the Corporation for Supportive Housing and the primary provider agencies have a demonstrated record of moving people into housing and helping them achieve housing stability.

Primary providers are responsible not only for supporting participants in finding and maintaining housing, but they also directly provide or coordinate a full continuum of services and supports.

The service model is designed to meet the needs of the participants, not the convenience of program staff. Participants are not required to agree to seek or participate in any particular course of care or treatment in order to enroll or remain in the project. The primary provider's goal is to engage participants with flexibility and creativity, establishing effective working relationships over time. The flexible financing structure promotes stewardship of resources while targeting service dollars to where each individual needs them most.

In addition to providing housing and primary support for all medical, mental health, chemical health and independence goals, the project features collaboration among key stakeholders.

While Hearth Connection brokers agreements among agency decision-makers to participate in the project, primary providers are responsible for identifying resources, coordinating the delivery of services and facilitating a support team with each participant. The support team is the vehicle for ensuring seamlessness of services at the participant level, resolving conflicts in planning, identifying systemic barriers to service coordination, and empowering participants to develop lasting support networks for meeting their needs and goals.

This dual systems- and participant-level commitment makes a deeper level of cooperation among agencies and disciplines possible, including the identification and removal of financial, regulatory, data collection and other barriers. When barriers are identified, Hearth Connection convenes the parties to address them and to promote effective and efficient service coordination.

The Supportive Housing and Managed Care Pilot shows early evidence of effectiveness. As the project continues, Hearth Connection will share both the successes and challenges with stakeholders to help Minnesotans and others understand more about ending long-term homelessness.

The Supportive Housing and Managed Care Pilot

Facts about Families

- 217 participants from 53 families, including 154 children in Blue Earth County and Ramsey County.
- 18 families were or have been enrolled for less than 90 days. Median length of enrollment for the remaining 64 families who have been or are enrolled is 17 months.
- Families average 4 members per household (1.25 adults and 3.75 children).
- Average age for children is 9.6 years. Average age for adults is 33.9 years.
- Once obtaining housing, 79% of families have remained in the same housing unit for as long as they have been enrolled.

Ramsey County Family Analysis

- Long-time county residents (16+ years).
- Long histories of homelessness (2+ years for families, longer for single adults).
- 60% African American, 24% Caucasian, 10% Native American, 3% Hispanic and 3% multiracial.
- At the point when they applied, 16 families were living in shelter, 16 were doubled up, 3 were living on streets or in vehicles.
- Upon referral, families self-reported a high prevalence of mental health issues (49%), chemical dependency (30%), and dual diagnoses MI/CD (21%), but primary providers report after working with families that most families have some history of addiction combined with some level of mental health problems.
- In two years before enrollment, 22 families had 99 emergency shelter stays.
- High overall housing stability: Average tenancy is 263 days. More than half (55%) of families have been in their current housing for more than 13 months.
- Low housing turnovers: 19 families have stayed in the same home since moving in initially. Just 4 families (10%) account for half (47%) of the 19 housing changes in Ramsey County.
- Preliminary data on participant incomes used to calculate rental assistance suggests that the average gross family income increased by 52% (from $520/mo to $791/mo) between the first and second year of enrollment.
- The median length of enrollment for families in Ramsey County is 559 days (18 ½ months).

Blue Earth County Family Analysis

- 75% Caucasian, 20% East African immigrants, 5% African American.
- In 2000, Blue Earth County provided 123 months of service for 16 families who enrolled in the pilot in 2001. State and County human services spent $457,000 on these contacts, averaging $3,700 per month of contact.
- There has been a 57% decrease in child protection incidents after enrollment.

The Supportive Housing and Managed Care Pilot

Demonstration of Outcomes

What the pilot can demonstrate now

- Significant housing stability for families
- High enrollment retention
- Most challenging group of chronic or long-term homeless families and single adults
- High costs for eligible single adults and families determined from analysis of county administrative data on shelters, detox, chemical dependency treatment and mental health
- Completion of first qualitative process study

What the pilot will be able to demonstrate this calendar year

- Summary analysis of baseline outcome interviews with participants, covering health, behavioral health, productivity, housing histories and client satisfaction
- Identification of matched comparison group for cost and outcome study
- Further analysis of county administrative data for single adults and families, adding emergency assistance, child protection encounters and out-of-home-placement (covering pre- and post-enrollment periods and matched comparison group)
- Analyses of health care use and expenditures from health plan and State health and human services data, covering matched comparison group and participants pre- and post-enrollment

What the pilot will be able to demonstrate when completed

- Documentation of the characteristics of families and single adults who are homeless for extended periods of time
- Documentation of reductions in utilization of government-funded services and the cost offsets associated with them, including health care, chemical dependency treatment, mental health services, economic assistance, crisis interventions, corrections and out-of-home placement of children
- Documentation of the improvements in participant outcomes, including housing stability, health, productivity, self-sufficiency and general quality of life
- Documentation of best practices for how agencies across sectors must work together to coordinate and integrate services to improve outcomes and increase efficiencies, and lessons learned
- Documentation of best practices associated with effectively housing and supporting families and single adults moving from homelessness to self-sufficiency
- Strategies that incorporate local, state and federal government programs and financing for housing, health care and social services, as needed to address long-term homelessness broadly
- Public-private infrastructure for consistent delivery of a high quality intervention, with accountability mechanisms for ongoing oversight

Human Service Funding and Supportive Housing Overview

Human Service funding mechanisms for community-based housing and service options are not typically focused on particular providers, projects or settings but on the individual who may be eligible for the program or setting. Major policy and philosophical differences have developed in the human service and housing communities as a result. We need to understand how these difference affect efforts to develop "supportive housing" so that we can make the best use possible of all the resources at hand.

It is an important first step to make sure that everyone is on the same page when defining supportive housing goals. Are we primarily interested in aiding the development of project-based models that combine housing and services in one setting, or are we also talking about affordable, community-based housing options that have supportive services available to the residents in scattered site settings? Does this have to be an either/or question? There are important policy reasons for considering different models of supportive housing development, including improved client choices, outcomes and autonomy as well as increased efficiency/savings for government.

I. Human Services and Housing Development Funding typically are not structured in the same manner. The goals of the programs can and do differ.

A. Human Services-
   - Individual eligibility
   - Individual outcomes
   - Individual choice and flexibility.
   - The separation of housing funding from service funding.

B. Housing Development-
   - Capital funding and operating funding considered together.
   - Stability and adequate cash flow are important.
   - Long-term financing is important.

C. Supportive housing funding-
   - Must combine the Human Service focus on individuals with the Housing developer's need to focus on stable funding for the setting.
   - Three funding elements need to be considered together:
     - Capital-Operating-Services

II. How does Human Services Funding "Flow?"

A. State supervised, county administered system-What does that mean in practical terms?
   The county contracts with the provider.
   Meet with counties early and often during project development.
   Policy development can and does occur at both levels.

B. Funding sources:
   Federal-State-County-Other Charitable
   The Big "M" (Medicaid)

C. Funding types:
   1. Income supplements -What are "Entitlements?"
   2. Payments for services-Rates
   3. Grant programs
   4. Appropriations vs. Forecasts-Why this makes a difference when seeking funding for a project?

Housing Options Continuum-From a Service Perspective

Imagine a housing continuum that can be created with institutions at one end and apartments/single family homes at the other. Supportive housing options can and do exist all along the continuum.

RTC→ICF/MR→Nursing Homes→Boarding Care→Adult Foster Care→Board and Lodging→Assisted Living→(New supportive housing models)→Apartments-→Condos-Coops→Single Family Homes.

Each supportive housing type along this continuum has similar funding issues, making it important to understand the three elements essential to supportive housing development:

1. Capital funding for construction/rehabilitation,

2. Income supports and/or rental subsidy to pay for the operational expenses of the housing to be developed, and

3. The availability, coordination, and adequacy of payment for services for the residents of the supportive housing project.

In discussing the availability of funding from human services programs, not only are the restrictions of the funding source (entitlement, grant, rate) important to consider, but also the requirements of the funding type (capital, operating, service) must be taken into account as well.

The Publicly Funded State and County Mental Health System

Minnesota has a state-supervised, county-administered public mental health system. The mission and framework are articulated within the Comprehensive Mental Health Acts for Adults and Children. The target populations are adults with serious and persistent mental illness and acute mental illness, and children with severe emotional disturbance.

Funding and assuring quality are the responsibility of both the state mental health authority, which is the Department of Human Services and the local mental health authority, which is the county board of commissioners.

The mental health service system for children and adults developed by each county board must include the following:

- education and prevention services
- emergency services
- outpatient treatment
- community residential treatment
- acute care hospital inpatient treatment
- Regional Treatment Center (state hospital) inpatient treatment;
- screening
- case management

The adult service system must also include community support services (includes day treatment), while the children's mental health service system must also include early identification and intervention services, professional home-based family treatment, therapeutic support of foster care, and family community support services.

Children's Collaboratives and Adult Mental Health Initiatives are two creative service delivery models that local areas can use to improve access, achieve better coordination of care, expand service options, and integrate funding to treat adults and children with serious mental illness.

Excerpt from DHS Briefing Book: Toward Better Mental Health in Minnesota: a Community Approach (Second Edition, February 2001)

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Minnesota Department of **Human Services**

2003 session highlights

Adult mental health reform legislation

The Legislature acted to foster a broader array of community-based mental health services, including a range of permanent housing options. These measures begin to address concerns that 20 percent to 30 percent of people in inpatient psychiatric settings and 30 percent of those in residential treatment facilities could be better served in alternative settings.

- **Service closer to home.** In response to planning by counties and the Minnesota Department of Human Services Mental Health Division, there will be a broader array of mental health services located in closer proximity to where people live. People now accessing services by traveling to regional treatment centers will be able to access an appropriate level of care near their home communities and natural support systems as multiple smaller hospital units, crisis response services, in-home supports, long-term residential supports and other community services are developed.

- **Better access and choice.** A broader array of services will allow people with mental illness to be more appropriately matched to the services they need, thereby improving care, access and choice while increasing service capacity.

- **Increased mental health funding.** Configuration of smaller, local service units will allow vendors, including State Operated Services, to be eligible for new sources of public and private funding. Also, Medical Assistance will expand to cover intensive rehabilitation services, such as assertive community treatment teams and intensive residential treatment.

- **Consumer benefits will pay for services.** Individuals eligible for benefits, such as those provided through Medical Assistance or other third-party payors, will have services paid for by those benefits.

- **Financial incentives for community-based services.** Counties will have an incentive to participate in community-based options, as their cost share per patient for institutions for mental diseases, such as regional treatment centers, rises from 10 percent to 20 percent beginning July 1, 2004.

Residential treatment restructuring

- A portion of some 70 residential treatment facilities will be converted to facilities where more intensive treatment, short of hospitalization, can be provided. This conversion will be accomplished in partnership with the regional adult mental health initiative process.

- Funding for other existing residential treatment facilities will be used to develop a range of housing options based on individual and community needs.

- Existing state funding for adult mental health residential treatment will be leveraged to bring in federal funding for these services.

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Blending of SOS into community-based system

- Movement to an expanded community-based mental health system will begin in the southwest region of the state served by Willmar Regional Treatment Center and northern regions served by Brainerd Human Services Center, Fergus Falls Regional Treatment Center and the Ah-Gwah-Ching nursing home.

- Clients who require hospital level of care will begin to receive those services in smaller hospital units located in or near their home communities rather than in regional treatment centers.

- Most SOS nursing home clients will move to community nursing homes. SOS will retain nursing home capacity for forensic clients who require that level of care.

- About 20 percent of SOS adult mental health clients and 50 percent of SOS nursing home clients who do not require hospital level of care will be served under the Community Alternatives for Disabled Individuals waiver or other community-based care.

- Individuals served in the Adult Mental Health Initiatives who have benefits through Medical Assistance, MinnesotaCare or other third-party payors will use these resources to pay for services. SOS and the Mental Health Division will work with initiatives to ensure that current levels of service to patients are maintained.

- Once community-based adult mental health services are in place and utilization of the regional treatment center ends, the county obligation to fund 20 percent of the cost of regional treatment center ends. DHS will work with counties to determine how they may continue to contribute to the community-based mental health system in an amount that will not exceed county funds historically contributed for the cost of care at the regional treatment center.

Offenders with mental illness

- A new initiative will provide alternative placements and treatment in the community for convicted offenders with mental illness who are being considered for a prison sentence. Courts will have authority to determine when this option would be consistent with public safety and the needs of the individual.

This information is available in other forms to people with disabilities by contacting us at (651) 582-1889. TDD users can call the Minnesota Relay at 711 or 1-800-627-3529. For the Speech-to-Speech Relay, call 1-877-627-3848.

Minnesota Department of Human Services

Consolidated Chemical Dependency Treatment Fund

What is the Consolidated Chemical Dependency Treatment Fund?

The Consolidated Chemical Dependency Treatment Fund (CCDTF) was created in 1988 to fund cost-effective chemical dependency treatment services for low-income, chemically dependent Minnesota residents. The CCDTF combines previously separated funding sources - Medical Assistance (MA), General Assistance Medical Care (GAMC), General Assistance (GA), state appropriations, and Federal Block grants - into a single fund with a common set of eligibility criteria. Counties pay 15% of treatment costs.

What Types of Services are Available?

- Inpatient chemical dependency treatment
- Outpatient chemical dependency treatment
- Halfway house service
- Extended care treatment

Approximately 50% of all state treatment admissions for Minnesota residents are paid for through the Consolidated Fund. A person's need for chemical dependency treatment is assessed by the local county social service agency or American Indian tribal entity. A treatment authorization is made based on uniform statewide assessment and placement criteria outlined in DHS Rule 25. Most treatment providers in the state accept Consolidated Fund clients.

Primary inpatient treatment typically lasts three to four weeks, extended care programs one to three months, and halfway house stays two to four months. Outpatient programs vary greatly, with lengths of treatment typically ranging from four to 12 weeks.

Who is Eligible?

The Consolidated Fund has two tiers of eligibility.

- Tier I is the entitlement portion, eligible individuals are persons who are enrolled in MA, GAMC, receive MSA, or meet the MA, GAMC or MSA income limits.
- Tier II includes those individuals not eligible for MA whose income does not exceed 215% of Federal Poverty Guidelines.

How Many People, How Many Dollars?

In FY 2002, 25,311 treatment admissions were authorized at an average cost of $3,287. This was an increase in the average cost of 6.7% from 2000.

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County-State Working Group on Supportive Housing

Policy Statement

The purpose of this policy statement on supportive housing is to guide state and county officials as they seek to improve the effectiveness of services, health care, and housing for families and individuals who are long-term homeless or at significant risk of homelessness.

Statement of the Problem

Effectively linking affordable housing to support services is necessary to achieving many state and county public policy goals. Many families and individuals need access to services in order to maintain housing and need affordable housing in order to live stable and successful lives.

Most families and individuals are able to choose their housing from the array of housing options available and choose a provider of services from a number of qualified vendors. For most families and individuals simply increasing the supply and availability of affordable housing is the most effective strategy for ensuring that they have access to the services and housing that they need.

However, a subset of all families and children are unable to obtain and maintain rental housing but for access to support services where they live. These families and individuals frequently are screened out or evicted from conventional housing because they need services and support in order to live in the community; and they frequently are unable to take advantage of service, support, or treatment programs because they lack affordable housing.

"Access to support services where they live" does not mean necessarily that services are mandatory in order to reside in the housing or that services are delivered on site. Rather, it means that access to services or to a coordinator of services is available as part of residing in the housing.

These families and individuals are either long-term homeless or at significant risk of homelessness at great cost to themselves, their children, their community, and to the human services, health care, and housing systems. Permanent supportive housing is a promising response to the needs of these families and individuals.

What is Supportive Housing?

Supportive housing is permanent affordable rental housing with linkages to the services necessary to enable tenants to live in the community and lead successful lives.

Why Should State and County Officials Care About Supportive Housing?

Supportive housing has the potential to achieve the following:

- either reduce costs to health care, mental health, chemical health, corrections, law enforcement, education, housing, and child welfare systems or achieve improved outcomes for families and individuals without increasing costs;

- improve outcomes for families and individuals in areas of household stability, increased employment, and reduced use of hospitals, jails, treatment facilities, emergency rooms, shelters and crisis services;

- reduce out-of-home placement for children and improve children's health, school attendance, and educational achievement;

- increase the effectiveness of services and health care by incorporating access to housing-based supports; and

- achieve housing stability for families and individuals who are at significant risk of homelessness or who are long-term homeless.

How Can We Increase the Availability of Supportive Housing?

In order to increase the availability of supportive housing, the following policy objectives must be met:

- Develop a way to pay for coordinated services in supportive housing for individuals or families in the following circumstances:
  - families and individuals that have multiple service providers with little or no cross communication, coordination, and attention to gaps or overlaps in services;
  - family members and individuals that have multiple diagnoses, needs for a variety of supports, and eligibility for multiple income maintenance, social services, and health care programs;
  - the housing is scattered site or single site.
- Develop coordinated working relationships, common understanding, and mutual expertise among the following:
  - state and county agencies with responsibility to serve at-risk populations;
  - capital funders of housing to ensure early and constructive coordination between providers and funders of services and developers of supportive housing; and
  - administrators of tenant-based and project-based rent assistance programs.

S U M M A R Y

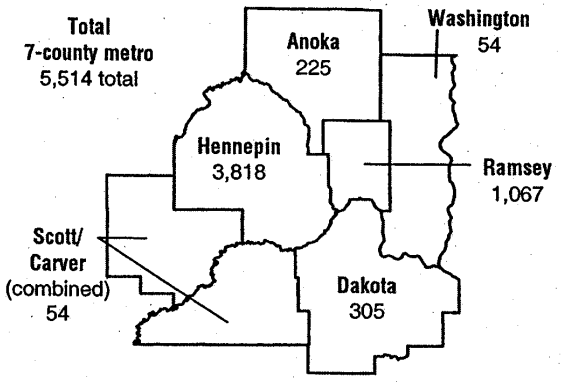
Addressing homelessness

A needs assessment and plan for the seven county metro area

Homelessness continues to grow in Minnesota's Twin Cities 7-county metro area. About 12,300 people now experience homelessness on any given night in this region, including those on the streets and those "doubled up" with friends, relatives, or acquaintances. Every night about 5,500 people, including more than 2,400 children, stay in the region's temporary housing programs, representing a 150 percent increase in individuals – and a 290 percent increase of children – over the past decade.

Addressing homelessness, a collaborative project by the Metro-wide Engagement on Shelter and Housing, the Corporation for Supportive Housing, the Wilder Research Center, and planners and advocates throughout the region, is an effort to refocus our collective problem-solving on an issue that has so far overwhelmed county-based planning and policy.

Persons sheltered on October 26, 2000, by county



Note: "Persons sheltered" includes those in emergency shelters (including those in hotels via emergency vouchers), battered women's shelters, and transitional housing programs.

Source: Wilder Research Center, Statewide survey of people without permanent shelter.

Our examination of homelessness as a regional problem leads us to one central conclusion: The 7-county metro area needs a Regional Committee to End Homelessness.

Why? Homelessness is a regional problem. People experiencing homelessness commonly migrate from one county to another within the region—sometimes for employment or to be nearer to friends, family, or services, but other times because a county's policies push them to seek services elsewhere.

What would the Regional Committee to End Homelessness look like? The Committee would be comprised of elected officials, county staff, practitioners and other stakeholders with adequate representation from each of the seven counties.

What would the Regional Committee to End Homelessness do? The Committee should establish a regional Blueprint to End Homelessness. We recommend that the Blueprint include the following four major coordinating and oversight roles for the Committee: Facilitating the coordination of county policies, strengthening and coordinating existing "Continuum of Care" planning, promoting funding alignment, and setting and monitoring region-wide goals, including unit production goals.

1. Facilitate coordination of county policies

Disparate policies look more like an attempt to move the problem elsewhere than an attempt to collectively problem-solve. People experiencing homelessness are confronted by different policies in different counties: In Dakota County, families, youth, and adults with special needs can receive emergency shelter after one night of residency; additional attention from the County's Supportive Housing Unit, however, requires 60 days of residency. Washington County has a one

night residency requirement, but has limited long-term shelter available for families or individuals. Only Hennepin and Ramsey counties provide emergency shelter to adults who have no children with them and no disabilities. Some counties that work very hard to get families out of the shelters and into permanent housing end up moving the families to other counties – where the family has not established residency, and therefore cannot access services.

The Regional Committee to End Homelessness would work with the existing organizations and county officials to eliminate the barriers associated with movement of individuals and families among counties in the region. For example, the Regional Committee could work to create a uniform system for accessing services.

2. Strengthen and coordinate existing "Continuum of Care" planning

The 7-county metro area includes six Continuum of Care regions, each of which annually submits a report to the U.S. Department of Housing and Urban Development to help secure federal funding for programs that address homelessness. Development of the Continuum of Care plans constitutes one of the region's most important efforts related to homelessness, but also leads planners and advocates to focus on individual counties rather than the region as a whole.

The Continuum of Care planning process is also complicated by a lack of common reporting definitions and procedures. Further, although many of the planning committees have similar goals, they generally do not work together to address these goals, and only recently have established a forum (the Metro-wide Engagement on Shelter and Housing) to share strategy and work cooperatively.

To strengthen and enhance the Continuum of Care planning process in the metro area, we recommend that the Regional Committee to End Homelessness work with the sub-regions to develop a metro-wide plan to end homelessness. By doing so, Continuum of Care planning would include the broader context of longer-term goals for the region. Additionally, the six current Continuum of Care committees would work with the Regional Committee to End Homelessness to implement county- and continuum-specific recommendations, including policy coordination, funding alignment, and oversight of production goals.

3. Promote funding alignment

One of the biggest hurdles that developers of transitional or permanent supportive housing face is funding both the capital costs of construction and the operating costs of providing on-site services for future tenants. Transitional and permanent supportive housing programs often must combine funding from several sources, including the Minnesota Housing Finance Agency, the U.S. Department of Housing and Urban Development, the Minnesota Department of Human Services, county and city sources, and private foundations. A project that secures capital funding but lacks service dollars is unable to start construction, causing costly delays and serious inefficiencies for those in need of services.

4. Set and monitor region-wide goals

To meet the charge of ending homelessness, the Regional Committee would establish specific goals for providing housing and services that both prevent homelessness and help people escape homelessness – sometimes referred to as "closing the front door and opening the back door."

The Regional Committee, in conjunction with existing Continuum of Care committees, county and city planners, and others, would be responsible for refining and adopting production goals, including deciding where units will be sited. As a starting point for these discussions, however, we estimate that the 7-county region currently needs more than 5,000 additional bed spaces for people experiencing homelessness, roughly as follows:

- 3,240 units for adults without children, including at least 1,910 units of supportive housing and 680 units of targeted affordable housing
- 1,600 units for families with children (roughly 4,800 beds), including at least 945 units of supportive housing and 420 units of targeted affordable housing
- 300 to 400 units for unaccompanied youth

In sum, to better address homelessness, and ultimately put an end to the problem, the 7-county metro area needs a Regional Committee to End Homelessness. In addition to the four major coordinating and oversight

roles discussed above, the Regional Committee would, no doubt, address many of the key issues raised through this needs assessment, including the region's racial disparities in homelessness; the need for domestic violence prevention and treatment; the need to improve the "mainstream" services that fail to prevent homelessness among many adults, families, and youth; and the other issues recapped below. The Regional Committee would also work in concert with groups pushing to increase the supply of affordable and subsidized housing in the 7-county metro area.

Needs assessment: Recap of key findings

Economic context and county policies

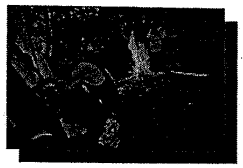
- In the 1990s the Twin Cities 7-county region experienced strong economic growth, low unemployment rates, and high rates of homeownership. This prosperity drove down vacancy rates and drove up housing prices.
- More recently, the economic downturn has left many in the region without jobs.
- Large disparities persist between Whites and non-Whites in terms of income and housing opportunities.
- Many of the new jobs that economists project for this region over the next few years do not pay wages that will adequately cover housing and living expenses.
- People experiencing homelessness in the 7-county region contend with a mixed bag of policies concerning homelessness and emergency housing:

  Some counties have residency requirements. Others do not.

  Some counties limit shelter stays. Others do not.

  Some counties give vouchers to single adults. Others do not.

The needs of people experiencing homelessness



- An estimated 12,300 people are homeless on any given night in the 7-county metro area, including those in temporary housing programs, those "doubled up" with others, and those staying on the streets.
- On any given night about 5,500 people are housed through the region's temporary housing programs, including:

  Nearly 2,000 in emergency shelters (and through emergency motel vouchers)

  Almost 400 in domestic violence shelters

  More than 3,100 in transitional housing programs
- The number of persons sheltered on any given night more than doubled over the last decade, and the number of children sheltered almost quadrupled to more than 2,400. About 100 unaccompanied youth are housed nightly in the region, with many others doubled up or on the streets.
- Other known changes in the characteristics of adults lacking permanent shelter in the 7-county metro area include:

  The percentage employed has grown to 44 percent overall and 39 percent of those in emergency shelter.

  Long-term homelessness – lasting a year or more at a time – has risen to include 39 percent overall (36 percent of those in emergency shelter).
- African Americans are highly overrepresented among those experiencing homelessness, and American Indians and Latinos are also over-represented.
- Every county in the 7-county metro area "exports" people experiencing homelessness to other counties in the region, with Hennepin County as the most common destination.

- Battered women's shelters are not the only programs that house victims of domestic violence. Histories of domestic violence are very common for women and youth experiencing homelessness.

- Many people experiencing homelessness have had problems with mental illness, chemical dependency, or the law, and many have recently passed through "mainstream" chemical dependency, mental health, and correctional programs.

- It is not uncommon for youth who become homeless to experience multiple bouts of homelessness. Some youth have difficulty accessing temporary housing, and some are turned to trading sex for shelter, or become victims of the sex industry.

- When those experiencing homelessness are asked what is needed to solve the problem, they are most likely to say, "Affordable housing."

Capacity and planning

- In the 7-county metro area, 121 temporary housing programs provide more than 5,600 beds for people experiencing homelessness, including nearly 2,000 in emergency shelters, nearly 400 in domestic violence shelters, and roughly 3,200 in transitional housing programs. Additionally:

  12 programs provide emergency hotel vouchers, with the capacity to temporarily house approximately 176 people.

  25 programs provide about 850 slots of permanent supportive housing for the formerly homeless.

- Relatively few programs serve unaccompanied youth (26 programs and 413 slots).

- Most of the programs in the suburban counties serve homeless families; suburban counties provide little capacity to house single adults and even less for homeless youth.

- Prisons, psychiatric programs, hospitals, and other treatment programs commonly discharge people directly into temporary housing programs, yet several of these programs report that their staff are not trained to meet the needs of those recently discharged.

- The 7-county metro area is organized into six "Continuum of Care" regions, each of which annually submits a report to the US Department of Housing and Urban Development. This process provides a good avenue for local participation and coordination, but leads providers and planners to focus on their local area rather than the metro region as a whole.

For more information

This summary presents highlights of *Addressing homelessness: A needs assessment and plan for the 7-county metro area*, available at www.wilder.org/research (or contact: Wilder Research Center, 1295 Bandana Boulevard North, Suite 210, Saint Paul, Minnesota 55108; 651-647-4600).

Prepared by Wilder Research Center for Metro-wide Engagement on Shelter and Housing, with funding from Minnesota Housing Finance Agency.

JUNE 2003

Executive Summary

"The bottom line is that we need to cultivate relationships to help offenders get housing. This is labor-intensive work, but the results are tremendous in keeping offenders out of prison."

Housing for offenders? This is not a topic that immediately engenders broad-based empathy or a call to action. Housing shortages abound, particularly affordable housing units. Why should policymakers pay special attention to housing difficulties experienced by offenders? Simply put, the answer is public safety.

Offenders released from jails and prisons are increasingly finding that they cannot gain access to suitable housing. The result? They sleep in cars, find emergency housing along with more vulnerable populations, cohabitate with other felons in substandard housing, or live a vagrant lifestyle, from friend to friend until their welcome runs out. The label of "offender" is often synonymous with a "scarlet letter" as they are branded as a poor risk to accept on a rental lease. Instead of a welcome mat, they encounter barriers that deliver a message that they are shunned from gaining access to housing units. And case workers report that many offenders are subsequently being revoked and returned to incarceration. State or county residential care is much more expensive than community care or self-sufficiency, and these offenders will eventually be released again.

Approximately 3,800 inmates are released from Minnesota prisons each year and many more from county jails. As a society, we have two choices: 1) Allow offenders to be subject to inadequate or substandard housing conditions, insurmountable access at an increased public safety risk, or a revolving door in and out of jails and prisons at an increased cost to the taxpayer; or 2) create reasonable pathways for offenders to find suitable housing and corresponding support services so they can gain self-sufficiency and a restored sense of hope.

This report represents a beginning step toward finding solutions that work, both for the offender and his/her family as well as the public at large. The reader will not find a "breakthrough" strategy in the recommendations, but there are important first steps that will hopefully lead to solutions that bring long-term and meaningful change.

Focus Groups

As a result of increasing concerns expressed by corrections professionals over the inability of offenders to acquire adequate housing, the Minnesota Department of Corrections (DOC) held four focus group sessions over the fall of 2000. Each session was attended by over 60 city, county, and state officials along with case managers, housing advocates, and service providers. Concerns spanned the entire state and encompassed urban, rural and suburban features. The summary below describes the group's findings and recommendations.

Focus Group Findings

- The lack of access to appropriate housing for offenders results in diminished public safety.
- While public concern about housing for offenders is understandable, offenders evoke a level of concern among communities and property managers that makes access to housing almost insurmountable.
- Helping systems do not always coordinate or communicate with each other. Sometimes policies and practices by one agency cancel the efforts of another.
- Specialized offender housing is not geographically disbursed appropriately. There is excessively high concentration in some areas and unavailability in others.
- Given public sentiment often predisposed against housing offenders in their communities, creative solutions are necessary.
- The objectives of correctional halfway houses should be clarified and contract administration altered accordingly.
- The highest priorities around housing services for offenders are, in order of priority:
  - — Guaranteed emergency bed access
  - — Transitional housing
  - — Supportive housing
  - — Access to market rate and affordable housing
- Housing placements upon release from prison could be improved with changes at the correctional institution.

DOC Recommendations

- Improve system coordination/communication and focus on offender housing needs by establishing an interagency work group to:
  - — Review, coordinate, and recommend appropriate changes in policies and practices.
  - — Assist and inform referral and direct-care professionals of existing housing.
  - — Conduct a statewide summit with regional work teams.

- Increase public awareness of the issue of offender housing.

- Increase rental placements by building upon existing housing interventions proven to be effective. Do this by:
  - — Developing how-to packets, offender-provided certification training programs, and a centralized listing of housing options for access by probation officers and housing case managers.
  - — Increasing housing service contracts.
  - — Issuing exploratory community-driven Requests for Proposals to encourage innovative housing options for offenders with the greatest needs.
  - — Training probation officers.
  - — Reducing probation officer caseloads.

- Explore short-term emergency sex offender housing options until a more permanent solution can be found.

- Assess the social and health needs of the offender population to develop a more thorough and complete understanding of their housing and service needs.

- Set aside corrections funding to create a supply of supportive housing units (new and existing) for offenders.

- Improve DOC transitional services for prison releasees by:
  - — Beginning release planning earlier in the process. Release planning should begin at intake, with intense planning moved to six months before release instead of the current four-month mark.
  - — Ensuring that each releasing facility has a special needs unit or other trained staff to assist inmates who are mentally ill or mentally delayed to develop appropriate release plans.
  - — Conducting a discharge mental health assessment on every offender identified with a major mental illness prior to release from the institution. Assessment results should be used to address the transition plan and the information transferred to the field agent.
  - — Ensuring that offenders requiring psychotropic medication are provided with an appropriate supply at release and that they have access to follow-up health care services. Set up a process for monitoring the taking of medication as part of the release plan.
  - — Ensuring that, whenever possible, the offender identifies a local case manager(s) to assist with transitional issues upon release.
  - — Extending the identification card pilot projects beyond the pilot sites.
  - — Examining DOC policies to determine how to encourage more long-term involvement between inmates and the community that will continue after release. Programs such as AMICUS and Prison Fellowship could be expanded.
  - — Reviewing DOC policies on halfway houses including clarification of roles and outcomes desired, funding options that better match service levels desired, and length of stay.
  - — Holding an annual planning session with prison case workers and probation officers to coordinate policy, identify problems and solutions, and improve transition from institution to field services and vice versa.
  - — Conducting a listening session with vendors who serve offenders of color to determine how to best provide transitional services that are comprehensive, supportive, and culturally-specific.
  - — Conducting "transition fairs" at each medium-custody facility to provide information on available housing, employment, and other community services.

Solutions lie largely at the community level. This is where the largest number of offenders are supervised by community agents; agencies that can lend support, planning and services are based; and volunteers needed to support local efforts live. That is not to say that state agencies shouldn't play an important role. State agencies can and should reexamine policies, coordinate statewide strategies, help seek funding, and provide technical assistance so that local planning efforts can succeed. It is the DOC's intent to put these recommendations in action by collaborating with other state agencies, county personnel, the private sector, and service providers.

Minnesota Interagency Task Force on Homelessness
Mission Statement

The State of Minnesota Interagency Task Force on Homelessness works to effectively use state resources to prevent and end homelessness.

Purpose

To prevent and end homelessness the Interagency Task Force on Homelessness has been established to:

- Investigate, review and improve the current system of service delivery to people who are homeless or at risk of becoming homeless.
- Improve coordination of resources and activities of all state agencies relating to homelessness.
- Advise the Minnesota Housing Finance Agency in managing the Family Homeless Prevention and Assistance Program.

Values

The task force members work collaboratively, with commitment, openness, flexibility, cooperation, and respect for the roles and responsibilities of each state agency. We promote culturally competent service delivery through our funding recommendations.

Who we serve

We serve the organizations working directly with people who are homeless and/or who are at risk of becoming homeless in Minnesota. We work primarily with advocates, service providers, communities, cities, counties, state agencies, the legislature, the Governor and the federal government.

Objectives

The Interagency Task Force on Homelessness:

- Identifies, reduces and eliminates barriers to ending homelessness.
- Maximizes the capacity of the state to effectively access and manage federal and state resources.
- Directs and advises the Family Homeless Prevention and Assistance Program.
- Develops an annual work plan and goals based on the mission statement of the Interagency Task Force on Homelessness and semi-annually evaluate progress on achieving the goals.

The main objective of the Interagency Task Force on Homelessness for 2002-2003 is to implement a statewide plan and strategies to prevent and end homelessness.

Membership

Membership will consist of representatives of state agencies and organizations invited by the Commissioner of the Minnesota Housing Finance Agency. Members will act as a Family Homeless Prevention Program Advisory Committee resource and advisor.

Minnesota Statutes 2001, Table of Chapters

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462A.29 Interagency coordination on homelessness.

The agency shall coordinate services and activities of all state agencies relating to homelessness. The agency shall coordinate an investigation and review of the current system of service delivery to the homeless. The agency may request assistance from other agencies of state government as needed for the execution of the responsibilities under this section and the other agencies shall furnish the assistance upon request.

HIST: 1990 c 520 s 2

Interagency Task Force on Homelessness Members:
Human Services
Children, Families & Learning (moving to DHS)
Health
Corrections
Crime Victims Services
Veteran's Affairs
Economic Security
Trade & Economic Development
Metropolitan Council

A Review of Funding Activity and Households Assisted under the Family Homeless Prevention and Assistance Program, 2000 and 2001

Summary and conclusions
The Family Homeless Prevention and Assistance Program has three main goals: to prevent homelessness, to reduce the length of shelter stay among emergency shelter users, and to reduce repeat shelter use, e.g., by helping people into permanent or transitional housing.

This analysis is based on data available to us through a new database of information. Information should be useful to MHFA program staff in assessing program or provider success in meeting goals. While some of the facts presented here may not be entirely unexpected, they are useful in quantifying or verifying what we may already have suspected.

FHPAP assists a relatively large number of households at a relatively low cost per household.

Two-thirds of households assisted in 2000 and 2001 in the metro area.

The greatest amount of cash assistance provided is for housing – primarily for rental assistance vouchers.

More than 50% of all assisted households received services (only), while the remainder received either cash alone or in combination with services.

Some basic facts concerning characteristics of households assisted under FHPAP include:

- Single parent families comprised the greatest proportion of assisted households, and women headed most of these families (i.e., one female adult with one or more children under the age of 18).
- More than 50% of all FHPAP-assisted households, statewide, were households of color (i.e., a race other than white). In the Minneapolis/St. Paul metropolitan area nearly 70% of households assisted in the last two years were of color.
- FHPAP-assisted households in all areas of the state had extremely low incomes. Median household incomes in both metro and Greater Minnesota were less than 30% of HUD's estimated median family income.

Measuring duration of participation is difficult, however, the MHFA assists people for what we estimate to be a relatively short period of time, either preventing homelessness for them or helping them into transitional or permanent housing following homelessness.

The program was designed to allow providers the flexibility to meet varying local needs. MHFA staff collects a limited amount of basic information from all grantees concerning what assistance they provide and what are the general characteristics of the people they assist.

MHFA staff also has information and outcome measures from local providers that show us how successful FHPAP has been in meeting specific local goals.

With the advent of a statewide information system on assistance to the homeless we may have even better data in the future on FHPAP assistance provided in Minnesota and how

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Continuum of Care – Program Summary

What is Continuum of Care?

The core principle behind Continuum of Care (CoC) is that individuals and families in crisis should access a logical, interconnected system of housing and social service supports, no matter where on the crisis "continuum" they find themselves. The fundamental components of a CoC system are:

- homelessness prevention
- outreach and assessment
- emergency shelter
- transitional housing
- permanent housing
- permanent supportive housing, and
- services to address needs in all housing settings

A participatory planning process guides the creation or improvement of a CoC system. The CoC concept originated from the McKinney Vento Act with the U.S. Department of Housing and Urban Development (HUD) in 1995. The first plans were created in Minnesota in 1996. The planning process is conducted by a CoC committee - one for each of Minnesota's 13 regions.

The CoC Committees are responsible for assembling information about homeless services in the region, identifying gaps, and developing strategies to fill gaps. CoC Committees also review housing proposals and coordinate the application processes by local providers for federal and state funding opportunities and provide certification of consistency with the regional CoC plan.

Why is a Continuum of Care Plan Important?

- CoC plans coordinate and organize resources on a regional level to meet the needs of homeless and near-homeless individuals and families.

- CoC plans serve as statements of need to access funding from a variety of local, state, federal and private resources. Resources include: Emergency Shelter Grant Program (ESGP), Transitional Housing Program (THP), Emergency Services Program (ESP), Family Homeless Prevention and Assistance Program (FHPAP), Shelter Plus Care (S+C), Supportive Housing Program (SHP), SRO MOD Rehab, and Projects to Assist in the Transition from Homelessness (PATH) funding. **In 2001, CoC plans helped organizations attract $19.9 million in federal resources for homelessness response.**

- CoC plans provide a basis for the development of the homeless sections of the State's Consolidated Plan to the federal Department of Housing and Urban Development (HUD). The State's Consolidated Plan details how ESGP, HOME, and Community Development Block Grant (CDBG) funds are directed.

How are Continuum of Care plans developed?

In Minnesota, each CoC region is charged with the development of a CoC plan through:

- effective communication between service providers
- inclusive participation of a broad range of community members (locally-elected officials; housing, employment and support service providers; homeless and formerly homeless individuals; housing developers; local business community; and faith-based groups)
- solid data-gathering practices
- investigating the local factors that shape homelessness

Both HUD and the Minnesota Interagency Task Force on Homelessness (ITF) recognize HUD's "Exhibit One" application document as an official CoC Plan.

What help is available to Regional CoC Committees?

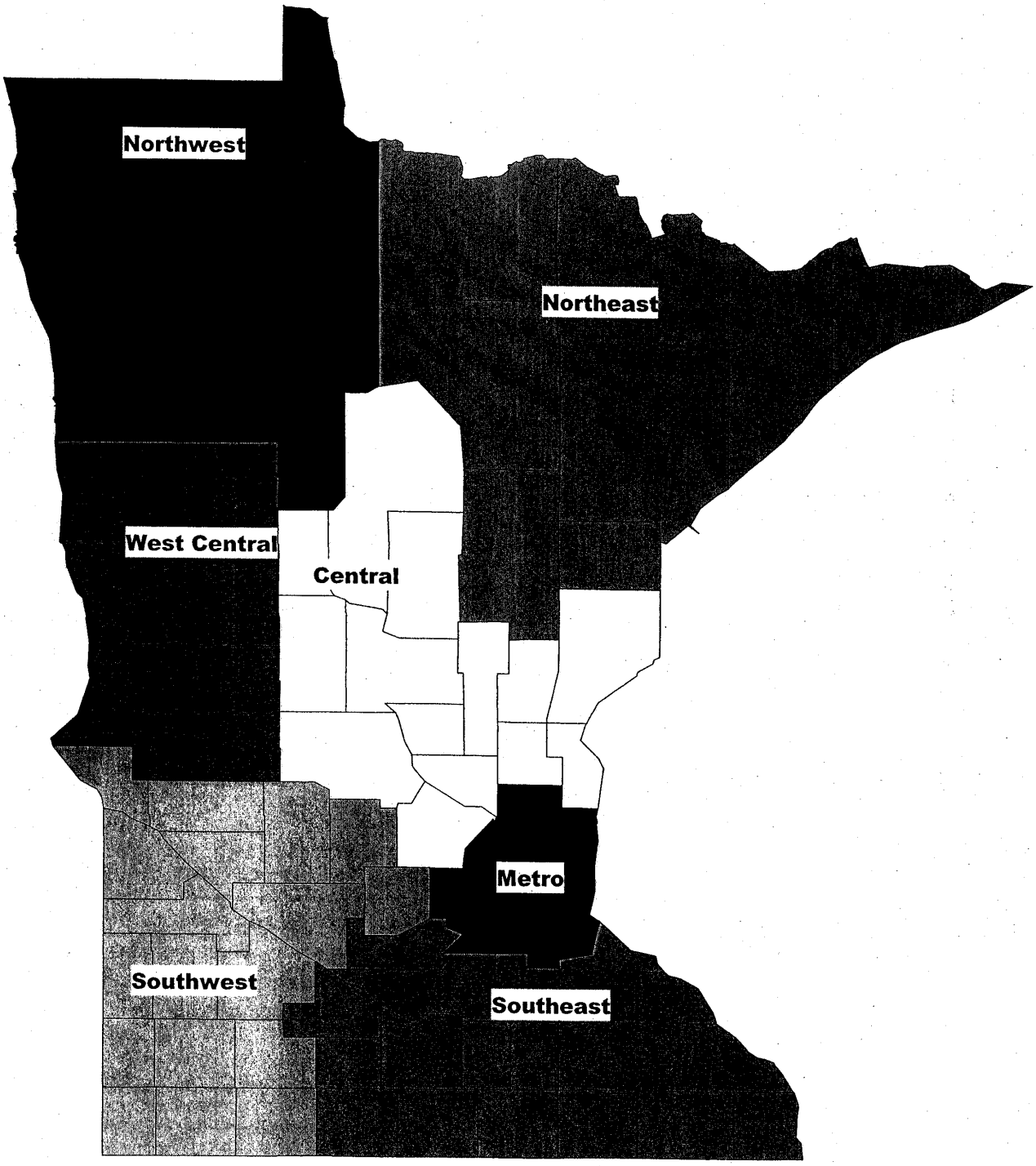
The Interagency Task Force on Homelessness The ITF can assist regions with gathering homelessness data for inclusion in the CoC Plan. Examples of such data include: Wilder Shelter Survey results, CFL Quarterly Shelter Survey results, census data such as poverty and housing burden, public assistance case loads, food shelf usage and unemployment data.

Members of the ITF also serve as informal advisors to CoC committees in Greater Minnesota and communicate trends and regulations related to homelessness planning and programming at the federal and state levels.

The ITF, established in 1990, is an interdepartmental coalition of representatives of state agencies, whose mission is to prevent and end homelessness. Current task force membership includes representatives from the following agencies: Minnesota Housing Finance Agency (MHFA), CFL, Department of Human Services, Department of Trade and Economic Development, Veterans Services, the Veterans Homes Board, Department of Health, Department of Corrections, Department of Planning, and the Minnesota Center for Crime Victim Services.

Financial and technical assistance is available from various organizations (including the MHFA, Minnesota Housing Partnership, and the Corporation for Supportive Housing) to organizations pursuing specific housing developments within CoC systems. In Greater Minnesota, the Minnesota Housing Partnership monitors the progress and provides financial and technical assistance to six regional CoC committees though a capacity building grant. In the Twin Cities Metropolitan Area, the Metro-wide Engagement on Shelter and Housing is assisting the six metro regions through a Homeless Planning and Coordination Grant.

For more information on Continuum of Care contact Cherie Shoquist, Minnesota Housing Finance Agency 651.297.3120, cherie.shoquist@state.mn.us, In Greater Minnesota contact Mary Ulland Evans, Minnesota Housing Partnership 507.876.2268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The Cost of Homelessness

For mayors, city councils and even homeless providers it often seems that placing homeless people in shelters, while not the most desirable course, is at least the most inexpensive way of meeting basic needs. This is deceptive. The cost of homelessness can be quite high, particularly for those with chronic illnesses. Because they have no regular place to stay, people who are homeless use a variety of public systems in an inefficient and costly way. Preventing a homeless episode, or ensuring a speedy transition into stable permanent housing can result in a significant cost savings.

- *A recent study of supportive housing in Conecticut compared Medicaid costs for residents for six-month periods prior to and after their move into permanent supportive housing. Reimbursements for mental health and substance abuse treatments decreased by $760 per service user while reimbursements for inpatient and nursing home services decreased by $10,900.*[10]

Following are some of the ways in which homelessness can be costly.

Hospitalization and Medical Treatment

People who are homeless are more likely to access costly health care services.

- *According to a report in the New England Journal of Medicine, homeless people spent an average* ***of four days longer per hospital visit*** *than did comparable non-homeless people. This extra cost, approximately $2,414 per hospitalization, is attributable to homelessness.*[11]

- *A study of hospital admissions of homeless people in Hawaii revealed that 1,751 adults were responsible for 564 hospitalizations and $4 million in admission cost. Their rate of psychiatric hospitalization was over 100 times their non-homeless cohort. The researchers conducting the study estimate that the* ***excess cost for treating these homeless individuals was $3.5 million*** *or about $2,000 per person.*[12]

Homelessness both causes and results from serious health care issues, including addictive disorders.[13] Treating homeless people for drug and alcohol related illnesses in less than optimal conditions is expensive. Substance abuse increases the risk of incarceration and HIV exposure, and it is itself a substantial cost to our medical system.

- *Physician and health care expert Michael Siegel found that the average cost to cure an alcohol related illness is approximately $10,660. Another study found that the average cost to California Hospitals of treating a substance abuser is about $8,360 for those in treatment, and $14,740 for those who are not.*[14]

Prisons and Jails

People who are homeless spend more time in jail or prison -- sometimes for crimes such as loitering -- which is tremendously costly.

- *According to a University of Texas two-year survey of homeless individuals, each person* ***cost the taxpayers $14,480 per year****, primarily for overnight jail.*[15]

- *A typical cost of a prison bed in a state or federal prison is* ***$20,000*** *per year.*[16]

Emergency Shelter

Emergency shelter is a costly alternative to permanent housing. While it is sometimes necessary for short-term crises, it too often serves as long-term housing. The cost of an emergency shelter bed funded by HUD's Emergency Shelter Grants program is approximately **$8,067,**[17] **more than the average annual cost of a federal housing subsidy** (Section 8 Housing Certificate).

Lost Opportunity

Perhaps the most difficult cost to quantify is the loss of future productivity. Decreased health and more time spent in jails or prisons, means that homeless people have more obstacles to contributing to society through their work and creativity. Homeless children also face barriers to education.

Dr. Yvonne Rafferty, of Pace University, wrote an article which compiled earlier research on the education of homeless children, including the following findings:

- *Fox, Barnett, Davies, and Bird 1990: 79% of 49 homeless children in NYC scored at or below the 10th percentile for children of the same age in the general population.*
- *1993: 13% of 157 homeless students in the sixth grade scored at or above grade level in reading ability, compared with 37% of all fifth graders taking the same test.*
- *Maza and Hall 1990: 43% of children of 163 homeless families were not attending school.*
- *Rafferty 1991: attendance rate for homeless students is 51%, vs. 84% for general population.*
- *NYC Public Schools 1991: 15% of 368 homeless students were long-term absentee vs. 3.5% general population.*[18]

Because many homeless children have such poor education experiences, their future productivity and career prospects may suffer. This makes the effects of homelessness much longer lasting than just the time spent in shelters.

HOUSING FACTS & FINDINGS

Volume 4 Issue 5

New Strategies and Collaborations Target Homelessness

By Dennis P. Culhane

Homelessness is back in the news, and is receiving increased attention from policy makers. Some communities have experienced a surge in homelessness, attributed to the slowing of the nation's economy alongside continued strength in metropolitan housing markets. New York City, faced with a record number of families in its shelter system this summer, drew the wrath of advocates when it opened a homeless intake center in a former city jail. In San Francisco, the issue became a major focus of debate during the recent mayoral election, as widespread street homelessness has persisted despite a decade of investments in the local homeless service system. Yet contrary to the pessimism that these examples may invite, many local communities have recently joined national advocacy organizations, as well as the Bush administration, in embracing the ambitious goal of "ending homelessness" in ten years. In some cases they have been joined by foundations and local business coalitions in pressing for more, and more strategically deployed, public and private resources to combat the problem.

What has changed? Several developments characterize the increased focus on ending homelessness:

- Recent research on homelessness has helped to identify effective solutions, thus making the problem more manageable.

- Leadership by federal, state, and local policy makers has stimulated action at all governmental levels.

- Involvement of the private sector, including through public-private partnerships, has helped to rally support for efforts to end homelessness.

While these developments suggest progress is being made, several problems on the horizon, left unaddressed, threaten to undermine many of the gains that are hoped for, and will require careful monitoring.

Research Contributes to a Shift in Policy Focus

Research on homelessness has helped policy makers and advocates to understand what really works and thus to refocus public policy to more effectively address "chronic" or long-term homelessness among single adults. Studies document that as few as 15 percent of the single adults who experience homelessness do so repeatedly or for a year or more, but account for 60 percent of the emergency shelter system's expenditures. An estimated 200,000 to 250,000 single adults in the United States are "chronically homeless." Nearly all are disabled by behavioral and physical health conditions, and many are extensive users of other acute care service systems.

"Supportive housing"—permanent housing with attendant social services—was in the past often considered prohibitively expensive, but has emerged as a good investment because it is shown to substantially reduce the use of other publicly funded services. For example, New York City established a comprehensive supportive housing program for homeless people with severe mental illness. A major study of the program calculated that long-term homeless people with severe mental illness used an average of $40,500 a year in public shelter, corrections, and health care services. For those placed in the permanent supportive housing program, the reduced use of acute care services nearly offset the costs of the supportive housing. Evaluations of similar programs nationally have found that most supportive housing programs for homeless people with mental illness boast retention rates of 80 percent up to one year following placement, while leading to significant reductions in hospitalizations and shelter use.

Research is also influencing the approach to homelessness among families. Evaluations of subsidized housing programs have found very high success rates for nearly all the homeless families placed, even those who previously experienced long homeless spells. Two studies in New York City found that 92 percent of families who exit shelter with subsidized housing placements remain housed two years after placement. An experimental study found that follow-up case management services in New York did not improve retention rates compared to subsidies alone. While shelter-based services and post-discharge services may provide an important value to some families, the rental subsidies alone appear to solve their homelessness. These successes raise questions about the validity of the "housing readiness" concept, which has been used to justify the enrollment of families in costly service-intensive shelter and transitional housing programs for up to two years.

Research provides little evidence that welfare reform is causing an increase in family homelessness, as was predicted by the legislation's critics in 1996. One recent local study found that changes in unemployment and rental housing costs, not welfare caseloads, were the significant factors associated with shelter admission rates among families. (Thus, concurrent increases in both unemployment and housing costs provide a plausible explanation for recent spikes in family shelter admissions in some cities.)

Shifting Federal Policy

The Clinton administration significantly changed federal efforts to address homelessness. The U.S. Department of Housing and Urban Development's (HUD's) Continuum of Care policy promoted local coordination, filling gaps in service availability, and much-needed increases in resources. But this policy approach bore a risk: the systematic substitution of the "homeless system" for gaps in the larger mainstream social service systems. Improved facilities also risked creating incentives for longer stays in homeless programs. Priority for federal housing assistance for people in homeless facilities also risked attracting individuals and families who had no other realistic options for obtaining such assistance. (This federal preference was dropped in 1998, but many localities have maintained it, in part to keep people moving through shelter systems that would get log-jammed without it.)

In the latter years of the Clinton administration, the Republican Congress initiated a shift in policy. Based on the emerging evidence from research, and urged by some national advocacy organizations, Congress took steps to stop the slide of HUD homeless funds away from housing and toward services. It required that one-third of McKinney-Vento Act funds be used to provide permanent supportive housing for the homeless with disabilities. Although the annual renewal of existing service-oriented programs keeps the funding balance heavily tilted toward services, the new priority is putting housing programs at the top of the queue among new projects in many communities. Unless these housing programs can continue to be renewed outside the McKinney-Vento appropriation, however, the ability to add new supportive housing units will be constrained, and will hamper efforts to meet the Bush administration's ambitious goal of "ending chronic homelessness in ten years."

HUD Secretary Mel Martinez has, like his two predecessors, made homelessness one of the agency's top priorities. "Solving the challenge of homelessness demands more than simply moving individuals off the street and into shelters," Secretary Martinez said in his 2003 budget message. "It requires investing in permanent solutions that decrease the number of homeless men and women."

The Secretary has demonstrated his intent to work toward fulfillment of the Bush goal by creating a new multi-agency initiative (funded at $35 million this year) with partners in the departments of Veterans Affairs and Health and Human Services (HHS) to provide more supportive housing for the chronically homeless. The administration's commitment is further demonstrated by its regeneration of the U.S. Interagency Council on Homelessness. Philip Mangano, a former homeless advocate from Massachusetts, whose primary focus there was getting mainstream service systems (public departments of corrections, mental health, foster care, and substance abuse) to reform their discharge planning practices, was appointed Executive Director of the Interagency Council.

Another development at the federal level is congressional action to require more systematic monitoring of homeless program use to measure results. Federally funded programs that target the homeless must implement "homeless management information systems" by 2004. Such systems have already been successfully implemented in more than a dozen jurisdictions, and have enabled those areas to systematically measure the number of people served in the homeless system, their characteristics, and the amount of time they stay in the homeless system. As a result of the congressional mandate, this capacity will be enhanced across the country, enabling an annual assessment of how local systems are faring in achieving goals.

States and Local Governments Plan to End Homelessness

Prodded by the National Alliance to End Homelessness's "Ten Year Plan to End Homelessness" (see Why America *Can* End Homelessness in Ten Years), local and state governments, service providers, and advocacy groups are developing their own plans to end homelessness. Indianapolis Mayor Bart Peterson is one of the local leaders challenging his community to make the fight against homelessness everyone's business. "The plight of these vulnerable families affects the broader community and all concerned citizens of Indianapolis," Mayor Peterson has said. "Homelessness and the lack of affordable housing contribute to children failing in school, family violence, and loss of employment."

Paralleling the new federal themes, the typical local plan embraces three broad goals:

1. Moving people who experience long-term homelessness and who have disabilities into permanent supportive housing.

2. Preventing new persons from entering homelessness, especially those already involved in mainstream social welfare systems.

3. Moving people who experience homelessness much more rapidly back into permanent housing (minimizing their stay in the homeless system).

Some plans are following the example of Columbus—Franklin County, Ohio, which has emerged as a national model for strategic planning and implementation. The Columbus effort achieved success in part because it included local government and business leaders in the planning process, and used careful data analysis to make its case for new funding and an outcome-oriented redirection of existing resources.

Obtaining resources to implement state and local plans remains a challenge. While an increased federal role is certainly necessary, some states are also examining what they can do in the area of housing and housing support services. New York and Massachusetts have both made investments in supportive housing for homeless adults. States are also addressing the problem of homeless families. At least nine states (Connecticut, Kentucky, Maryland, Minnesota, New Jersey, North Carolina, Michigan, Virginia, Pennsylvania) have tapped Temporary Assistance for Needy Families (TANF) surpluses to fund homelessness prevention or housing relocation. Federal restrictions on how much and how long TANF funds can be used to support families with housing emergencies limit what states can do, so advocates are pressing for greater flexibility.

The Private Sector Engaged

Private-sector support is increasingly important in the fight against homelessness. Some local business organizations, interested in reducing visible street homelessness in commercial corridors, are working with traditional service providers to expand street outreach programs and connect the street homeless to services.

In New York and Philadelphia, Business Improvement Districts (BIDs) are working to improve the way the police and the courts handle quality-of-life crimes by the street homeless, including through the use of restitution, treatment alternatives to incarceration, and placement in housing programs. In Washington, DC, the Downtown BID established the Downtown Services Center, a drop-in center that offers comprehensive, coordinated programs and services to the homeless. Both local government agencies and nonprofit organizations participate as service providers. The BID foots the bill for the facility and overall coordinating expenses, and trains its employees to provide outreach services to homeless people on the streets. The International Downtown Association prepared a report for HUD titled *Addressing Homelessness: Successful Downtown Partnerships* that presents case studies,

including the DC BID example, of responses to homelessness in America's downtowns. The report is intended to help local leaders "...find tools and techniques that fit their local circumstances..." to address homelessness.

Foundations are also playing a leadership role, such as by underwriting the costs of local "blueprints" or convening local funders to partner in implementation. Several foundations are also using their resources to promote national policy changes and the greater engagement of philanthropy, including the Schwab Foundation, the Hilton Foundation, the Melville Charitable Trust, the Butler Family Fund, and Fannie Mae Foundation.

Challenges

These activities support a sense of optimism that progress is being made in the effort to reduce or end homelessness. The focus on solution-oriented approaches in particular, over expanded emergency and temporary accommodations, has brought fresh enthusiasm to the effort. But these plans to "end homelessness" are extremely ambitious, requiring major changes to a variety of famously intractable social welfare and other public systems, not to mention significant allocation or reallocation of resources. And the pitfalls are many—political and economic constraints can limit implementation, unintended consequences can undermine achievement of goals, and external forces can overwhelm the best of intentions.

With respect to implementation challenges, although the Bush administration's intent has been clearly stated, HUD has not been given the housing resources to achieve the goal of ending chronic homelessness in ten years. And HHS—which many hope will provide the service funding so HUD can put its resources into housing—has not articulated its plan to pay for the services to accompany the housing. Moreover, given that many successes have been achieved because the states played a key leadership role, a successful national effort may have to be advanced on 50 fronts, not just one. This is daunting, particularly given that state-level policy making and expertise in this area is uneven in presence and effectiveness. Reformers may also face resistance from some local service providers. Providers who have developed services infrastructures dependent on HUD McKinney-Vento funds for survival may resist shifting resources away from their activities. New resources could help to avoid the conflict. But, for better or worse, the homeless "system" now has its own bureaucracy and defenders.

Even more threatening are the forces that could overwhelm the homeless system from the outside. Homelessness is essentially a residual phenomenon. Most local homeless service systems are quite modest in size, relative to the larger social welfare bureaucracies, and they are not the masters of their destiny. Even small changes in the practices of the larger social welfare systems can have huge impacts on demand for shelter. Several of these larger players pose a particular threat—corrections and foster care, to name only two examples. In either case, large numbers of discharges could increase demand for emergency shelter if the mainstream systems do not deploy necessary "aftercare" resources.

Finally, as always, extant factors in the economy that are beyond the reach of the social welfare system can threaten the best of plans to reduce homelessness, as witnessed in some cities this year. The dual forces of increasing unemployment and increasing housing costs, which are exacerbating the affordable housing crisis, could drive increases in family homelessness in particular, regardless of reforms undertaken in the homeless system. The prospect of increased homelessness could be seen as forcing a choice upon federal, state, and local policy makers: Should more shelters be built to accommodate increases in housing emergencies among poor families, or should a more systematic prevention effort be established, perhaps within the TANF program, that provides transitional or emergency rental assistance to families in crisis? Of course, the possibility of continued increases in homelessness, including among working people and heads of family households, should also focus more attention on the production of affordable housing. Given the challenges communities typically face in siting new homeless programs (NIMBYism, or a "Not In My Backyard" attitude), it may be time to ask that question before taking on the struggles of siting and paying for more homeless facilities.

Conclusion

As homelessness experiences renewed attention, there is reason for hope that substantial progress can be made. Within the homeless system, new priorities for solutions are being established, coalitions among private and public partners are being formed, and a more general appreciation of the value of supportive housing for the chronically homeless has inspired new commitments. But new resources will be required to make these commitments real. A greater understanding of the role that the larger mainstream social welfare systems can play in mitigating the risk for homelessness has also inspired homeless advocates and policy makers. But it remains to be seen whether the mainstream systems will pay attention to homelessness, or will agree to focus resources on their "aftercare" responsibilities. In the end, it is not enough that the homeless service system decides to reform itself, or reorient its priorities. Homelessness is a product of larger crises in affordable housing and in social welfare, and without commensurate reforms in those arenas, successful reforms in the homeless service system could be easily undermined.

Dennis P. Culhane is Associate Professor of Social Welfare Policy at the University of Pennsylvania.

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KEY CHARACTERISTICS OF PERSONS EXPERIENCING CHRONIC HOMELESSNESS

The working group shall: **Determine the key characteristics of individuals and families experiencing long-term homelessness for whom affordable housing with links to support services is needed.** Laws of Minnesota, 2003, Chapter 128, Article 15, section 9.

BACKGROUND DEFINITIONS OF CHRONIC HOMELESSNESS

HUD, HHS and VA Define a Chronically Homeless Person 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. *Federal Register, Vol. 68, No. 80, Friday, April 25, 2003, Notices, 21598.*

The Wilder Research Center Survey Defines Chronic Homelessness as: Current episode of homelessness that has lasted more than 12 months. *Homeless Adults and Children in Minnesota, p. 10, Wilder Research Center, June 2001.*

SELECTED CHARACTERISTICS OF CHRONIC HOMELESSNESS

2001 Wilder Survey Main Characteristics for Homeless Adults Fitting the Chronic Criteria:

- Report alcohol use (50%) and/or have been admitted to a detox center (43%)
- Report persistent mental health problems (32%) and/or have lived in a facility for persons with mental health problems (22%)
- Received care in an emergency room in last six months (41%)

Persons who were homeless for more than one year remained steady at about 30% in 1991, 1994, and 1997, and then increased to 36% in 2000.

When asked their total income, only 25% of all persons surveyed (including persons fitting crisis, episodic and chronic homelessness criteria) reported an income of over $800.

Significant Risk Factors of the Hennepin County 200 Families:

- Domestic violence (95%)
- Criminal history (89%)
- Chemical dependency (85%)
- Mental health (70%)
- Cognitive limitations
- 63.5% use cash grants or Food Stamps

Hennepin County 200 Families Phase 2 Report, 1999. (In Phase 1, 1997, Hennepin County identified the 200 families that utilized more than $29 million in human services funding per year for 1996 and 1997. In 1999, using the identified families, Hennepin County continued the work of examining multi-problem families to describe an integrated social service delivery system that would be more cost effective and produce better outcomes for the most expensive social service families in Hennepin County. (Of these families, 53% experienced homelessness.)

HHS Characteristics Associated with Chronic Homelessness:

- Disability - serious health conditions, substance abuse, and psychiatric illnesses
- Heavy Use of Services - 10% of the users of homeless shelters consume 50% of the days
- Engagement with Treatments - past experiences with mainstream services
- Multiple Problems - complex services needs
- Fragmented Systems - services not flexible or comprehensive

Ending Chronic Homelessness, Strategies for Action, Department of Health and Human Services, Report from the Secretary's Work Group on Ending Chronic Homelessness, March 2003.

Main Characteristics of Chronic Homeless, Fannie Mae Foundation, Housing Facts and Findings:

- Severely mentally ill
- Disabled by behavioral and physical health conditions
- Extensive user of other acute care service systems
- Repeatedly homeless for a year or more

Strategies and Collaborations Target Homelessness by Dennis Culhane, Fannie Mae Foundation Housing Facts & Findings, Volume 4, Issue 5, 2003. Culhane is a University of Pennsylvania Associate Professor of Welfare Policy and Research Associate Professor of Psychology.

RECOMMENDATION FOR KEY CHARACTERISTICS OF PERSONS EXPERIENCING CHRONIC HOMELESSNESS

An individual or adult family member with children with:

Mental illness,
Chemical dependency, or
Dual diagnosis of mental illness and chemical dependency; and
who has either lacked a permanent place to live continuously for a year or more,
or has lacked a permanent place to live at least four times in the past three years,
or prior to any incarceration or institutionalization.

Plus: Domestic Abuse and Neglect, Criminal History, Cognitive Limitations and Chronic Health Conditions (including HIV/AIDS)

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS

Related Groups and Initiatives

Interagency Task Force on Homelessness: A task force of state agencies operating programs serving homeless households. Coordinates state resources, planning, and agencies' activities. Oversees policies and practices of the state's 13 Continuum of Care regions. Advises MHFA on administration of the Family Homeless Prevention and Assistance Program. Established in legislation and convened by the Commissioner of the MHFA since 1990.

Continuum of Care Committees: Thirteen regional committees that are responsible for assembling information about homeless services in the regions, identifying gaps, and developing strategies to address homelessness. The Continuums have sought HUD McKinney-Vento funding to fill housing and service development gaps annually since 1996.

Metropolitan Engagement for Shelter and Housing (MESH): Representatives from county planning departments, housing advocates and service providers participate in a forum coordinating information and problem solving on homelessness housing issues; meeting since 2001.

Hennepin County Funders' Council and **Ramsey County Funders' Council:** Representatives of housing funders meet to coordinate and implement housing production goals, problem solve and coordinate information for housing providers; both operating since 2000.

Hennepin County Community Advisory Board and **St. Paul Area Coalition for the Homeless (SPACH):** Agency/advocate forums for sharing information and problem solving in serving homeless households. The Board has operated since 1999, the Coalition since 1990.

HIV Housing Coalition: Agency/advocate coalition recommending policies, priorities for federal Housing Opportunities for Persons with AIDS (HOPWA); operating since 1994.

Ryan White Advisory Council: Federally mandated body coordinating state's response to needs of persons with HIV/AIDS; operating since 1995.

State Advisory Council on Mental Health: Advises the Governor, Legislature, and state agencies on mental health problems/issues. Established in legislation and operating since 1987.

DHS Supportive Living Work Group: Study group formed at the request of the State Advisory Council to review supportive housing needs of persons with serious and persistent mental illness; operated during 2000.

DHS Rule 36 Work Group: Study group organized by the Department to assess the status of the treatment facility network, realignment options; operated during 2001.

Chronically homeless families and individuals in Minnesota (prepared by Wilder Research Center, 7/16/03)

Definition

This brief report summarizes preliminary analysis based on information from Minnesota's 2000 homeless survey about families and individuals who could be considered "chronically homeless." These people were identified from survey data based on a combination of their current and prior experiences of homelessness and the presence of identifiable disabilities. (This method is parallel to, but not identical to, the new federal construct for chronic homelessness.) Those identified as "Minnesota chronically homeless families" (at least one adult with at least one child present) or "Minnesota chronically homeless individuals" (a youth or adult not accompanied by children at the time of the survey) were:

- Homeless for at least one year during the current episode, or currently homeless for at least one month and with multiple episodes of homelessness; *and*
- Suffering from at least one professionally-diagnosed disability:
  - Mental illness,
  - Substance abuse disorder, and/or
  - Chronic health condition (e.g. asthma, TB, diabetes, HIV/AIDS).

Estimates

When the above criteria are used, chronically homeless families represent about one-quarter of all homeless families on a single night. Given the typical length of shelter stays for families, this definition would result in an annual estimate for chronically homeless families between 1000 and 1200 over a 12 month period for the state as a whole.

Chronically homeless individuals represent a larger proportion of the total homeless population, somewhere between 25 and 40 percent of all homeless persons depending on age (younger individuals are less likely to be chronically homeless than older individuals). Statewide estimates are more difficult for this group, but using average length of stay, we would estimate that between 1800 and 2400 individuals (those not accompanied by children) would be considered chronically homeless over the course of a year.

Numbers (data in this section based on single night counts)

The 2000 statewide homeless survey identified:

- 392 chronically homeless families (10.3 percent of the 3804 homeless persons, 27.2 percent of the 1443 homeless families), who were accompanied by
  - 932 children (27.3 percent of the 3416 accompanied homeless children identified by the survey)
- 47 chronically homeless individual youth age 10-17 (24.6 percent of the 191 homeless unaccompanied youth)

- 94 chronically homeless individual young adults age 18-20 (33.5 percent of the 281 homeless individual young adults)
- 792 chronically homeless individual adults age 21 or older (41.9 percent of the 1889 homeless individual adults)

	Unaccompanied youth	Individual adults	Adults with children	Children with adults	TOTALS
"MN Chronic"	47	886	392	932	2257
Not chronic	144	1283	1051	2484	4962
Total	191	2169	1443	3416	7219

Characteristics

The table below shows some key characteristics of chronically homeless individuals and families (including those with multiple episodes), and compares these people to the general homeless population.

Characteristics of chronically homeless individuals and families

	Unaccompanied youth	Individual adults			Families (adults with children)
	N=47	age 18-20 n=94	age 21+ n=792	comb. N=886	N=392
Percent women	60.0%	44.2%	30.3%	32.6%	92.1%
Race					
African American	24.5%	22.8%	32.2%	31.2%	45.8%
African Native	12.2%	1.1%	0.6%	1.1%	2.3%
American Indian	24.5%	15.2%	12.9%	13.5%	11.0%
Asian/Pac. Islander	0.0%	0.0%	0.9%	0.8%	0.5%
White	26.5%	43.5%	46.0%	45.0%	33.5%
Other	12.2%	17.4%	7.4%	8.3%	6.9%
Mean age	15.9	18.8	42.4	40.5	32.0
Metro	52.0%	73.7%	74.0%	73.1%	75.3%
Greater MN	48.0%	26.3%	26.0%	26.9%	24.7%
Shelter Type					
Battered women	20.0%	11.6%	43.3%	39.9%	15.1%
Emergency	0.0%	0.0%	2.1%	1.9%	5.9%
Transitional	32.0%	44.2%	44.0%	43.5%	76.5%
Street/unsheltered	48.0%	44.2%	10.6%	14.7%	2.6%
In MN 2 years or less	12.0%	26.3%	17.8%	18.2%	19.7%
Currently employed	36.0%	34.7%	28.7%	29.5%	48.3%
Education level					
Less than HS/GED	86.4%	52.7%	20.1%	24.9%	27.7%
HS/GED only	13.6%	39.6%	49.0%	47.1%	38.5%
Some college	0.0%	7.7%	30.9%	28.1%	33.8%
Women fleeing abuse	43.3%	35.7%	34.0%	34.9%	43.6%

The table on the next page shows comparable figures for all homeless individuals in Minnesota in 2000, in the same individual/family and age groupings. In brief, a comparison of these tables shows the following differences.

Compared to youth who are not chronically homeless, chronically homeless youth are:

- More likely to be women (60% vs. 50%)
- More likely to be African American, African Native, or American Indian
- More likely to be living in the 7-county metro area (52% vs. 45%)
- More likely to be living in transitional housing (32% vs. 20%)
- More likely to be employed (36% vs. 27%)
- More likely to be high school graduates (14% vs. 7%)
- More likely to be fleeing abuse (43% vs. 28%)
- Less likely to be White (27% vs. 48%)
- Less likely to be living in a battered women's shelter (20% vs. 38%)

Compared to young adults (age 18-20) who are not chronically homeless, chronically homeless young adults are:

- More likely to be living in unsheltered locations (44% vs. 32%)
- Less likely to be living in transitional housing (44% vs. 53%)
- Less likely to be employed (35% vs. 42%)

Compared to adults (age 21 and older) who are not chronically homeless, chronically homeless adults are:

- More likely to be White (46% vs. 38%)
- Less likely to be recently arrived in Minnesota (18% vs. 28%)
- Less likely to be employed (29% vs. 40%)

Compared to families who are not chronically homeless, chronically homeless families are:

- More likely to be living in transitional housing (77% vs. 64%)
- More likely to be employed (48% vs. 43%)
- More likely to have some college education (34% vs. 27%)
- More likely to be fleeing abuse (44% vs. 34%)
- Less likely to be living in a battered women's shelter (15% vs. 25%)
- Less likely to be recently arrived in Minnesota (20% vs. 30%)

Characteristics of all homeless individuals and families

	Unaccompanied youth N=191	Individual adults age 18-20 n=281	Individual adults age 21+ n=1889	Individual adults comb. N=2170	Families (adults with children) N=1443
Percent women	50.3%	53.0%	26.3%	29.7%	88.7%
Race					
African American	18.7%	33.5%	40.5%	39.6%	52.1%
African Native	4.8%	1.4%	1.5%	1.4%	3.4%
American Indian	19.8%	12.6%	10.4%	10.7%	9.7%
Asian/Pac. Islander	0.5%	2.9%	1.1%	1.4%	0.7%
White	47.6%	36.3%	37.8%	37.6%	27.6%
Other	8.6%	13.3%	8.6%	9.2%	6.5%
Mean age	15.6	18.7	38.2	35.7	30.9
Metro	45.0%	69.8%	78.2%	77.1%	77.2%
Greater MN	55.0%	30.2%	21.8%	22.9%	22.8%
Shelter Type					
Battered women	37.7%	13.1%	46.9%	42.5%	24.7%
Emergency	0.0%	1.8%	4.0%	3.7%	9.2%
Transitional	19.9%	53.2%	38.7%	40.6%	63.7%
Street/unsheltered	42.4%	31.9%	10.3%	13.1%	2.4%
In MN 2 years or less	13.1%	23.1%	28.1%	27.5%	29.6%
Currently employed	27.2%	42.3%	40.1%	40.4%	43.4%
Education level					
Less than HS/GED	93.3%	48.9%	19.4%	23.1%	28.5%
HS/GED only	6.7%	42.6%	51.8%	50.7%	44.7%
Some college	0.0%	8.5%	28.8%	26.2%	26.8%
Women fleeing abuse	28.1%	34.2%	35.5%	35.3%	34.1%

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 2: Levels of Services and Supportive Housing Models

MEETING SUMMARY

1. Welcome and Member Introductions

Assistant Commissioner Gomez welcomed and thanked Working Group members, staff and the large number of stakeholders and people in the community that have given generously of their time in providing input with these difficult service and housing issues. Commissioner Fabian echoed Assistant Commissioner Gomez and added that since the last meeting, the governor stated at a cabinet retreat that the Supportive Housing Working Group is one of his priorities. He is very interested in the outcome of this work. Commissioner Marx added further thanks and highlighted the purpose of the meeting: to reach a common understanding of the goal we are trying to reach to make available housing and service options that allow families and individuals who have experienced chronic homelessness to be successfully housed over the long-term and the guiding principles we'd like to use as we approach the next phase of our work. Member introductions followed.

2. Review of Key Characteristics of Chronic Homelessness

Greg Owen from Wilder Research Center reported that there are a minimum of approximately 3,000 homeless adults and 2,000 homeless children meeting the definition of chronic homeless a year. Cutbacks to shelter services this year may have increased the numbers. Approximately one-half of the persons with chronic homeless characteristics report mental illness and chemical dependency using the most stringent definition. Using a less stringent definition, proportions go up to seventy-five or eighty percent. Commissioner Marx appreciated the value of the conservative approach to analyzing the survey numbers regarding chronic homelessness and stated that we can look forward to new survey on October 23, 2003 and fine-tuning this analysis.

3. Review of Proposed Service Choices and Housing Options

Commissioner Marx presented the work of staff, members and stakeholders in producing documented service choices and housing options for the Working Group to consider. He reviewed the supportive housing principles, emphasizing that one size does not fit all, there are a variety of services and housing options. The principles include:

- Maximize choice of housing and services for families and individuals; ensure flexible housing and service options that respond to need.

- Encourage families and individuals to utilize services, but don't mandate services as a condition tenancy.
- Utilize innovative practices that result in cost containment and use evidence-based models for services and housing that have demonstrated positive results.
- Prioritize models that integrate families and individuals into communities, near public transportation and services.
- Provide the necessary housing tenancy supports to find and maintain housing, a critical service need for people who have experienced chronic homelessness.

Commissioner Marx introduced Sharon Autio, Director of Mental Health at the Minnesota Department of Humans Services and Cherie Shoquist, Homeless Policy Analyst at the Minnesota Housing Finance Agency to present the information on service choices and housing options. State agencies met with over 30 organizations and many more individuals. Part of the result of this work is the recognition that no single model fits the target population, we need a range of service choices and a variety of housing options. There are three broad service levels: outreach and engagement, intensive services, and stabilization for two groups: families and individuals/unaccompanied youth. In all instances housing services are essential. *For more information, see Service Choices and Housing Options.*

4. Identify Supportive Housing Options that Address the Services Needs of People Experiencing Chronic Homelessness

Services choices for families with children, individuals, and youth include: initial assessment, medical and psychiatric services, medication management and monitoring, chemical dependency treatment and relapse prevention, integrated mental health and chemical health services, independent living skills, crisis services and response, transportation, employment, education, training, supported work, financial management, assistance applying for benefits, legal services, community involvement, recreational activities, parenting, child safety, child development, children's health, children's education, child care, respite, reunification, services for children, one-to-one mentoring for youth, watchful eye (low level monitoring by on site staff) and housing tenancy support.

Housing options include: single site developments of 16-36 units, up to 50 units for families and 16 units or less or up to 31 units or more for individuals/youth; clustered sites with a number of single family homes, townhouses, duplexes or apartments in the same building or neighborhood; scattered sites of single family homes, townhouses, duplexes or apartments for families and individuals/youth; and a safe haven/harm reduction model drop in site with meals, shower, laundry, secure storage, phone, single rooms for single night, and rooms with private bath for individuals.

5. Solicit Information on Resources and Funding

Commissioner Marx invited members and stakeholders to attend a meeting with individuals experiencing homelessness at Central Lutheran Church on Monday, September 15th. Also, a tour will be planned in late October of various supportive housing services in metro area. The government agencies will be working together to look at their funding options for the next meeting on Wednesday, October 15th at the Metropolitan Council. Please contact supportive.housing@state.mn.us with questions and comments.

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Hennepin County

An Equal Opportunity Employer

Summary of Key Research Findings To Date on Cost-Effectiveness of Supportive Housing for Families
April 2003

Supportive housing provides affordable housing with on-site case management and other supportive services intended to stabilize residents who have experienced chronic homelessness and other issues, such as substance abuse, and promote their self-sufficiency. Two supportive housing projects funded in part by the Hennepin County Children, Family and Adult Services Department (CFASD) are Portland Village, with 24 apartment units located in Minneapolis, and Perspectives, with 52 units located in St. Louis Park. The department is evaluating these projects to determine whether supportive housing reduces county-funded crisis services in child protection, out-of-home placement, and substance abuse treatment.

The analysis looks at social services purchased by CFASD beginning in the six months before and six months after families moved into supportive housing to address the questions: *does supportive housing reduce residents' use of high cost crisis services, and does overall service usage show a shift towards long-term stability?* Recognizing that six months is a relatively short time to evaluate change in this target population, we are continuing to track service usage and costs. The key findings below combine the results of 18 families from Portland Village and 25 from Perspectives who remained housed there for at least six months from the beginning of our studies in 2002:

Key Findings

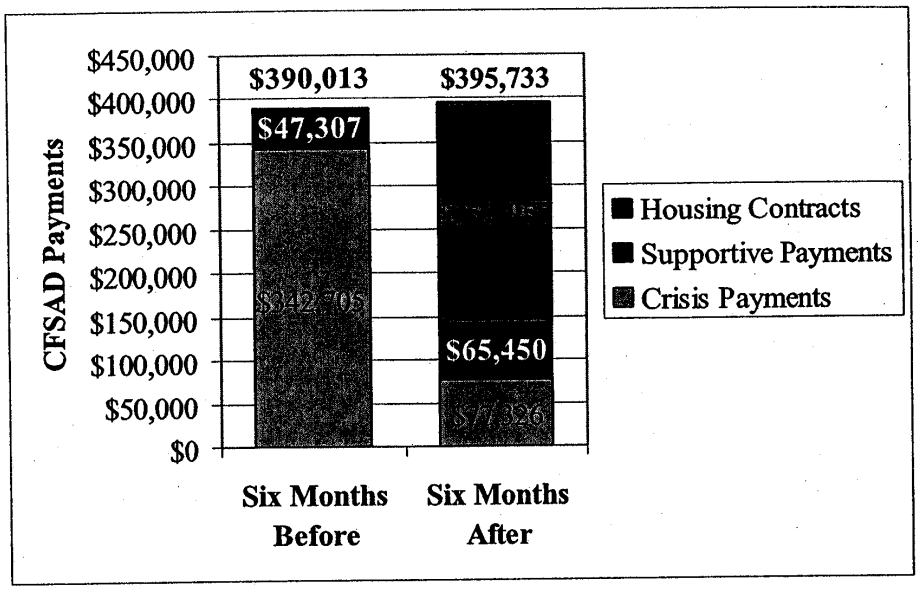
- Crisis costs declined by an average of $6,200 per family, primarily because of reduced chemical health treatment and children's days in foster care.

- There was a significant shift in CFASD funding from crisis services to supportive/preventive services (mostly CFASD's cost for the supportive housing contracts). The total amount CFASD spent was nearly the same, but before families moved into supportive housing, 88% of funds purchased crisis services. After families moved into supportive housing, 22% were spent on crisis services. See Figure 1 on page 2.

- At this point in the study, supportive housing for chronically homeless families is essentially cost-neutral to the department—the contracts pay for themselves. Over the long term, as successful families achieve self-sufficiency and move into independent housing, CFASD would eventually save money from all types of CFASD interventions. This analysis will be available in a subsequent report.

- This analysis is limited to services and payments made by the Children, Family and Adult Services Department and does not count services provided by other Hennepin County departments (e.g., Community Corrections, Economic Assistance). The reduction in CFASD crisis services indirectly indicates that total potential savings in human services are underestimated.

Figure 1, Combined CFASD Payments for 43 Families Remaining Housed at Portland Village and Perspectives Supportive Housing



Study Population and Methods

Forty-three out of 67 families housed at the beginning of the study periods (December 2001-January 2002 for Portland Village and July-August 2002 for Perspectives) continued to live in supportive housing for at least six months. The findings in this summary focus on this population. The evaluation also has findings on the eight families who left because they achieved stability and moved into other permanent housing, and on the 16 families who left due to relapse. Technical reports on both Portland Village and Perspectives research can be found on CFASD's Internet site: http://www.co.hennepin.mn.us/cfasd/welcome.html in the bottom right portion of the web page. The full reports also include results for all 67 families on social work cases opened, employee hours recorded in time reporting, and number of occurrences and days children lived in foster care.

For more information on data analyzed in this summary, contact:

Mark Herzfeld, CFASD Evaluation Unit (612-348-2651)
mark.herzfeld@co.hennepin.mn.us

Nancy Devitt, CFASD Administration (612-348-5109)
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CFASD Costs For 43 Families at Portland Village and Perspectives Supportive Housing

Payments Beginning Six Months Before and Six Months After Families Moved into Their Apartment

Combines costs for families remaining housed in their program for at least six months.

	Portland Village		Perspectives		Total	
Six Months Before	Total from 18 Families	Average Per Family	Total from 25 Families	Average Per Family	Total from 43 Families	Average Per Family
Chemical Health Treatment	$37,719	$2,095	$95,623	$3,825	$133,342	$3,101
Child Foster Care	$65,767	$3,654	$91,194	$3,648	$156,961	$3,650
Child Protection Cases	$24,619	$1,368	$27,783	$1,111	$52,402	$1,219
Total "Crisis" Payments	**$128,105**	**$7,117**	**$214,600**	**$8,584**	**$342,705**	**$7,970**
Early Childhood Cases	$539	$30	$2,660	$106	$3,199	$74
Mental Health	$19,948	$1,108	$14,181	$567	$34,129	$794
Child Care Assistance	$2,024	$112	$5,779	$231	$7,803	$181
Other Misc.	$1,375	$76	$802	$32	$2,176	$51
Total "Supportive" Payments	**$23,885**	**$1,327**	**$23,422**	**$937**	**$47,307**	**$1,100**
Total Payments	**$151,991**	**$8,444**	**$238,022**	**$9,521**	**$390,013**	**$9,070**
Six Months After						
Chemical Health Treatment	$1,465	$81	$765	$31	$2,230	$52
Child Foster Care	$8,352	$464	$26,716	$1,069	$35,068	$816
Child Protection Cases	$27,370	$1,521	$12,659	$506	$40,028	$931
Total "Crisis" Payments	**$37,186**	**$2,066**	**$40,140**	**$1,606**	**$77,326**	**$1,798**
Early Childhood Cases	$193	$11	$3,857	$154	$4,049	$94
Mental Health	$34,680	$1,927	$7,135	$285	$41,815	$972
Child Care Assistance	$8,533	$474	$4,002	$160	$12,535	$292
Other Misc.	$6,465	$359	$585	$23	$7,050	$164
Six Months of Housing Contract*	$85,957	$4,775	$167,000	$6,680	$252,957	$5,883
Total "Supportive" Payments	**$135,827**	**$7,546**	**$182,579**	**$7,303**	**$318,407**	**$7,405**
Total Payments	**$173,014**	**$9,612**	**$222,719**	**$8,909**	**$395,733**	**$9,203**

Net Payment Changes for 43 Families

	Total Dollars	Per Family	Percent Change
Chemical Health Treatment	-$131,113	-$3,049	-146%
Child Foster Care	-$121,893	-$2,835	-78%
Child Protection Cases	-$12,374	-$288	-21%
Net "Crisis" Payments	**-$265,379**	**-$6,172**	**-87%**
Early Childhood Cases	$850	$20	66%
Mental Health	$7,686	$179	16%
Child Care Assistance	$4,732	$110	98%
Other Misc.	$4,874	$113	148%
Six Months of Housing Contract*	$252,957	$5,883	100%
Net "Supportive" Payments	**$111,942**	**$2,603**	**196%**
Net Total Payments	**$5,720**	**$133**	**2%**

*Includes amounts paid for families not remaining for six months.

Prepared by Hennepin County Children, Family, and Adult Services, 4/7/03

Note: Eight women without children at Perspectives were excluded from the study.

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WILDER RESEARCH CENTER

SUMMARY

New Foundations: 2002 Summary of Crestview Community

How thirteen Crestview residents are faring one year later

"Before I moved here, [my child] never lived with me on a day in and day out basis."
"Me just staying clean…The support I get from New Foundations and my sisters in the community, the meetings, and my willpower to do it. Man I love this life!"
"I'm glad I have my life back."

These are just some of residents' many appreciative feelings after living at Crestview Community, a project of New Foundations.

New Foundations is a nonprofit organization founded in 1994 to serve homeless women in recovery and their children. New Foundations began its program at Crestview Apartments in St. Paul in February 1997. Crestview, which currently houses 29 families, provides ongoing recovery support, housing, and comprehensive supportive services to families.

In 2002, New Foundations renewed its contract with Wilder Research Center to conduct independent follow-up interviews with Crestview participants. The interviews were conducted one year after they moved from Crestview Community or one year after they moved from New Foundations' transitional housing program to its permanent housing program. Some residents participated first in transitional and then in permanent housing. During 2002, 33 participants were eligible to be interviewed. Of those, thirteen (39 percent) were contacted and completed the interview. The remaining eligible participants had no current forwarding information or were unable to be reached. One resident was eligible for and completed both interviews in 2002, resulting in a total of 14 responses.

All 13 residents interviewed currently live in stable housing. Nine residents moved from transitional to permanent housing within Crestview, and five residents moved from Crestview. Of those five, one said she owns her home, and four said they have Section 8 housing; none of these residents needed to stay in a shelter in the year since leaving Crestview.

At the time of the interview, twelve residents were either currently employed or enrolled in a school or educational program, and three residents were interested in pursuing one or both of these options. None of the residents was involved with child protection, and twelve of the fourteen respondents said they had stayed sober in the last year.

Of the residents who had children living with them while at Crestview (or one year ago), 11 of the 13 indicated that their same children are still living with them. With the exception of one child who was not yet school-age, all of the residents' children attended school last year. Those who attended two schools did so for reasons such as starting kindergarten, middle school, or post-secondary school, transferring to a new school, or living with a new parent.

Resident comments about how Crestview has been most helpful to them

Results/getting life back on track

"I feel that having supportive housing has been most helpful….Supportive housing is a good program that helps people stay on their feet…. It gives them back their independence when you're on drugs."

Staff support and resources

"[Staff are] very helpful, they give good feedback, they have a lot to offer in terms of furniture, financial support, jobs."
"The support of the staff….I didn't know how to live life on my terms. But the staff really helped me."
"The staff. The groups – speaking to us and learning to live without drugs. Life isn't easy but it's better than being on the street."

Positive community for family

"Me and my children grew closer together."
"My kids are happy. I'm not waking them up in the middle of the night saying 'we gotta go.' They love where we're living, the way we're living."

continued

2002 Follow-up interview responses (current and former Crestview residents)

Unless otherwise noted, all 13 women answered each question for a total of 14 responses.[1]

Current type of housing	
Own home	1
Section 8	4
Crestview (permanent housing status)	9
Have you needed to stay in a shelter in the last year? (of the five not living at Crestview)	
No	5
Yes	0
Are you currently employed or enrolled in school/educational program?[2]	
Employed	9
Enrolled in school or educational program	3
Not employed or enrolled in school/program, but seeking this	3
Are you currently involved with child protection?	
No	14
Yes	0
Stayed sober in the last year?	
Yes, able to stay sober	12
Relapsed once or more but currently sober	1
Currently not sober	1

How many of your children live with you now compared to one year ago?[3]	
No children lived with me then or now	0
One child then, one child now	7
Two children then, two children now	2
Three children then, three children now	2
Four children then, four children now	1
How many schools have your children attended in the last year?	
Not in school	1
One school	15
Two schools	10
If more than one school, why did child change schools?	
Child started kindergarten	2
Child started middle school	2
Child started post-secondary program	1
Child started/transferred to a new school	2
Child moved/lives with other parent or relative	3

1 Some residents participated first in transitional and then in permanent housing. In 2002, one resident was eligible for and completed both interviews resulting in 14 total responses.

2 The reason for fifteen responses is that a couple of residents are either (1) both employed and enrolled in school or an educational program or (2) employed or enrolled while considering seeking other educational or employment options.

3 Two residents did not have all of their same children living with them both while at Crestview (or one year ago) and one year later.

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For more information
For more information about this summary, contact New Foundations, 651-227-8976.
Author: Shelly Hendricks
JANUARY 2003

NEW FOUNDATIONS- CRESTVIEW COMMUNITY APARTMENTS
East St. Paul, MN

Housing Model: Single-site Supportive Housing For Families

Type of Housing: Permanent (31 units)

Number and Type of Units: 31 units (three 1-bedroom & twenty-eight 2-bedroom units)

Sponsors of the Project/Partners:
Ownership – Crestview Community Partnership (New Foundations/PPL) Each partner has a fifty-percent ownership interest in the property and shares equally in all management decisions. New Foundations: Co-General Partner and Primary Service Provider (with sole authority for tenant selection). Project for Pride in Living: Co-General Partner Developer and Property Manager PPL has a strong affordable housing development background, and in recent years the agency has broadened its focus to include the development of supportive housing projects as well as the provision of property management services to those projects. The agency created its Property Management Division to be an "enlightened landlord," and provided tenants with support services as well as links to other available community resources. PPL has produced more than 1,000 units of affordable housing throughout Minneapolis and St. Paul.

Services Model: The Crestview Community services model is at the heart of New Foundations' purpose and mission. Established in 1994, New Foundations provides affordable housing and comprehensive services for homeless chemically dependent women in recovery and their children. Their mission is to work in partnership with New Foundations' families and with the community, to replace addiction with recovery, poverty with economic stability, and homelessness with community. Together, we create a vibrant housing environment where women can achieve education and employment goals, strengthen families, build relationships, and contribute to the community. Children reunite with their moms, and each child gets support and nurturing to enhance emotional and physical health, succeed in school, develop friendships, connect with the community, and believe in the future.
New Foundations' services philosophy requires an approach that:

- Recognizes and reinforces family strengths, diversity, cultural values and traditions.
- Models and nurtures a supportive community.
- Empowers residents to shape Crestview's community and services and to advocate for others.

Tenant Profile: Tenants come to Crestview from homeless shelters, treatment facilities, battered women's shelters, correctional facilities, or from the streets. In 2001, fifty-two women, one husband, and seventy-two children lived at Crestview.
Crestview resident profiles at move-in:
100% were homeless
100% had no Income or had Incomes below the poverty line

83% had criminal histories
87% were unemployed
80% had experienced physical and/or sexual abuse
100% were recovering from chronic chemical dependency
45% had the dual diagnosis of chemical dependency and mental illness

Physical Description of the Housing : Crestview Community is comprised of two adjacent properties containing 31 residential units and on-site community space. All of New Foundations program staff offices out of the community space and is used for both individual and group meetings with residents. More than a just an environment for delivering social services, residents view the community space as the hub of activity within the community. There is a constant flow of tenants and their children coming and going from the space, some seeking help or keeping appointments while others simply dropping by to say hello/visit with each other/welcome new members, etc. Crestview also houses an on-site space for children's services as well as a fully equipped outdoor playground.

Project Financing: (From 2000 acquisition and rehab)

Capital:

Primary Sources:	MHFA, St. Paul CDBG, Private Foundations
Total Development Cost:	$ 1.68 Million
Per Unit Development Cost:	$ 54,231
Per Unit Operating Cost:	$ 6,417 – (Project-based Section 8)
Per unit Service Cost:	$ 20,371 – (HUD SHP, Ramsey Co., Private Foundations)

Program Effectiveness Fact Sheet

AMHERST H WILDER FOUNDATION

ROOF Project

Rebuilding Our Own Future

In operation since 1994

What is the ROOF Project?

The ROOF Project is a transitional housing project designed to help homeless families in Ramsey County obtain affordable housing with supportive services.

It is a collaborative effort funded by HUD, Ramsey County, Family Housing Fund, Minnesota Department of Children, Families & Learning, and the Amherst H. Wilder Foundation.

Current providers include Wilder Supportive Housing and Employment Services, Emma Norton Residence, East Metro Women's Council, Project ReCONNECT, and the United Cambodian Association of Minnesota.

The ROOF Project has three primary goals:

1. Participants will obtain permanent housing.
2. Participants will improve their employment skills and increase their income.
3. School-aged children will maintain regular school attendance.

Services

The ROOF Project works directly with landlords to secure access to well-maintained and affordable housing for participating families.

Through workshops and individual counseling, the ROOF Project helps families better understand the obligations and responsibilities of both tenants and landlords.

The program also helps participants improve or acquire skills that relate to maintaining housing, including: budgeting, finding and selecting appropriate child care, and job search and retention skills.

The ROOF Project supports school success for children by encouraging families to participate in parenting education, and helping them enroll children in school or arrange tutoring.

Participants

To be eligible to receive ROOF services, a participant must be living in an emergency shelter, a transitional or supportive housing program for persons who come from emergency shelters, recently discharged (within one week) from a non-correctional institution where the individual has lived for at least 30 days, staying in places not meant for habitation, or otherwise homeless within a week.[1]

During 2001-2002, the ROOF Project served 75 families. Heads of households ranged in age from under 18 to 50.

Many of these families had difficult rental histories, multiple evictions, criminal backgrounds, or other serious barriers to housing.

Forty-four of the families were African American, twenty were white, eight were Asian, one was American Indian, and two families identified themselves as being of Hispanic origin.

Measuring Results

The ROOF Project is evaluated every year using three data sources:

1. Demographic data collected when participants enter the program
2. Discharge data reflecting changes in clients' housing, employment, and educational status
3. Follow-up data gathered from interviews three months into the program and 12 months after participants leave the program

Fifty-two percent completed the survey 12 months after completion of the program.

Permanent housing:
Seventy-five percent of respondents were living in permanent housing at the time of project exit; 81 percent were in permanent housing 6-12 months later.

Employment Skills:
Seventy-one percent of adult participants had completed some type of employment-related training by project exit.

Forty percent of adult participants were employed at least part-time by project exit. Fifty-eight percent were employed at least part-time 6-12 months later.

Children's school attendance:
At follow-up, 100 percent of respondents reported that their children were attending school on a regular basis.

Forty-seven percent of parents reported that their children improved in completion of schoolwork, school grades, relationships with peers, or participation in school extra-curricular activities.

Satisfaction

Participants were very positive about the ROOF Project. They expressed the greatest satisfaction with their individual outcomes, the accessibility of the program, and the professional manner of the staff.

Learn more

To learn more about the ROOF Project, call Susan Marschalk at **651-917-6210** or visit our web site at ***www.wilder.org***.

March 2003

[1] This is the definition of homelessness used by HUD to determine eligibility.

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The Supportive Housing and Managed Care Pilot Process Evaluation: Year One

Executive Summary

The Supportive Housing and Managed Care Pilot (the pilot) is a demonstration project designed to engage state and county governments with community agencies and participants in addressing the problem of homelessness. The pilot provides affordable housing and other supports necessary for homeless people to help them lead healthier lives in the community. The pilot targets single adults and families whose homelessness is exacerbated by other difficulties such as medical problems, mental illness, chemical dependency, and histories of trauma. Hearth Connection, the nonprofit agency that manages the pilot, contracted with The National Center on Family Homelessness to conduct a rigorous independent evaluation of the pilot. This report presents the findings from the first year of the process evaluation.

The pilot is an innovative and important supportive housing model for hard-to-serve homeless families and individuals. Although some supportive housing programs have served this population, few have attempted to clearly define a potentially replicable service model, introduce a creative funding mechanism, and conduct a rigorous independent process, outcome, and cost evaluation. To our knowledge, this is the first supportive housing demonstration project to date that is developing and evaluating an enhanced service model with a unique financing mechanism for the hardest-to-serve homeless people.

Although the literature demonstrating the effectiveness of supportive housing is limited, especially with regards to homeless families, preliminary findings indicate it is an effective strategy for helping families obtain stability in the community. The pilot is taking previous service models a step further by attempting to serve homeless people with complex needs living in both an urban and rural setting who have long histories of homelessness. Many have also been high service utilizers, substantially driving-up the costs of care across multiple service systems. The pilot has introduced a creative funding mechanism that will be assessed as the project continues.

As described in this report, the process evaluation finds that the pilot is serving this difficult population and is achieving positive client outcomes. The helping relationship, the linchpin of the service model, has been well developed and well understood by staff. The staff is truly dedicated to caring for this population, despite the complex challenges of caring for homeless people with economic, medical, mental health, chemical dependency and trauma issues. Understandably, at this stage in the pilot, support teams (part of the pilot's coordination strategy) are developing unevenly. In addition, relations between Hearth Connection and one primary provider agency in Ramsey County, have

encountered some difficulties. However, both groups are open to discussion and negotiation to smooth future relations.

The strong support of a broad range of community stakeholders as well as the diverse skill and knowledge of the pilot's Board of Directors and evaluation advisory group has helped to facilitate development of the project to date. Communications between Hearth Connection and its many stakeholders are in place. Complex contextual factors beyond the purview of the pilot may complicate some of the project's goals, but are being carefully monitored by the project staff and stakeholders. Throughout the pilot, stakeholders and staff continue to struggle with issues of ethnicity, culture and class, as well as ways of fully integrating consumer input into the process. Hearth Connection's willingness to work openly with the evaluation team and to use this report to strengthen the project bodes well for future growth and development of the model.

This report documents the pilot's achievements to date and highlights some challenges to be addressed. During the data collection period, the pilot served 48 families in Blue Earth and Ramsey Counties. Findings in this report are derived from interviews and focus groups that captured the views and experiences of more than 90 stakeholders, including state and county administrators, primary provider staff, and pilot participants. The findings are grouped into three categories: Participants; Service Delivery; and Organizational Structure and Management.

With regard to pilot participants, the evaluation finds:

1. The pilot is reaching the hardest to serve families and they have complex needs.
2. The pilot is having a positive impact on participants.
3. Change is understandably incremental for pilot participants.

With regard to service delivery the evaluation finds:

1. Most participants have good relationships with primary providers.
2. Intake and service delivery processes are generally consistent.
3. Front line primary provider staff values the pilot's service model, particularly the ability to use resources flexibly and to spend substantial time working with individual participants.
4. The primary provider staff member's role is multifaceted and very demanding.
5. Support teams are established unevenly across pilot sites.
6. Participant accountability can be problematic.
7. Primary provider staff, particularly in Ramsey County, are challenged by the difficult mental health, chemical dependency, and trauma issues presented by pilot participants.
8. In Ramsey County, some children in the pilot are not adequately served.

Regarding the pilot's organizational structure and management, the evaluation finds:

1. Pilot stakeholders represent a broad spectrum of interests and experiences, and they are invested in the pilot's success.
2. Stakeholders support the pilot's values and goals.
3. Communications and accountability structures and processes between Hearth Connection and its many stakeholders are generally in place.
4. Contextual barriers pose challenges to implementation.
5. Contextual and structural factors have eased development and implementation in Blue Earth County.
6. Throughout the pilot, stakeholders struggle with issues of ethnicity, culture and class.
7. People Taking Action perceives that it is not fully integrated into the pilot's communications and organizational structure.
8. Relations between Hearth Connection and one primary provider agency are confused and conflicted.
9. One primary provider agency's staff expectations and responsibilities have the potential to compromise staff health, positive participant outcomes, and healthy provider-participant relationships.

Based on these findings, the pilot is off to a promising start. The pilot's notable successes — targeting the hardest to serve population, having high enrollment, maintaining highly committed staff, placing participants in housing, and establishing a flexible service model—serve as a solid foundation for future effectiveness. The challenges, particularly those relating to the difficulties of collaboration, are inevitable given the number of stakeholders, the stage of the project, and the inherent complexity of collaborative ventures. While these challenges are not unexpected, the pilot and its stakeholders have an important opportunity to address them at an early stage.

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hearth connection

The Supportive Housing and Managed Care Pilot
Supportive Housing Models

History
Access to a variety of supportive housing configurations is a critical feature of the Supportive Housing and Managed Care Pilot. During the design of this project, consumers expressed a range of preferences: some to live in scattered-site apartments, others to live in settings with people who were on a similar journey. Stakeholders understood that different models might work better for different people. At the same time, new development of supportive housing was also necessary to meet the demand for affordable, supportive communities for people moving out of homelessness.

Blue Earth County
Eight of the twenty families participating in Journey Home live in a supportive housing community that includes on-site service and community space. Owned and operated by Partners for Affordable Housing, River Town Homes was converted from private-market student housing, to a families supportive housing community at the same time as the pilot was beginning for families. There are affordable three- and four-bedroom apartments, priced below market rate thanks to capital financing from MARIF, HUD and private sources. Pilot service dollars support on-site services. The River Town space if the service hub for all participating families. Both scattered-site and site-based models present challenges and opportunities for community-building. All require effective partnerships with families, landlords and neighbors.

The adults who are in housing in the Blue Earth STEP pilot are in scattered-site apartments. Blue Earth County and Hearth Connection have supported planning by the Salvation Army to create supportive housing for chronically homeless single adults in Mankato because a community setting might be very beneficial for some participants. Access to rental assistance, and good partnerships with landlords, are key to making any model work. Peer support and community-building take extra effort in scattered sites.

Ramsey County
The majority of Project Quest families live in scattered-site homes. Several live together in smaller supportive housing communities. Again, landlord relationships are key, requiring Project Quest to balance the interests of landlords with those of participants. Some families might be better served by supportive housing communities that offer both increased safety through a 24-hour front desk and community with other families that share similar experiences.

The 64 adults in the Project Homeward and Delancey Street teams are predominantly in scattered-site housing. Project Homeward has one cluster model within a large, affordable housing campus, where up to 10 participants have their own apartments, with an on-site service and community space that acts as hub for services to all Project Homeward participants.

hearth connection

The Supportive Housing and Managed Care Pilot

Facts about Families

- 217 participants from 53 families, including 154 children in Blue Earth County and Ramsey County.
- 18 families were or have been enrolled for less than 90 days. Median length of enrollment for the remaining 64 families who have been or are enrolled is 17 months.
- Families average 4 members per household (1.25 adults and 3.75 children).
- Average age for children is 9.6 years. Average age for adults is 33.9 years.
- Once obtaining housing, 79% of families have remained in the same housing unit for as long as they have been enrolled.

Ramsey County Family Analysis

- Long-time county residents (16+ years).
- Long histories of homelessness (2+ years for families, longer for single adults).
- 60% African American, 24% Caucasian, 10% Native American, 3% Hispanic and 3% multiracial.
- At the point when they applied, 16 families were living in shelter, 16 were doubled up, 3 were living on streets or in vehicles.
- Upon referral, families self-reported a high prevalence of mental health issues (49%), chemical dependency (30%), and dual diagnoses MI/CD (21%), but primary providers report after working with families that most families have some history of addiction combined with some level of mental health problems.
- In two years before enrollment, 22 families had 99 emergency shelter stays.
- High overall housing stability: Average tenancy is 263 days. More than half (55%) of families have been in their current housing for more than 13 months.
- Low housing turnovers: 19 families have stayed in the same home since moving in initially. Just 4 families (10%) account for half (47%) of the 19 housing changes in Ramsey County.
- Preliminary data on participant incomes used to calculate rental assistance suggests that the average gross family income increased by 52% (from $520/mo to $791/mo) between the first and second year of enrollment.
- The median length of enrollment for families in Ramsey County is 559 days (18 ½ months).

Blue Earth County Family Analysis

- 75% Caucasian, 20% East African immigrants, 5% African American.
- In 2000, Blue Earth County provided 123 months of service for 16 families who enrolled in the pilot in 2001. State and County human services spent $457,000 on these contacts, averaging $3,700 per month of contact.
- There has been a 57% decrease in child protection incidents after enrollment.

The Supportive Housing and Managed Care Pilot

Demonstration of Outcomes

What the pilot can demonstrate now

- Significant housing stability for families
- High enrollment retention
- Most challenging group of chronic or long-term homeless families and single adults
- High costs for eligible single adults and families determined from analysis of county administrative data on shelters, detox, chemical dependency treatment and mental health
- Completion of first qualitative process study

What the pilot will be able to demonstrate this calendar year

- Summary analysis of baseline outcome interviews with participants, covering health, behavioral health, productivity, housing histories and client satisfaction
- Identification of matched comparison group for cost and outcome study
- Further analysis of county administrative data for single adults and families, adding emergency assistance, child protection encounters and out-of-home-placement (covering pre- and post-enrollment periods and matched comparison group)
- Analyses of health care use and expenditures from health plan and State health and human services data, covering matched comparison group and participants pre- and post-enrollment

What the pilot will be able to demonstrate when completed

- Documentation of the characteristics of families and single adults who are homeless for extended periods of time
- Documentation of reductions in utilization of government-funded services and the cost offsets associated with them, including health care, chemical dependency treatment, mental health services, economic assistance, crisis interventions, corrections and out-of-home placement of children
- Documentation of the improvements in participant outcomes, including housing stability, health, productivity, self-sufficiency and general quality of life
- Documentation of best practices for how agencies across sectors must work together to coordinate and integrate services to improve outcomes and increase efficiencies, and lessons learned
- Documentation of best practices associated with effectively housing and supporting families and single adults moving from homelessness to self-sufficiency
- Strategies that incorporate local, state and federal government programs and financing for housing, health care and social services, as needed to address long-term homelessness broadly
- Public-private infrastructure for consistent delivery of a high quality intervention, with accountability mechanisms for ongoing oversight

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RS EDEN SUPPORTIVE HOUSING SERVICES

Supportive Housing Services
Since 1997, RS Eden has developed or participated in the development of 250 units of affordable, sober, safe, and supportive housing that have helped thousands of youth, single people, and families rebuild their lives—and directly and indirectly stabilized and revitalized many Minneapolis and St. Paul communities.

Alliance Apartments—124-unit development on the edge of downtown Minneapolis; serves previously homeless and chemically dependent men and women.

Central Avenue Apartments—61-unit development in Northeast Minneapolis; serves low-income, homeless individuals with mental health issues, with support services provided by a non-profit partner, Mental Health Resources.

Portland Village—26-unit multifamily development in Minneapolis's Phillips neighborhood; serves homeless, economically disadvantaged families whose lives have become chaotic as a result of substance abuse and criminal behavior.

7th Landing—residential building for 13 on West 7th Street in St. Paul; provides affordable supportive housing to young adults who are aging out of the foster care system, with support services by a nonprofit partner, Growing Home. In addition, this development has 4 commercial bays, two of which are occupied by a neighborhood barber, and two for which a coffee house or other community gathering type tenant, are being sought.

Jackson Street Village—townhome complex in St. Paul's North End neighborhood for 24 families recovering from substance abuse, with management and support services by the Wilder Foundation.

Lindquist Apartments—26-unit development in North Minneapolis set for completion in late 2004; for single young men and women aging out of corrections, foster care, and other social services. Support services to be provided by Life's Missing Link (formerly known as Professional Sports Linkages), which will also lease part of the second floor. This development will include RS Eden's new multipurpose operations center.

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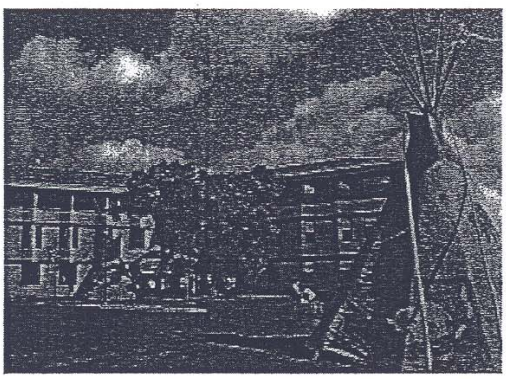

ANISHINABE WAKIAGUN
1900 16th Avenue South, Minneapolis, MN 55404

The Mission of ANISHINABE WAKIAGUN is to provide a culturally unique permanent supportive housing environment in which sobriety is encouraged for chronically intoxicated, homeless men and women.

Culturally unique: Where the design of our services draws on the strength of Native American culture, providing and incubator for ideas that have a positive impact on the whole community.

Anishinabe Wakiagun is a permanent supportive housing program. It is a wet/dry facility that does not require residents to be sober in order to stay in their housing. The goal is to minimize the negative consequences of the residents drinking patterns for the individual and the community through providing a stable, culturally appropriate living environment that encourages a reduction in alcohol consumption. Anishinabe Wakiagun is not a shelter; it is a permanent housing facility that encourages long-term residency to maximize stability in the individuals' life.

TARGET POPULATION

We house late stage chronic public inebriate men and women. Our residents typically have twenty or more admissions to detoxification centers in the last three years, two or more attempts at chemical dependency treatment, physical deterioration due to alcohol use, have been homeless for most of the last five years, and show evidence that they are incapable of self-management due to alcohol use. The screening process is designed to screen out those individuals who do not meet the criteria of being late stage chronic inebriates.

Average cost for one admission to the area detox is $300. If additional medical treatments are required - because of victimization by physical assaults and robberies, or serious stresses brought on by exposure to the weather and being rousted by the police- one client can cost the county considerably. In 1994, three chronic alcoholics cost Hennepin County an average of $85,000 each for continuous revolving door crisis services. With such incredible costs, citizens, police, health care professionals and elected officials have called for a better way to address this issue. Anishinabe Wakiagun's costs to provide board, lodging, and supportive services to this population are about $18,750 per year per person. This program stabilizes the living situations of these individuals resulting in a better standard of living at a lower cost.

The residents' average age is 45. Thirty of the rooms are designated for men, and 10 for women. Approximately 10% of the residents receive SSI payments. The other 90% had no income at the time of intake.

SERVICE DESCRIPTION

Case Management. The case manager is in contact with local and out-state human services, housing and chemical dependency programs to assist the client in finding the services that are most appropriate for that individual. Because they have a long-term history with the client, the program supervisor is able to assist in making appropriate referrals.

Relationship needs of this group often include involvement with one or more residents in Anishinabe Wakiagun and the staff members who have gotten to know them from daily contact. As residents of Anishinabe Wakiagun, many have found the following: Socialization within their own cultural group; a place where they are welcome and feel a sense of place; stability (a positive routine) instead of street survival; respect and acknowledgment that they are worthwhile persons; attachment to this Indian community (acceptance or appreciation, instead of rejection or mere tolerance); working with professional staff who share their life experience, culture and background; acceptance within a spiritual and social context within their own community.

Health Management. There are a large number of health concerns for the chronic inebriate population. Because of their long history of alcohol abuse there are organic diseases that have resulted. Often the individuals sustain injuries while under the influence of alcohol. In either case, the medical problem is often not attended to until the situation has escalated to a crisis point. When this occurs, expensive emergency services are required, such as ambulance service and HCMC Emergency Room visits.

The goal of the health case management component is to reduce the number of times these emergency services are accessed by each individual in the program and to connect them to the mainstream health care system. This is accomplished through maintaining frequent contact with the client and assessing their physical well being at each meeting. The program supervisor encourages the client to get medical attention before the situation reaches a crisis point. This can be accomplished through the in-house clinic operated in conjunction with the Community University Health Care Center. In addition, the program supervisor assists the client in making outside clinic appointments, arranging for transportation, and following up on the situation to make sure that the client is going to appointments and following the medical recommendations. The program supervisor tracks each resident's health care coverage status and makes sure they stay eligible. 100% of our residents have health care coverage.

Incentives and Supportive Services. Appropriate incentives and supportive services can go a long way in reducing the harm done to individuals and the community that result from chronic alcoholism. Some incentives at Wakiagun include assistance with cable TV costs for those staying sober and activities, such as going out to the movies and to Pow Wows.

For people in the late stages of chronic alcoholism there are often no tangible immediate positive results for staying sober. Being sober does not necessarily get them housing, clothing or food. At the same time there are losses that they incur, such as loss of companionship with friends who are still drinking, loss of focus in their daily routine. Their identity is closely tied to their drinking habits. They can feel lost. Providing these incentives can provide them with the sense that they are moving forward.

- ***Other activities.*** There are other incentives that can help client remember that they can do something other than drink. Many chronic inebriates find that they are in a position where there is nothing left for them to do except drink. Ties with family have been cut, skills they may have attained have deteriorated, and they no longer have access to activities other than drinking. The Anishinabe Wakiagun gives them other options such as those briefly discussed below:

- ***Recreational Activities.*** Recreational activities located in Wakiagun include things such as weight lifting, game nights for table games, music nights (outside music groups performing at Wakiagun) and camping trips.

- ***Spiritual Activities.*** Members of the community are encouraged to use the Wakiagun site for traditional and other spiritual activities in which residents can choose to participate. In addition, transportation is provided to spiritual activities at other sites.

- ***Plant Care.*** Anishinabe Wakiagun is designed to be a place where life and culture can be celebrated. In accordance with this, the building has indoor and outdoor plants, and an out door vegetable garden. Residents are encouraged to take on the responsibility of caring for the community garden and plants.

These incentive and support services are provided in conjunction with AIHCDC's Kola Street Case Management Project.

ADMISSION AND DISCHARGE

1. Admission Criteria

Anishinabe Wakiagun is very specific permanent housing targeting American Indian chronic alcoholics. All applicants must show current evidence of excessive alcohol use. In addition, the target group will have the following characteristics:

- 20 or more admissions to detoxification centers in the last three years.
- Two or more attempts at chemical dependency treatment.
- Evidence of police intervention due to alcohol use.
- Use of hospital emergency room services due to alcohol use.
- Chronic homelessness related to alcohol use (Homeless most of the last five years).
- Evidence of physical deterioration due to alcohol use.
- Evidence that the individual is a danger to themselves due to their alcohol use.
- Evidence that the individual is incapable of self-management due to alcohol use.
- Failure to obtain necessary food, clothing or medical care due to alcohol use.

Each individual seeking admission is expected to meet at least three of these additional criteria. Those individuals meeting more of the criteria are given a higher priority. Highest priority is given those who meet several criteria including current homelessness and evidence that they are a danger to themselves due to their alcohol use. In addition to this list of criteria, we also have an initial interview form that is filled out for each individual before they are admitted.

Factors that would disallow admission:

- Primary addiction related to drug use rather than alcohol use.
- Extended history of criminal violence or drug dealing.
- Alcohol addiction deemed not to be at the chronic or recidivist stage.

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ALLIANCE APARTMENTS
719 East 16th Street, Minneapolis, MN 55404

Housing Model: Large Single-Site Supportive Housing Apartment Building.

Type of Housing ☑ Permanent (100 units) ☑ Transitional (24 units)

Number and Type of Units of Housing: 124 small efficiency units, each housing one person, in a single building on the south side of Minneapolis. Opened in 1997.

Sponsor(s) of Project:

- *Alliance Housing, Inc.* is a nonprofit whose mission is to provide safe, affordable housing to homeless single adults and families. Formed in 1991, Alliance Housing owns nine duplexes and one eight-plex and rents to formerly homeless adults and their family members.
- Their partner, *Central Community Housing Trust* (CCHT) is an experienced provider of affordable housing in Minneapolis. Its mission is to acquire, improve and preserve decent, safe and affordable housing for low and moderate income persons. CCHT has developed more than 1100 units of affordable housing.

Support Services partner is

- *RS Eden,* Formed in 1971, RS Eden (formerly Eden Programs) is committed to habilitating drug dependent individuals who may also be involved with the criminal justice system or are anti-social in nature.

The property is managed by:

- *The Gavzy Group*, a for-profit, professional property management company.

Tenancy Profile: Tenants are single adults, both male and female. All were formerly homeless, either living on the streets or in shelters or coming out of residential treatment facilities, detox, the criminal justice system, etc. 29 of the 100 permanent units are targeted to veterans. While there are no mandated disability preferences, 80-90% of the permanent housing tenants have substance addiction, about half have psychiatric disabilities/dual diagnosis, and 10% have HIV/AIDS. Tenants do not have to be engaged in services prior to entry into the housing, although

about 40% of the tenants are referred from detox, residential treatment, jail, or other service programs.

Physical Description of the Housing: Alliance Apartments' 124 units are located in a single building, the result of the renovation of a 1960s, 3 1/2-story former nursing home and the new construction of a new addition. Units are small 250 sq. ft. efficiency units with kitchenette and full bath, and are furnished. There is an on-site common room for use by tenants and a supervised entry.

Service Description: RS Eden provides four case managers, an employment specialist, a community developer, and a services office manager. Service staff work on-site Monday through Saturday with coverage from 8 to 12 hours a day. Participation in services is not a condition of tenancy. Services are available for as long as is needed by the individual tenant.

Property Management: Property management staff for the project includes a site manager, assistant site manager, office manager, and maintenance and janitorial services. There is 24-hour coverage of front desk, 75% of which is provided by tenants who are hired for the job. A resident council advises management.

Project Financing

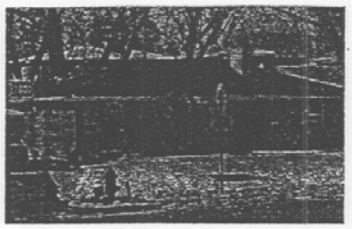
- *Development type:* Rehabilitation with new addition
- *Development total budget:* Approx. $7.4 million ($59,680/unit)
  $59,688/unit
- *Development sources and amounts:*

Equity syndication	$3.2 million
Federal Home Loan Bank AHP grant	$300,000
Philanthropy	$900,000
HOME	$414,000
State housing funds	$190,000
MHFA loan	$800,000
City CDBG	$186,186
HUD SHP	$400,000
Veterans Administration	$541,000
Other	$428,000

- *Predevelopment funding sources:*
  Corporation for Supportive Housing

Recoverable Grants	$ 75,000
Predevelopment Loans	$319,000

- *Operating Sources:*
  HUD McKinney Sect 8 Mod Rehab subsidies for all permanent units, 10 yr term
- *Services Sources:*
  State and county service grants ($286,000 annually, 2-year grants)
  HUD SHP grant for services to tenants in 20 of the permanent units for 3 years
  Minn. Group Residential Housing Program funds services to 10 tenants
- Term of guaranteed housing affordability: minimum 15 years, maximum 30 years.



COMMUNITY INVOLVEMENT PROGRAMS
1600 Broadway Street NE, Minneapolis, MN 55416

Housing Model: Scattered-Site Small Developments and Shared Supportive Housing in Nine Suburban Hennepin County Municipalities.

Type of Housing ☑ Permanent (96 units)

Number and Type of Units of Housing: 14 units in 2,4 and 6-plex apartment buildings
66 units (bedrooms) in 21 shared single-family homes
16 units of adult foster care

Sponsor(s) of Project:

- *Community Involvement Programs* is a nonprofit human service and supportive housing provider for people with disabilities. Formed in 1971, CIP provides a broad range of residential housing, community based services and supportive housing to adults with serious and persistent mental illness and developmental disabilities in the metro area and north central Minnesota. CIP owns and manages its' supportive housing program.
- *Various Partners* – CIP has developed several partnerships over the years to provide services to supportive housing residents. As an example, *Spectrum CMH* serves as the primary service provider at a four-plex development owned and managed by CIP in Crystal, MN, serving single parent households with MI.

Support Services: Tenants in CIP properties may access a variety of community supports, both professional and mainstream. Tenants are not required to accept CIP services to live in most CIP properties. CIP does provide services that range from adult foster care to intensive community supports and skilled nursing, to independent living skills and mental health monitoring. CIP is a licensed Home Health Provider, ARMHS, and CADI provider

Property Management: The CIP Housing Division manages 28 properties, that are administratively and financially discreet from the human service operations of the organization.

Tenancy Profile: Tenants are primarily single adults, both male and female. Many were formerly homeless, either living on the streets or in shelters or coming out of residential treatment facilities, detox, the criminal justice system, etc. Some units are targeted to specific levels of care and need. Tenants do not have to be engaged in services prior to entry into the housing. Primary referral sources are through county case mgmt. Rule 36 facilities, self referral and word-of mouth.

Physical Description of the Housing: CIP's properties are located in nine suburban Hennepin County communities in a area from Eden Prairie (SW) to Plymouth (NW) to the west and St. Louis

Park(SE) and Crsytal (NE) to the east. Most of CIP's properties are formerly foreclosed single family HUD homes acquired between 1990 and 1997. CIP properties blend into the surrounding suburban neighborhoods and no special conditional use or licensing is required (with the exception of the adult foster care homes). Tenant have their own bedroom and share the space and upkeep of the rest of the home. Single-family homes are typical 3 and 4 bedroom suburban homes built between 1950 and 1980. CIP's other properties include a duplex, four-plex, six-plex and one town home unit.

Service Description: CIP employs a team approach using Individualized Care Planning to provide and coordinate services to tenants. As such, services vary broadly based on individual needs. In adult foster care settings, CIP can provide 24 supervision. In other community based housing services range from daily contact to occasional support. Participation in services is not a condition of tenancy. Services are available for as long as is needed by the individual tenant.

Property Management: CIP's housing division includes a Director position, Housing manager and 2.5 Fte maintenance positions.

Project Financing:

Capital - Funding for acquisition and renovation has come from a host of federal, state county and city sources over the years. Major funding sources include HUD SHP, HUD Sec. 811, MHFA, Henn Co. Administered HOME and AHIF programs and City CDBG funds. CIP's property assets are currently valued at about $8 million dollars

Operating: CIP expends about $ 350,000 annually to operate it's housing division.

Services - CIP's mental health services, supporting both tenants and individuals living in other independent community settings operates on an annual budget of about $900,000



MENTAL HEALTH RESOURCES
STEVENS COURT - MINNEAPOLIS

Housing Model: Clustered Scattered Site Apartment Units in Stevens Square Neighborhood of South Minneapolis.

Type of Housing ☑ Permanent Subsidized Rental

Number and Type of Units of Housing: 28 master-leased apartments in 9 buildings

Sponsor(s) of Project:

- *Mental Health Resources Inc. (MHR)* - MHR provides a range of clinical and community based services and supportive housing to persons experiencing serious and persistent mental illness and in some cases secondary chemical dependency issues. MHR operates in several metro-area counties.
- Steven Community Associates – Is a for-profit owner and manager of over 600 apartment units in the Stevens Square neighborhood of south Minneapolis.
- HUD SHP program funds are used to provide rent subsidies and services to program participants.

Support Services : MHR provides supportive counseling, mental health support, living skills and recreational opportunities for participants. The services occur in-home and at a centrally located office/ participant space leased to MHR by the management company in one of the apartment buildings. Staffing consists of 1.8 fte counselors, a .25 mental health worker position and a team leader.

Tenancy Profile: Tenants are single adults, both male and female experiencing serious and persistent mental illness. All were formerly homeless, either living on the streets or in shelters. Many tenants have a substance abuse history and long histories of homelessness and interaction with criminal justice and mental health systems. Tenants are referred from, shelters, county case managers and the Hennepin County Access program. MHR is currently expanding its services to include shelter outreach and a housing first approach to stabilizing currently homeless candidates.

Physical Description of the Housing: Stevens Community Associates owns over 600 housing units in numerous low rise apartment buildings surrounding an urban park in south Minneapolis. MHR master-leases 28 units in 9 apartment buildings. There is an on-site office in one building with a common room for use by tenants

Project Financing: the $580/mo. rents are subsidized through the HUD SHP program. Tenants pay 30% of their monthly income as a 'participation fee' in the program. Services are also funded through the HUD program.

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Program Effectiveness Fact Sheet

AMHERST H WILDER FOUNDATION

Single-Room Occupancy Housing

In operation since 1985

What is Single Room Occupancy Housing?

The Wilder Single-Room Occupancy (SRO) Housing Program provides housing for low-income, single adults who need a well-maintained and supportive place to live.

Housing and supportive services are available at two locations—American House in downtown Saint Paul and Wilder Apartments on Snelling near University Avenue.

Each of these handicapped-accessible sites offers furnished rooms, laundry facilities, and shared kitchen and dining areas.

The major goal of the SRO programs is for residents to achieve greater stability in their lives by:

1. Improving their general living situation
2. Being employed and/or enrolled in school
3. Reducing personal problems
4. Reducing barriers to self-sufficiency

Services

While needing or using support services is not a condition of residency in the Single Room Occupancy Program, both sites are "service enriched" facilities.

An on-site resident services coordinator is available to help residents find employment, obtain medical care and manage mental health issues, secure transportation, maintain sobriety, and address financial matters and other challenges.

Residents are encouraged to take an active role in maintaining the vitality of the building as a community.

They are involved in resolving interpersonal conflicts, developing building policies, assisting with security, coordinating recreational activities, and scheduling transportation services.

Residents

At the time of the 2000 survey, 127 people resided in Wilder's SRO buildings. Of these, 36 percent were white, 32 percent were African American, and 21 percent were Native African.

Eighty-nine percent of residents were male, 93 percent were single, and 17 percent were military veterans.

Sixty-four percent of the residents were between the ages of 30 and 50. Sixty-three percent lived in temporary housing prior to Wilder SRO housing.

The average annual income for SRO residents in 2000 was just over $10,000.

Measuring Results

The SRO program is evaluated every three years by the Wilder Research Center. Face-to-face interviews were last conducted in October 2000.

General living situation. The program objective was for 75 percent of the residents to report that their general living situation had improved since entering a Wilder SRO. At the time of the 2000 survey, 89 percent reported that their living situation had improved.

Employment and Education. The program objective was for 60 percent of the residents to be employed or enrolled in school. At the time of the survey, 79 percent of residents were either employed or enrolled in school or both.

Reduction of personal problems. The survey showed a statistically significant decline in the percentage of respondents reporting the following personal problems (before vs after program entry):

- Homelessness and lack of money for housing (30%)
- Inability to afford rent (21%)
- Terminated relationship or divorce (20%)
- Eviction or displacement (18%)
- Unemployment (12%)
- Personal crisis (11%)

Client Satisfaction

Eighty-six percent of the residents rated their overall satisfaction with Wilder's SRO Housing as favorable, and 95 percent would recommend the program to others.

Learn More

To learn more about the Wilder Single Room Occupancy Program, call Keith Denison at **651-646-5256,** or visit our web site at ***www.wilder.org***.

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Program Effectiveness Fact Sheet

AMHERST H WILDER FOUNDATION

Redeemers Arms

In operation since 1999

What is Redeemers Arms?

Redeemers Arms is a 150-unit independent living community providing safe, affordable, service-enriched housing for older adults and younger disabled people in Saint Paul.

Redeemers Arms is located in the Summit-University area of Saint Paul, within easy distance of four colleges, the Minnesota Science Museum, the Cathedral, and the RiverCentre.

Services

Residents of Redeemers Arms have access to a variety of services. There is a full-time service coordinator who can help residents arrange for home health or personal care, meal delivery, assistance with medication, or other services that help maintain their quality of life.

The service coordinator also refers residents for help with personal budgeting, county case management, mental health crisis management, transportation, and food.

Residents have access to a resource lab with computers that residents can use to search for jobs, become familiar with the internet, or learn basic computer skills.

The residents

During 1999-00, Redeemers Arms was home to 150 residents. Of these, 61% were Caucasian. The majority were female. Seventy-seven percent had some physical or mental disability. Their average annual income was $7,500.

Recent resident comments

"I thinks it's great that the staff at Redeemers love us. It feels like a family."

"I am able to relate well with the Service Coordinator. She helps me with my goals."

"I like living at Redeemers because there are direct support services."

Looking ahead

Redeemers Arms is a newly acquired property. Results from the first formal program evaluation will be available in spring of 2001.

Learn more

To learn more about Redeemers Arms, call ***651-224-7665*** or visit our web site at ***ww.wilder.org***.

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Hennepin County's Housing for Chronic Inebriates
Analysis March 2003

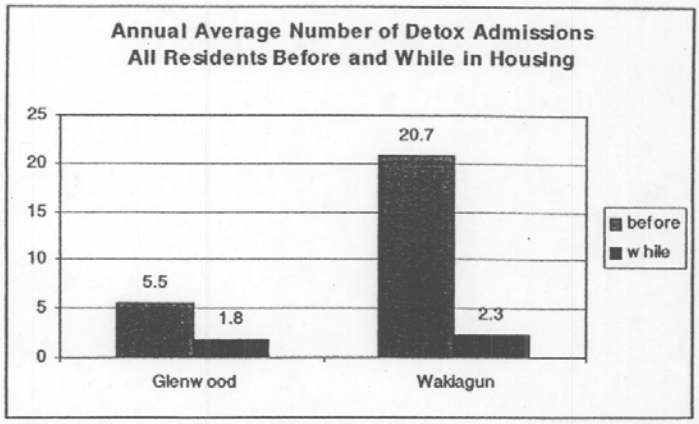
Hennepin County has two facilities that provide housing for homeless chronic inebriates. They are the Glenwood and Anishinabe Wakiagun.

- The Glenwood opened in May 1995, as a permanent residence for chronically inebriated men. The Glenwood houses 80 residents at a time. Twenty-seven percent receive SSI; the remainder receive GA. Thirty percent are veterans. Half the residents are white, one quarter are African American, one quarter are Native American. The typical Glenwood resident has a history of multiple detox admissions and failure in traditional treatment programs. The Glenwood is located at 173 Glenwood Avenue No., near Glenwood and Lyndale in north Minneapolis. It is run by Catholic Charities.

- Anishinabe Wakiagun opened in September 1996. It is a permanent supportive housing program for American Indian men and women who are chronic inebriates. It houses 40 residents at a time. One quarter receive SSI, the remainder receive GA. Of the new admissions in 2002, 41 percent were veterans. The profile of the Wakiagun resident is similar to the Glenwood – men and women with a long history of detox use and failed chemical dependency treatment. Wakiagun is run by the American Indian Housing and Community Development Corporation. It is located at 1600 E. 19th Street, near Bloomington and Franklin in south Minneapolis.

Hennepin County has evaluated both programs to see whether residents of the program (1) meet the profile of high users of detox prior to entry and (2) reduce their use of detox and other emergency services while living in the residence.

Both the Glenwood and Wakiagun admitted individuals with a lengthy history of alcohol abuse and detox and emergency room encounters related to acute intoxication. Both facilities saw a statistically significant decline in detox usage for its residents while they were in the program. It is notable that Anishinabe Wakiagun took in residents with a much greater history of detox involvement in the community within the past year.

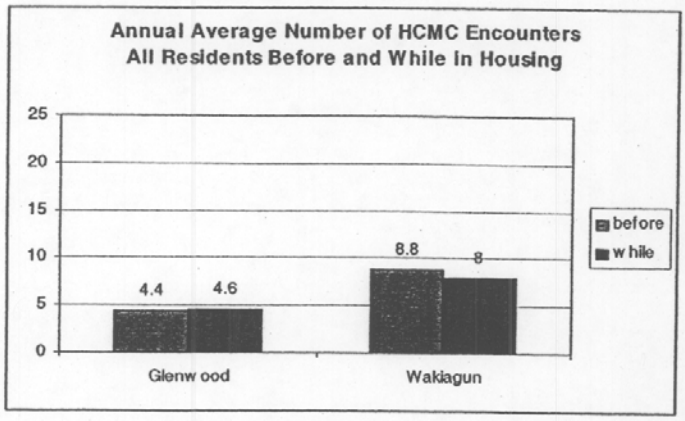


Detox currently cost the county approximately $300 a visit. The decline in detox suggests that there are 1032 "saved" detox admits each year for these 120 individuals, which represents roughly 11-12 percent of the county's detox capacity.

Both facilities also admitted residents with a history of using HCMC's emergency room for acute intoxication. While the number of admissions was not as high for the emergency room as for detox, the cost of each encounter is likely more expensive – closer to $500 a visit.

The change in emergency room use is not statistically significant. A more in-depth review of medical usage was conducted to understand what impact, if any, these housing programs had on health care

utilization. That study found that average costs did not decline, due to a handful of extremely expensive inpatient hospitalizations.



However, the median cost of health care declined from $9,297 per year to $5,218. In addition, the "cost drivers" shifted. For chronic inebriates on the street, injuries were the most significant factors for driving health care costs. While living at one of these residences, illness was the most significant factor.

If these programs are no longer available to Hennepin County to house its chronic inebriate population:

- 120 individuals who are high users of detox and the emergency room may be left homeless and likely revert back to their levels of detox usage. We have seen this with residents who have moved in and out of the Wakiagun. While living at Wakiagun, their use of detox is minimal. When they are back on the street, it returns to the "pre-Wakiagun" levels. As noted above, these 120 individuals account for more than ten percent of the current detox capacity. The system couldn't absorb these individuals.

- The detox van/downtown police pick up intoxicated individuals and either transport them home, to shelter, to detox or to HCMC if they are highly inebriated and the detoxes are full. They estimate that they currently make 450 trips a year to return Glenwood and Wakiagun residents to their homes. Without housing, these individuals would be taken to detox or to HCMC. The number of trips would be much higher than 450, however, since they wouldn't have a home to drink in and would be publicly intoxicated instead, generating calls to 911 for police response.

- While the number of emergency room visits does not decline significantly while these individuals are in housing, the nature of the visits shifts. HCMC and other hospitals would be serving individuals with more acute intoxication as their primary diagnosis, which leads to a different medical intervention (placed in Special Care and strapped down) than for illness alone. Total ER visits will increase, since their diseases will continue to progress, but emergency staff will also have to treat injuries and acute intoxication. There will also be more admissions generated by the police bringing in intoxicated individuals with no place to go. At a cost of $500 per ED visit for acute intoxication, the 450 additional visits to HCMC by the detox van and squads in the downtown Minneapolis area would cost $225,000.

  The staff at Glenwood and Wakiagun ensure that residents keep their medical coverage up-to-date. If the residents were back on the street, it is likely that their coverage in GAMC, soon to be MinnesotaCare, will lapse, making them uninsured at HCMC and other area hospitals.

- All of these individuals were homeless prior to entering the facilities and would be homeless if the facilities were to close. This leaves 120 homeless men to enter the shelter system, which operates at capacity with 789 slots today. Again, the system couldn't absorb these individuals.

Project H.O.M.E.

1515 Fairmount Avenue
Philadelphia, PA 19130
phone: 215-232-7272
fax: 215-232-7277
www.projecthome.org

Overview

Housing and Supportive Services: A Continuum of Care

Project H.O.M.E. has developed a proven and effective program to assist persons in overcoming chronic homelessness. This "continuum of care" is carefully designed to deal with the complex issues of persons with special needs such as mental illness and addiction. The continuum consists of street outreach, a range of supportive residential services from entry-level to permanent housing and comprehensive services, including health care, education and employment. These residences and services allow each person to break the cycle of homelessness, move toward self-sufficiency and achieve his or her fullest potential. An important element of the continuum is individualized treatment programs that rebuild and support each person's dignity in the context of a strong and caring community.

Please "visit" our residences and learn more about our support services.

- Street Outreach
- Entry-level Housing
- Transitional Housing
- Permanent Housing
- Supportive Services

Supportive Services

At every stage throughout the continuum of care, residents of Project H.O.M.E. have access to a range of supportive services to assist them in achieving self-sufficiency. These services are tailored to the specific needs and goals of each resident. They include:

- **Health Care:** On-site health care is available at all our sites. Health education services are also available to our residents. These services are provided by Philadelphia Health Management Corporation and Jefferson University Medical College.

- **Mental Health services:** All of our residents with mental-health issues are linked to mental health services through several providers. Many of our residents attend mental health day programs. Project H.O.M.E. caseworkers coordinate

with staff of these programs to assure continuity and effectiveness of mental health services.

- **Recovery services:** A full-time staff Addictions Counselor works with Project H.O.M.E. residents who are dealing with substance abuse issues. Residents attend a variety of outpatient recovery programs, treatment centers, and support groups to assist them in their recovery.

- **Education:** Project H.O.M.E.'s Adult Learning Program provides a range of education opportunities, including GED preparation, basic literacy, computer training, and arts programs.

- **Employment:** Because employment is a critical component of overcoming homelessness, Project H.O.M.E. residents are taught life skills, job training and employment readiness. Many of our residents take entry-level custodial or reception jobs at our sites. Many others work at one of our two businesses -- the Back Home Café & Catering or Our Daily Threads Thrift Store.

St. Columba

St. Columba is a Safe Haven in West Philadelphia for chronically homeless, mentally ill men. It targets "hard-to-reach" homeless men, many of whom are older, physically frail and resistant to programs and services. It has a dual residence:

- The **25 Safe Haven Beds** are targeted for those men just coming off the street and in need of close supervision and support. Services are provided on a 24-hour basis, including case management, support services and on-site medical care.
- The **15 Single Room Occupancy (SRO) Permanent Supportive Housing units** are for chronically homeless men with disabilities who are able to perform daily living tasks and can provide 30% of their income towards rent.

Location: 4133-9 Chestnut Street, Philadelphia, PA 19104
For more information please contact: Lisa Razzi, Program Coordinator - (215) 232-7236

Best Practice – Outreach

Pathways to Housing, Inc.
New York City, New York

Founded in 1992, Pathways to Housing offers scattered site permanent housing to homeless individuals with psychiatric disabilities and addictions. Despite the challenges this population presents, Pathways is unique in what it does *not* require of its residents: "graduation" from other transitional programs, sobriety, or acceptance of supportive services as a condition of tenancy. The vast majority of clients are moved directly from the streets into permanent, private market housing. The program then uses Assertive Community Treatment (ACT) teams to deliver services to clients in their homes. The ACT teams help clients to meet basic needs, enhance quality of life, increase social skills, and increase employment opportunities. The program currently serves over 400 people

Target Population

Eligibility
Pathways to Housing is designed to end homelessness for people living on the streets with concurrent mental illness and addiction. In order to be eligible for the program, an individual must be homeless, must have a psychiatric disability that compromises their ability to function, and must be willing to meet with a service coordinator twice a month during the first year of tenancy. Priority is given to women and elderly people because they are at greater risk of victimization.

The program provides an alternative to the more common "linear residential treatment programs," which move people through a continuum of services beginning with outreach, some intermediary housing which helps people become "housing ready," and ending with permanent housing. Pathways provides clients with housing first, and then offers services and treatment to people in their homes.

Referrals
Most clients are contacted through the outreach efforts of Pathways staff. Other referrals come from city outreach teams, shelters and drop-in centers. 1999 data showed that 65% of tenants had last lived on the streets, 18% in shelters, 7% in treatment facilities, and the remainder had lived with friends, at the YMCA/YWCA, or in transitional facilities.

Project Description

Housing
Pathways to Housing staff assist clients in locating and selecting private market rental housing. The housing department keeps logs of new vacancies among the over 200 landlords they work with, and works to negotiate leases and complete Section 8 applications. The greatest challenge to the program is finding vacant apartments at fair market rent. Landlords are amenable to renting to Pathways' clients because they get guaranteed rental payments. Tenants pay 30% of their income towards rent, and Pathways pays the remaining amount if the client does not have a Section 8 voucher.

The agency also leases two transitional apartments for use by clients who have been accepted into the program, but have not yet found an apartment of their own. The average length of stay in these units is 15 days.

Services

Pathways to Housing uses Assertive Community Treatment (ACT) teams to deliver services to clients in their homes. The teams are interdisciplinary and are on-call 24 hours a day, seven days a week. However, the tenant determines the type, frequency, and sequence of services. Service requirements are that the tenant meet with a service coordinator twice a month and participate in a money management program. Refusal to participate in sobriety or other treatment programs does not disqualify an individual, nor does a history of violence or prison time.

ACT teams consist of up to ten service coordinators, each with a particular expertise. The team leader is responsible for supervising the work of the team. The primary goals of the ACT teams are to meet basic needs, enhance quality of life, increase social skills, and increase employment opportunities. Each team sees approximately 70 clients. When a team cannot provide the services directly, tenants are referred and accompanied to the relevant programs. After the rent is paid tenants are required to develop a monthly budget with the service coordinator. The goal is for tenants to eventually manage their own money.

Staffing

Pathways to Housing employs 4 staff responsible for housing services, 40 service coordinators, 5 team leaders, 2 psychiatrists, 2 nurses and a vocational specialist. The staff make-up is culturally and racially similar to the population the program serves. Program success is attributed in part to staff composition that includes 50% consumer representation (i.e. people in recovery) that serve as role models.

Source of Funding

Funding for the Pathways program comes in two parts: housing subsidies and services. Around sixty-five tenants have Section 8 vouchers, and the remainder are subsidized by grants from the HUD Shelter Plus Care program and the New York State Office of Mental Health. The latter also provides funding for the ACT teams. Each unit with services costs approximately $20,000 per year.

Service Utilization/Outcome Data

Data from 2000 showed that 88% of the program's tenants remained housed after five years. Furthermore, Pathways staff contends that its residents have greater satisfaction with their housing, and greater psychological well-being because they were given a choice as to where to live, and what activities to engage in.

For More Information, Contact

Sam Tsemberis
Pathways to Housing
155 West 23rd Street, 12th Floor
New York, NY 10011
212-289-0000 ext. 101
212-289-0839 Fax
Pathman101@aol.com

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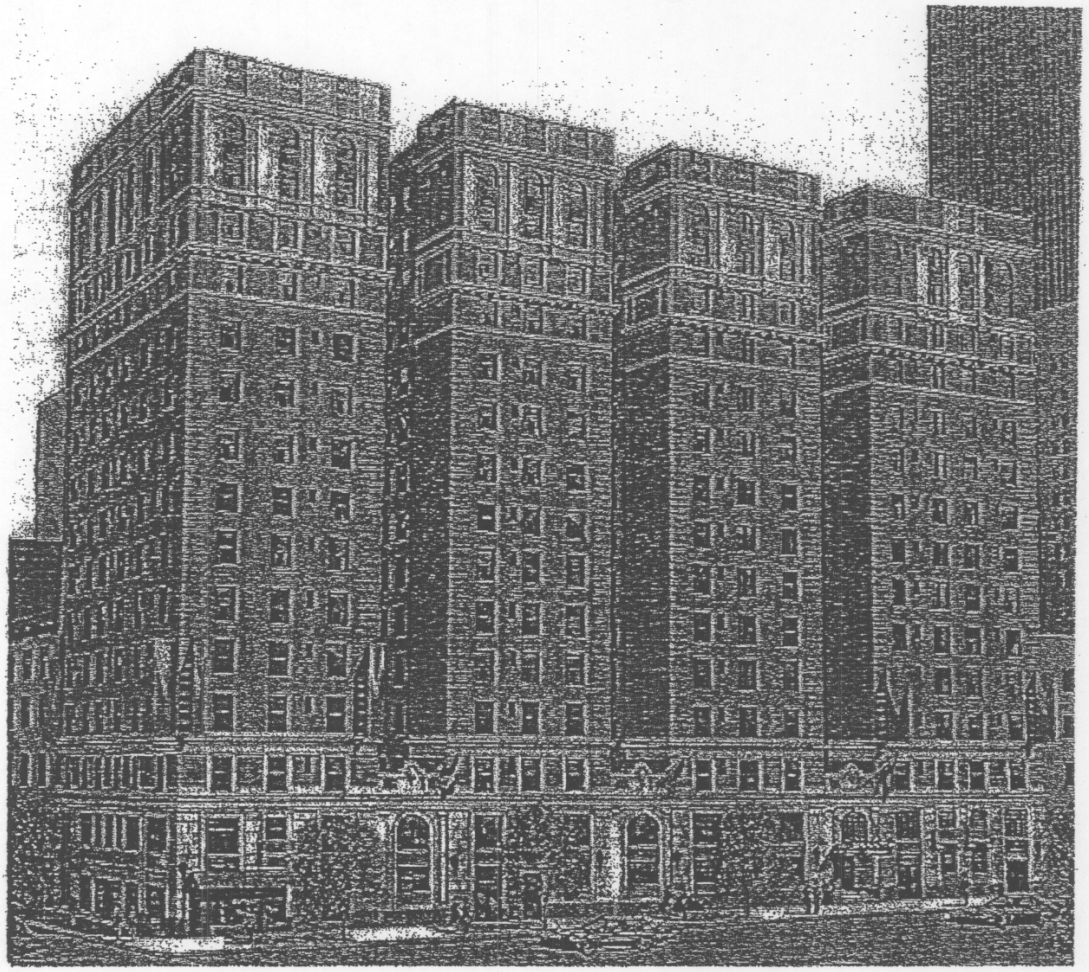
The Times Square – New York City



Project Name: The Times Square

30-97

Location: 255 West 43rd Street
New York, NY 10036

1. **Describe briefly the project's design and implementation.**

Between 1991 and 1994, Common Ground Community HDFC, Inc. transformed The Times Square from one of the most dilapidated and infamous commercial SRO's in New York City into a model of successful large-scale supportive housing. The project entailed a complete renovation of the building's interior and the creation of 652 new efficiency apartments, each with a private bath. More than 80% of the units were also equipped with kitchenette facilities. The design for the building included the creation of community space on each floor, the construction of an institutional kitchen and dining area on the 15th Floor, and an extensive renovation of the Renaissance Revival-inspired lobby and mezzanine. As part of the rehabilitation, Common Ground voluntarily sought National Register listing for the property and undertook a full historic restoration of the building, which was the first of the large midtown residential hotels built in conjunction with the early twentieth century emergence of the Times Square theater district.

The project provides permanent housing for low-income and previously homeless single adults, AIDS patients, the mentally ill and the elderly, including approximately 200 tenants who lived in the building prior to Common Ground's arrival. Our programs take a holistic approach to overcoming homelessness and joblessness, integrating high-quality housing with a range of services designed to foster self-sufficiency and independence among tenants. Working in partnership with the Center for Urban Community Services (CUCS), which maintains an extensive on-site staff at The Times Square, Common Ground has created an environment where tenants have access to extensive social and psychiatric services, a medical clinic, community facilities, job training programs and ongoing employment assistance. On-site businesses, including a restaurant and catering facility, a Ben & Jerry's franchise, and a Starbucks Coffee store, provide training and employment opportunities to tenants of The Times Square as well as to supportive housing tenants across New York City.

2. **What local urban issues did this project address? What were its goals? Were there issues that, in your judgment, might have been addressed but were not?**

Common Ground approached the rehabilitation of The Times Square at a grassroots level, actively seeking involvement from community constituencies including existing hotel tenants, Community Board members and local business leaders. Prior to its renovation, The Times Square Hotel was seen as a major liability to a neighborhood endeavoring to rejuvenate itself both socially and commercially. Common Ground's restoration of the building to its former grandeur, its provision of services to some 200 existing tenants, and its creation of high-quality apartments for a remarkably diverse group of low and moderate income individuals, transformed the building from an eyesore into a crucial component of the redevelopment initiative underway in Times Square.

Because of the scale and location of the project, Common Ground has found itself addressing issues which have not only local but city-wide and even national implications. As the largest supportive SRO in the nation, The Times Square provides a model for other organizations around the country seeking creative approaches to addressing homelessness and joblessness. In spite of its successes, however, The Times Square is still a work in progress. Common Ground continues to revisit its goals and objectives for the project, engaging in an ongoing analysis of which programs and facilities best serve the needs of its tenants and the community. Common Ground's economic development and job training programs, for example, have taken on a far greater role than initially anticipated. As the project matures, Common Ground will continue to consider new opportunities which will enhance the effectiveness of our programs and the overall dynamism of life at The Times Square.

3. **Describe the financing of the project. Do you think it could be replicated?**

Common Ground received a 30 year, $28.8 million low-interest loan from the New York City Department of Housing Preservation and Development's SRO Loan Program to cover the $9.5 million acquisition costs and a large portion of the project's $26.5 million renovation expenses. The syndication of Low Income Housing Tax Credits and Historic Rehabilitation Tax Credits generated an additional $22.35 million to cover remaining renovation costs -- particularly historic rehabilitation work -- and capitalized operating and social service reserves.

The construction of the 15th floor kitchen and dining space was financed by a $2.5 million bridge loan from the Metropolitan Life Foundation, a funding source which also helped Common Ground purchase furniture for each dwelling unit in the building. The bridge loan was secured and is being repaid with equity from tax credit investments. Additionally, a wide variety of public, corporate and philanthropic grants have supported the development and expansion of Common Ground's economic development and job training programs.

While a precise replication of The Times Square's complex financing could be achieved, shrinking public funds for affordable housing require that adaptations be made to the model. Common Ground is currently redeveloping another building, The Prince George Hotel, using the same creative mix of public and philanthropic support combined with the syndication of Low Income Housing and Historic Preservation Tax Credits. The Prince George, located on East 28th Street between Fifth and Madison Avenues, will provide 416 efficiency apartments along with social and employment services to a population similar to that of The Times Square.

Connecticut Supportive Housing Demonstration Program
Evaluation Report Highlights July 1, 2002

The Connecticut Supportive Housing Demonstration Program was initiated in June 1992 by the State of Connecticut and the Corporation for Supportive Housing. Between 1993 and 1998, the program financed the development of 281 units of affordable, service-enriched rental housing for homeless and at-risk populations, many of whom were coping with mental illness, histories of substance addiction, or HIV/AIDS. This demonstration also evaluated the success of the program, to determine whether the supportive housing model that had already been tested on a large scale in New York City and Chicago would work in the mid-sized cities and smaller communities of Connecticut.

A 2002 program evaluation, conducted by an independent evaluation team including researchers from The Center for Mental Health Policy and Services Research of the University of Pennsylvania Health Care System, found that supportive housing created positive outcomes for tenants while decreasing their use of acute and expensive health services. In addition, property values in the neighborhoods surrounding the supportive housing have increased or remained steady since the projects were developed. ***In short, supportive housing is a cost-effective use of Connecticut's resources to build healthy homes and communities for homeless and at-risk persons and families around the state.***

Some of the major findings from this third and final report of the program evaluation include:

Tenant Characteristics

- 444 people entered the housing as tenants in the nine Demonstration Program housing developments between June 1996 and February 2001.
- 351 tenants responded to an initial survey prior to the end of February 2001. These surveys revealed the following:
  - 34% of the surveyed tenants are women, 66% are men
  - Average age on entry into housing is 43 years
  - 78% were homeless at some point in their lives
  - Only 38% had lived independently in the time immediately before entering housing

  In the two years prior to entry into the housing:
  - 23% spent some time in jail or prison
  - 38% had been hospitalized for health reasons
  - 39% received mental health treatment
  - 34% received detox services
  - 29% were employed

Medicaid Data

Evaluators looked at Medicaid records to identify tenants' service utilization during the two years before and the three years after entering the housing. For the 126 Medicaid-eligible tenants who entered the housing and stayed in the housing for three years, the study found that they:

Decreased their utilization of restrictive and expensive health services:

- 71% decrease in the average Medicaid reimbursement per tenant using medical inpatient services.

Increased their usage of less expensive ongoing and preventive health care:

- These included services such as home health care, outpatient mental health and substance abuse services, and medical and dental services
- The number of tenants using medical or behavioral health outpatient services also increased after entering the housing, showing a peak at one year into their tenancy

Connecticut Supportive Housing Demonstration Program
Evaluation Report Highlights July 1, 2002

Tenant Outcomes

Tenants who entered supportive housing prior to January 1998 and stayed housed for at least three years reported the following at the time of their 36-month survey:

- High levels of functioning: 89% reported becoming more independent; 90% said they performed the activities of daily living 'very well' or 'ok'.
- 83% reported their health as good to fair
- Levels of satisfaction with all aspects of the housing and services are high.
- Tenant income increased: average income increased from $500 to $639 monthly
- Two-thirds of tenants reported being employed or in education and training programs
- The majority of tenants in the sample see their current housing situation as desirable for the present; but also as a stepping stone to another type of living situation. Only a third of the surveyed tenants said they planned to live in their building permanently.

Project Financial Stability

This portion of the study analyzed the financial stability of the nine housing projects, all of which had been in operation for at least 30 months as of February 2001: Liberty Commons in Middletown; Hudson View Commons and Mary Seymour Apartments in Hartford; Crescent and Fairfield Apartments in Bridgeport; Colony and Atlantic Park Apartments in Stamford; Cedar Hill Apartments in New Haven; Brick Row Apartments in Willimantic. Key findings of the analysis include:

- All nine projects are financially stable; seven of the nine are exceeding their original operating projections.
- Occupancy rates are high—vacancy rates range from only 1% to 12%.
- Turnover rates are low, ranging from 7% to 21%, indicating that property management has been able to keep tenancy stable and the flow of rental income steady.

Impact on Property Values and Economic Benefits

Evaluators analyzed sales of commercial buildings in each of the projects' immediate neighborhood, including apartment, retail and office properties, that occurred from just prior to the completion of the supportive housing projects (1996-1998) to the March 2002. They found that:

- Neighborhood property values increased for eight of the nine projects:
  - The neighborhood surrounding Mary Seymour Apartments in Hartford experienced a five-fold increase in property values.
  - Property values doubled in the neighborhoods of Liberty Commons in Middletown, Crescent Apartments in Bridgeport, and Cedar Hill Apartments in New Haven.
  - Property values increased by more than 30% in the neighborhoods of Hudson View Commons, Colony Apartments, Brick Row Apartments, and Fairfield Apartments.
- Where property values were highest (Atlantic Park Apartments in Stamford), neighborhood property values remained stable.
- The majority of neighbors and nearby business owners report that neighborhoods look better or much better than before the projects were built.*
- Development of the projects yielded $72 million in direct and indirect economic and fiscal benefits to Connecticut communities.*

Copies of the evaluation report are available through the Corporation for Supportive Housing, 129 Church Street, Suite 815, New Haven CT 06510, or through our web site at www.csh.org.

**This data is contained in the October 1999 report.*

From "Working together toward individual and community health," Harm Reduction Coalition, San Francisco, 1994

Harm Reduction is a set of strategies that encourage substance users and service providers to reduce the harm done by licit and illicit drug use. In supporting drug users in gaining access to the tools to improve their health and lifestyles, we recognize their competence to protect themselves, their loved ones and their communities.

The theory of harm reduction emerges out of community-based, public health interventions that support drug using communities in reducing drug-related harm. It challenges the traditional social service provision and moral/criminal and disease models by focusing on maximizing individual and community health through participation and ownership rather than repression and incarceration.

Harm reduction identifies the practices and beliefs which endanger individuals and communities, and works with them in a collaborative and nonjudgmental manner to reduce those dangers.

Practitioners of harm reduction distinguish themselves from other service providers by their willingness to engage with all people, regardless of personal values, and to face with them harm done to and by them.

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WORKING GROUP ON SUPPORTIVE HOUSING FOR PEOPLE EXPERIENCING 'CHRONIC' HOMELESSNESS

Supportive Housing for Ex-Offenders

The attached document is an excerpt from a report provided by an organization called Common Ground which is located in New York, New York. As noted this is in draft form. Common Ground staff expect to make available a finished version in October 2003.

Much of the information in this report can be very useful to any locality that addresses the need for supportive housing for ex-offenders. Although the statistics regarding the New York offender population are not applicable to Minnesota, the concepts on how housing is related to recidivism apply to any region.

The report provides brief descriptions of several existing programs located in several areas of the United States and England. Four of those descriptions were selected as most applicable to the Working Group's task and are provided for review.

Women's Prison Association, New York, New York
Delancey Street Foundation, San Francisco
Prisoner's Aid Association of Maryland, Inc.
Pioneer Human Services, Seattle Washington

Prisoners Aid Association of Maryland, Inc.
2000 North Calvert Street
Baltimore, MD 21218
Phone: 410.662.0351 or 410.727.8130

The Prison's Aid Association of Maryland, Inc., provides housing and supportive services for inmates and ex-offenders. They have three types of housing that are available to both men and women:

1. *The Shelter Plus Care:* This program is sponsored by the City of Baltimore and funded by HUD. Clients who meet HUD's eligibility requirements are provided with long-term housing up to five years, usually in a one-bedroom apartment. Residents are offered individual and groups counseling, as well as various financial support.

2. *Emergency Housing:* The emergency housing facility accommodates 16 men and women daily and provides them with two meals per day. The daily operations are performed by ex-offenders who are responsible for preparing the meals, assigning beds, and well-being of the residents. Clients are placed in case management, provided with information on Social Service programs, and are automatically assigned a seven day stay in the shelter.

3. *Transitional Housing:* Some clients are eligible to remain in emergency housing for up to six months and these folks are entered into the Transitional Housing program. Residents are placed in case management and the program requirements change for each individual. All residents are required to acquire full-time employment and are assisted in forming a budget and savings plan.

All clients receive services that include counseling, mental health treatment, subject abuse treatment, GED and computer classes, employment readiness, job placement, limited transportation to interviews, and career development. All services and programs are free or cost a minimal fee.

Pioneer Human Services
7440 West Marginal Way South
Seattle, WA 98108
Phone: 206-768-1990

Pioneer Human Services provides employment, training, counseling, community corrections, and housing services to 6,000 clients a year, primarily ex-offenders and former substance abusers. The Counseling and Housing services of PHS is divided as such:

- Housing and Residential Recovery Services – approximately 650 units of low income and alcohol and drug free housing are provided in 17 apartment buildings in Seattle and Tacoma. The St. Regis Hotel provides 132 beds of residential recovery services, low income, and overnight rooms to the public;

- Community Corrections – PHS directly operates six correctional programs, including the Bishop Lewis House and Madison Recovery House, which serve males in work release under state jurisdiction. The Helen B. Ratcliff House helps

transition female offenders. Pioneer Fellowship House and Tacoma Comprehensive Sanctions Center focus of federal offenders. Selma R. Carson Home serves juveniles returning from state facilities;

- Behavioral Health Services – Pioneer Counseling services provides outpatient mental health and chemical dependency counseling. Case Management Services Coordinate support services for residents of the residential units. School-based Counseling offers counseling to middle school students and their families in various Seattle Public Schools. The Spruce St. Inn serves runaway youth and their families. Pioneer Center North is an in-patient chemical dependency facility with a capacity of 153 beds. PNC provides involuntary services to person with long histories of addiction.

The employment and Training services of PHS are divided as such:

- Food Operations – PHS operates a retail food business, the Mezzo Café, at 3 locations in Seattle and Bellevue. Central Food Services prepares and delivers over 750,000 meals annually to PHS programs and to 3rd party consumers;

- Pioneer Construction Services – Sixty persons are employed to do remodeling and construction projects for both PHS properties and 3rd party contracts;

- Pioneer Distribution Services – Contract Services provides assembly, packaging, and warehousing services for customers. Food Buying Service distributes food to over 400 food banks and nonprofit groups in 25 states;

- Pioneer Industries – two manufacturing plants specialize in producing cargo liners for Boeing and sheet metal fabrication and finished products for customers. A 12-month Basic Training Program offers on-the –job training, which can be followed by an apprenticeship program.

- Pioneer Consulting Service – Pioneer consults with nonprofits, foundations, and other agencies in assessing social enterprise capabilities opportunities.

Delancey Street Foundation
600 Embarcadero Street
San Francisco, CA 94107
Phone: 415.957.9800
Fax: 415.512.5186

The Delancey Street Foundation is an innovative organization that provides long-term transitional supportive housing for approximately 1,000 former ex-offenders and substance abusers in New York City, San Francisco, Los Angeles, New Mexico, and North Carolina. The minimum stay is two years; the average stay is four years. During that time, all residents earn a high school equivalency and learn three marketable skills before graduating. They also learn the interpersonal and social survival skills necessary to be

independent, self-reliant, and drug-free in mainstream society. The Foundation supports itself primarily through a number of training schools that offer vocational skills to all the residents, including a moving and trucking school, restaurant and catering services, a print and copy shop, retail and wholesale sales, paratransit services, advertising specialties sales, Christmas tree sales and decorating, and an automotive service center. In addition to the housing for ex-offenders, the Foundation now has a program that provides a safe and nurturing community for at-risk youths.

Women's Prison Association
Hopper Home and Huntington House
110 Second Avenue
New York, NY 10003
Phone: 212.674.1163
Fax: 212.677.1981

The Women's Prison Association (WPA) has been helping incarcerated women reintegrate into the community since 1844. Agency services include assessment, court advocacy, the administration of court-ordered restrictions, counseling, field supervision, housing assistance, intensive supervision, job placement assistance, monitoring, recreational services, rehabilitation and residential services. Incarcerated women aged 18 and older may live at Hopper Home as an alternative to incarceration or the Sarah Powell Huntington House.

- *The Hopper Home* is an alternative to incarceration residential program for 16 women and a reporting program for 14 additional women. Emergency housing (1-14 days) is also available at the Hopper Home for homeless women ex-offenders seeking transitional or permanent housing. Women in the residential program usually stay for 8 months and go through four phases. To advance to the next phase, each participant must assess their own progress and present to the case management team why they are entitled to additional privileges. During the fourth phase, participants transition into living in the community where they are monitored for up to 6 months. All residents must show proof of stable housing before leaving the Hopper Home and those with drug addictions must participate in a community-based drug-treatment program.

- *The Sarah Powell Huntington House* is a transitional residence with support services for homeless women ex-offenders and their children. Clients are assigned to a case manager who helps them with individualized issues including reuniting with their families and locating permanent housing. The building has 27 two-bedroom apartments and 1 one-bedroom apartment, a Children's Center, and onsite social services. Nine of the two-bedroom apartments are for 18 women pending reunification with their children and the remaining 18 apartments are for women and their children. Clients tend to stay for up to 18 months.

EXECUTIVE SUMMARY

Need for Supportive Housing for Ex-Offenders

The need for supportive housing for ex-offenders is critical in this time when homelessness is higher than it has been in decades and the number of released prisoners is 300% higher than twenty years ago. In order to prevent ex-offenders from further contributing to the overall homeless population, we must first examine why many re-enter communities with no housing or prospect of housing. Reasons why persons leave the criminal justice system without stable housing include:

- Many are discharged without services from the most basic, such as attaining photo identification, to the most specialized, including medical and mental health services.
- Because the lengths of incarceration are longer than they were twenty years ago, persons exiting prisons have more difficulty readjusting outside a correctional facility.
- Many are unable to cope with the new stresses and differences of life outside a correctional institution and are often manifested in re-arrests.
- Many are likely not to have participated in prison-based programs such as vocational training, education, or drug treatment, therefore they are not adequately prepared to succeed on their own.
- Many return to a relatively few disadvantaged urban communities where the prevalence of crime and lack of legal, living wage employment opportunities are disproportionately higher than in other areas of the U.S.

In urban centers, such as New York City, *between 30-50% of parolees are homeless.*[1] Many ex-offenders who always had stable housing in the past have a difficult time finding and keeping housing once released. With little to no discharge planning prior to release, many newly released prisoners tend to return to or enter the shelter system. Housing services must be part of re-entry services provided to released offenders. Without a home, ex-offenders struggle to tackle the many other issues they face upon re-entry to he community.

There is a disproportionate prevalence of disadvantages experienced among persons in and exiting incarceration:

- 65% of state prison inmates have not completed high school.[2]
- Over one-third of all inmates report having some physical or mental disability.[3]
- 20-26% of all HIV/AIDS cases in the U.S. were releasees from correctional facilities; those with hepatitis B accounted for 12-16% of all cases in the U.S.;

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[1] Joan Petersilia, *When Prisoners Return to the Community: Political, Economic, and Social Consequences*, "Sentencing and Corrections," US Department of Justice, November 2000, No. 9, p. 5

[2] Conquest Offender Reintegration Ministries Online – Facts about Prisons and Prisoners, http://www.conquesthouse.org/sentproj1.html

[3] *Criminal Offenders Statistics*, Bureau of Justice Statistics, DOJ

those with hepatitis C accounted for 29-32% of all cases in the U.S.; and those with tuberculosis accounted for 38% of all cases in the U.S.[4]

- 70-85% of State prisoners are in need of drug treatment, however only 13% receive it while incarcerated.[5]

As of December 31, 2000, 1,381,892 prisoners were under Federal or State jurisdiction.[6] In 1999, nearly 600,000 individuals were released from State and Federal prisons and returned to their communities.[7] Of these 600,000 people, 62% were rearrested at least once within the following 3 years for a felony or serious misdemeanor and 41% were expected to return to prison.[8] *In New York City, nearly 75% of the inmates who are released from Rikers Island prison return within one year.*[9]

According to the Vera Institute, approximately 350 inmates are released into New York City every day.[10] In New York City, it is common for released prisoners to be dropped off at Queens Plaza in Queens or Port Authority in Manhattan before dawn with only a few dollars and subway fare. The immediate needs of ex-offenders, including food stamps, methadone, emergency cash, or a shelter bed, therefore cannot be met.

Supportive housing providers report that significant numbers of tenants are ex-offenders. Unfortunately, these numbers have not been formally tracked since the tenants came to supportive housing through the Department of Homeless Services and no accurate number exists of how many ex-offenders are currently served.

Nonetheless, the seamlessness with which these tenants have been served in supportive housing demonstrates that it is an effective model for this population. With ex-offenders moving into "mixed" buildings, including persons with mental illnesses and low income workers, it is a normative environment that successfully reintegrates people into the community.

Benefits of Supportive Housing for Ex-Offenders

According to the results of a recent University of Pennsylvania study, supportive housing significantly decreases the chance of recidivism into New York City jails and prisons. This study reveals that a "substantial and statistically significant decline in both the numbers of prison terms and in the number of days served following a NY/NY [supportive] housing placement, even after comparing the persons placed in NY/NY [supportive] housing with a set of matched controls."[11]

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[4] Jeremy Travis, Amy Solomon, and Michelle Waul, *From Prison to Home: The Dimensions and Consequences of Prisoner Reentry*, Urban Institute Justice Policy Center, June 2001.

[5] ibid

[6] *Prison Statistics*, Bureau of Justice Statistics, Department of Justice, www.ojp.usdoj.gov/bjs/prisons/htm

[7] Petersilia, 5

[8] Marta Nelson and Jennifer Trone, *Why Planning for Release Matters*, Vera Institute of Justice, 2000.

[9] Jennifer Wynn, *Inside Rikers*, St. Martin's Press: New York City 2001,7.

[10] ibid, 33.

[11] Dennis Culhane, Trevor Hadley, and Stephen Metraux, "NY/NY Housing and The Use of New York City Jail Services: An Analysis Merging Administrative Data," Preliminary Report to the Corporation for Supportive Housing, January 2001.

Supportive housing is an effective and efficient approach to meeting the housing and specialized service needs of ex-offenders in one comprehensive program. In addition to a home, supportive housing provides services, such as employment, substance abuse treatment, mental health counseling, and access to quality health care, that are necessary to address individual circumstances and maintain independent living. In fact, our experience and that of other service providers indicates that stable housing is a prerequisite for receiving and maintaining such services. Furthermore, the average cost of maintaining a permanent apartment with supportive services in New York costs far less than an inmate's stay in a New York prison, jail, shelter, hospital bed, or psychiatric bed.[12]

Current Funding and Legislation

Despite growing momentum within both government and the private sector to address prisoner re-entry issues, available funding to develop and operate supportive housing for ex-offenders remains scarce. Developers of these projects are forced to use patchwork financing schemes, drawing upon homeless assistance resources and funding targeted to people with special needs, to underwrite their projects. For this reason, many projects targeting ex-offenders are not likely to be developed in the present economy without new, dedicated resources.

Advocates and providers have been looking to the corrections system to fill the funding gap. Although some state corrections agencies have begun to express interest in undertaking this role, no projects have yet been developed.

Conclusion

The amount of money spent on inmate programs in State prisons far exceeds the cost of maintaining a single resident in a supportive housing facility. The average cost of maintaining a permanent apartment with supportive services in New York costs approximately $34 per day per person. In comparison, a New York State prison cell costs $79 per day per person, a New York City jail cell costs $112 per day per person, a New York City shelter cot costs $68 per day per person, a New York City hospital bed cost between $600-1600 per day per person, and a New York State psychiatric bed costs $350 per day per person.[13] Additional costs must be considered for female prisoners with children in the foster care system. Seventy-seven percent of incarcerated women are mothers, many of whom have children in foster care, which costs $20,000 per year per child in New York and adds to the cost of incarceration.[14]

Persons exiting the criminal justice system contribute significantly to the growing number of homeless individuals throughout the United States. Supportive housing has proven itself the most cost effective strategy to end homelessness, but the supply of units is limited. The city, state, and federal criminal justice systems must take the lead and

[12] Corporation for Supportive Housing: http://www.csh.org/ny.html

[13] Corporation for Supportive Housing: http://www.csh.org/ny.html

[14] "Reclaiming Lives, Reuniting Families, Rebuilding Communities," Project Greenhope: Services for Women, Inc. Pamphlet.

provide capital and operating support and partner with non-profit organizations for the development of supportive housing for ex-offenders.

Executive Summary

This report presents preliminary research on potential models for a community-based transitional housing program for ex-offenders. It was commissioned by the Fifth Avenue Committee's Developing Justice in South Brooklyn Program.

Here is a summary of my recommendations:

Intake

- Forty-five minutes should be the (minimum) standard for doing an intake.
- Intake should be done in a private office space.
- FAC should interview applicants three times each.

Supportive Services

- An ideal program creates enough structure to prop up the participant, but no so much that it weighs him down.
- Some Supportive service requirements ought to be built into the structure of the tenancy agreement. That way, the participant can consent to restrictions, and not just have them forced on him.
- However, most services not be required as a condition of tenancy.
- Amongst the voluntary services that ought t be made available to residents are:

1. Career development
2. Vocational training
3. Soft skills – like those taught in Cameo House's "Life Skills" classes
4. Financial management
5. Medical care
6. Family Reunification
7. Substance abuse recovery
8. GED preparation
9. Mental Health counseling and treatment

- FAC ought to look to the curriculum used by the Northern California Service League (or Women In Community Service) to prepare ex-offenders for life on the outside.
- The case manager should meet with each resident to determine how much he or she will save each month and then monitor that client's bank account to make sure that this is happening.
- FAC ought to seek a linkage with a clinic that can provide residents with a basic physical and ongoing care for major illness
- FAC should consider providing formal services to HIV positive ex-offenders

Eligibility

- FAC should exclude sex offenders and arsonists.
- FAC might consider doing outreach house low-income college students of color to find student tenants who would be interested in living in an integrated building that is not exclusively for ex-offenders.

House Rules

- There be just enough house rules set to ensure that residents generally get along. One way to do this is to try to keep the number of extra people in the building who are putting a strain on the shared facilities to a minimum.

1. No loud music after 10pm
2. Heavy restrictions on overnight guests
3. Visiting hours
4. Sign in/sign out for guests
5. Clean and sober environment

Security

- Other facilities have felt the need to keep someone on site at all times to deal with crises. FAC should as well.

Staffing

- FAC should staff the program with a full time building manager and a half time case manager, as well as some backup staff for when the building manager is away.

Budget and Funding

- My best guess is that operating costs will be in the area of $75,000 to $175,000 per year, depending on staffing. consider formally setting aside some units for former prisoners with HIV and applying for HOPWA funds.

Community

- Ask local police to vouch for the program's potential to reduce crime.
- Use relationships with the faith community.

Final Note

FAC may need to reconsider the economies of scale for this project. Given the staffing needs identified in this report, it may not be cost effective to renovate a building smaller than 20 units.

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Office of Justice Programs
National Institute of Justice

National Institute of Justice

Program Focus

Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program

Coordinating Community Services for Mentally Ill Offenders: Maryland's Community Criminal Justice Treatment Program

by Catherine Conly

Looking around his apartment, 45-year-old Ray Carver can hardly believe his good fortune.[1] Not long ago, he was living in abandoned buildings and drinking cheap whiskey. He had survived like that since he was a teenager, traveling up and down the East Coast, periodically being arrested for shoplifting or vagrancy and spending months at a time in jail. In his early twenties, Ray was diagnosed with schizophrenia by a psychiatrist in a District of Columbia jail. Since then, he had taken medication sporadically and had been institutionalized twice for his mental illness. Most of the time, however, he lived on the streets and drank heavily.

Highlights

The number of mentally ill individuals in the criminal justice system has grown dramatically during the past 30 years. Often homeless and suffering from other health-related concerns (e.g., substance abuse, HIV infection), these individuals may cycle continuously between the community, where they commit mostly minor offenses, and jail.

Recognizing this pattern and seeking to intervene productively, local policymakers have worked with officials in Maryland's Department of Health and Mental Hygiene and with other State officials to establish the Maryland Community Criminal Justice Treatment Program (MCCJTP), a multiagency collaborative that provides shelter and treatment services to mentally ill offenders in their communities. Created to serve the jailed mentally ill, the program now also targets individuals on probation and parole.

MCCJTP operates in 18 of the State's 24 local jurisdictions and features:

- Local advisory boards composed of local and State decisionmakers who provide ongoing leadership.
- Case management services that include crisis intervention, screening, counseling, discharge planning, and community followup.
- Services for mentally ill offenders who are homeless or have co-occurring substance use disorders.
- Routine training for criminal justice and treatment professionals.
- Postbooking diversion for qualifying mentally ill defendants.

The MCCJTP model features strong collaboration between State and local providers, a commitment to offering transitional case management services, the provision of long-term housing support to mentally ill offenders, and a focus on co-occurring substance use disorders. Criminal justice and treatment professionals credit MCCJTP with improving the identification and treatment of jailed mentally ill individuals, increasing communication between mental health and corrections professionals, improving coordination of in-jail and community-based services for mentally ill offenders and defendants, and reducing disruption in local jails. Case managers and clients report that MCCJTP's comprehensive services have improved the quality of many clients' lives.

Independent evaluation of MCCJTP service delivery mechanisms and client outcomes is now under way. The investigation will help in determining whether providing coordinated, community-based services to mentally ill offenders can significantly reduce recidivism, increase residential stability, reduce psychiatric hospitalization, and increase voluntary participation in substance abuse treatment.

When Ray was arrested for shoplifting in Salisbury, Maryland, he reported to the Wicomico County Detention Center's classification officer that he had been taking medication for schizophrenia. The officer referred Ray to the mental health case manager assigned to the jail by the county health department through the Maryland Community Criminal Justice Treatment Program. With that referral, Ray Carver embarked on a journey that would significantly change his life.

Thousands of mentally ill individuals pass through local correctional facilities each year. In 1996, one-quarter of jail inmates reported that they had been treated at some time for a mental or emotional problem.[2] Nearly 89,000 said that they had taken a prescription medication for those types of problems, and more than 51,000 reported that they had been admitted to an overnight mental health program.[3]

The dramatic growth of the population of jailed mentally ill persons has coincided with the policy of deinstitutionalization that resulted in the release of thousands of mentally ill people from psychiatric facilities to the community.[4] Additional factors, including cuts in public assistance, more stringent civil commitment laws, declines in the availability of low-income housing, and limited availability of mental health care in the community, are thought to have exacerbated conditions for the mentally ill and contributed to their increased involvement in the criminal justice system.[5] Many mentally ill offenders are charged with relatively minor offenses (e.g., prostitution, shoplifting, vagrancy),[6] but are not diagnosed or treated while in jail and are released back to their communities with no plan for treatment or aftercare.

Finding humane, constitutional, and effective ways to address the needs of mentally ill individuals is a challenge for local correctional facilities nationwide. Crowded, outdated, and designed to ensure secure confinement, most jails are not optimal treatment settings for the mentally ill.[7] Nonetheless, the nature of jail populations increasingly demands—and numerous court decisions require—that jails respond to the needs of the mentally ill.[8]

Researchers consistently recommend correctional strategies that result in early identification and referral of the jailed mentally ill to the most appropriate treatment setting, preferably in the community.[9] However, only a few jails have achieved this goal.[10] Even in jails where psychiatric services are models for others nationwide, a significant proportion of the mentally ill can go undetected and/or untreated.[11] In addition, many mentally ill individuals are released with no plan for community-based care.[12]

Mentally ill offenders are poorly equipped to serve as advocates for their own welfare. They often face multiple challenges, including homelessness, unemployment, estrangement from family and friends, substance abuse, and other serious health conditions such as HIV/AIDS, tuberculosis, and hepatitis.[13] In turn, community-based providers often find mentally ill offenders challenging to serve because of their "coexisting conditions, noncompliance, criminal records, unkempt appearance, and clinically difficult and challenging presentation."[14] Consequently, mentally ill individuals may cycle repeatedly through the health, mental health, social service, and criminal justice systems, each with its unilateral focus, and never become stabilized because of a lack of coordinated care and treatment. This "system cycling" is discouraging to the mentally ill offender and costly to the network of community-based providers.

Overview of MCCJTP

After years of study and discussion, local corrections officials in Maryland worked with others in local government, with State officials, and with representatives from the private sector to create MCCJTP. In various stages of implementation in 18 of the State's 24 local jurisdictions,[15] MCCJTP brings treatment and criminal justice professionals together to screen mentally ill individuals while they are confined in local jails, prepare treatment and aftercare plans for them, and provide community followup after their release. The program also offers services to mentally ill probationers and parolees and provides enhanced services to mentally ill offenders who are homeless and/or have co-occurring substance use disorders (see "MCCJTP: At the Forefront of Efforts to Aid Mentally Ill Offenders," page 4).

MCCJTP targets individuals 18 or older who have a serious mental illness (i.e., schizophrenia, major affective disorder, organic mental disorder, or other psychotic disorders), with or without a co-occurring substance use disorder. It is founded on two key principles:

- **The target population requires a continuum of care provided by a variety of service professionals in jail and in the community that is coordinated at both the State and local levels.** In this regard, agency participants include local mental health and substance abuse treatment providers and advocates, local hospital professionals, housing providers,

members of local law enforcement, and representatives of key State criminal justice, mental health, and substance abuse agencies.

- **Local communities are in the best position to plan and implement responses to meet the needs of the mentally ill offenders in their jurisdictions.** To that end, each participating jurisdiction has developed a local advisory board to oversee the conduct of needs assessments, coordinate program implementation, monitor service delivery, and expand program options.

MCCJTP's goals are to improve the identification and treatment of mentally ill offenders and increase their chances of successful independent living, thereby preventing their swift return to jail, mental hospitals, homelessness, or hospital emergency rooms. In some locations, MCCJTP also aims to reduce the period of incarceration (through postbooking diversion) and even reduce the likelihood of incarceration altogether (through prebooking diversion).

According to data maintained by the Maryland Department of Health and Mental Hygiene, almost 1,700 mentally ill individuals received services through MCCJTP in 1996 (see "The Mentally Ill in Maryland Jails," page 5). Funding for the 18 programs totals approximately $4 million annually and comes from local, State, and Federal sources. In addition, many agencies contribute administrative time and support services (see "MCCJTP Funding," page 5).[16] The funding supports the provision of case management services in each jurisdiction and other specialized services such as housing to meet the needs of mentally ill offenders.

This Program Focus reviews the history of MCCJTP, describes key program features, and discusses the benefits of and challenges to program operation.

MCCJTP: At the Forefront of Efforts to Aid Mentally Ill Offenders

Efforts to comprehensively address the needs of the jailed mentally ill are still relatively rare. According to a nationwide survey of jails conducted by researchers at the National GAINS[a] Center for People With Co-Occurring Disorders in the Justice System (see "Sources for More Information" at the end of this report), "most jails have no policies or procedures for managing and supervising mentally disordered detainees."[b]

Henry Steadman, one of the study's authors and a renowned expert on responses to mentally ill offenders nationwide, believes the features that set MCCJTP apart from most other efforts include:

- *Strong collaboration between State and local providers.* "Typically, States don't coordinate anything in these efforts," Steadman observed. "In addition, it is very rare for the State to do something that the county is receptive to without usurping county authority. It is usually left to the county to address the needs of the jailed mentally ill. The integration of funding streams at the different levels of government and the ongoing commitment by State officials involved in MCCJTP make the program unique."
- *Transitional case management services that link detainees with community-based services.* Based on their survey of jails nationwide, Steadman and his coauthor, Bonita Veysey, concluded that "case management services that link detainees, on release, to community services are seldom provided in jails of any size."[c] MCCJTP is a clear exception to this trend.
- *Long-term housing support for homeless mentally ill offenders.* According to Steadman, "Rarely do you see housing as a part of a jail/criminal justice program for mentally ill or substance abusing individuals. You may see some use of short-term housing vouchers but not the full-scale commitment Maryland has made."
- *Focus on co-occurring disorders.* "Officials in Maryland," Steadman noted, "have recognized that co-occurring disorders are the norm and not the exception." In his opinion, that awareness and the State's related programmatic response set MCCJTP apart from many of its counterparts across the Nation.

Notes:

a. GAINS = Gathering information, Assessing what works, Interpreting the facts, Networking with key stakeholders, Stimulating change.

b. Steadman, H., and Veysey, B., *Providing Services for Jail Inmates With Mental Disorders*, Research in Brief, Washington, DC: U.S. Department of Justice, National Institute of Justice, April 1997, NCJ 162207, page 1.

c. Ibid, 2.

The Roots of the Program

In the early 1990s, an estimated 600 to 700 mentally ill offenders were confined in local correctional facilities throughout Maryland.[17] Because they lacked sufficient numbers of appropriately trained staff to screen and treat the mentally ill, jails were neither sensitive, nor especially safe, places for most mentally ill individuals. In those days, according to several local corrections officials, the special needs of mentally ill offenders were generally ignored unless such individuals were suicidal or disruptive. The disruptive ones were usually "locked down," but not until staff had spent considerable time in crisis management, trying to subdue them or negotiate with mental health agencies for emergency commitments. Lacking mental health training, correctional officers were frustrated and sometimes insensitive in their handling of mentally ill offenders, which exacerbated an already difficult situation. Adding to the concerns of corrections officials was the high rate of recidivism among mentally ill offenders (see "Assessing Service Needs," page 6). One frustrated former warden of a detention facility in southern

Maryland, who has since become a strong advocate of MCCJTP, admits having asked publicly about the mentally ill offenders in his jail, "Can't we shoot them up with something and just keep them asleep while they're here?"

In 1991, at the request of the Maryland Correctional Administrators Association, the Governor's Office of Justice Administration (GOJA) formed an interagency State and local task force to help define a strategy for responding to mentally ill offenders in the State. After careful review of available national research and reports on the topic by previous State task forces (see "Building on Research," page 7), the GOJA task force concluded that offenders with serious mental illnesses require a coordinated treatment approach that combines the expertise of criminal justice and treatment professionals.

The Jail Mental Health Program pilot

The State's Mental Hygiene Administration (MHA), part of the Maryland Department of Health and Mental Hygiene, assumed primary responsibility for the design and implementation of a pilot program to aid local detention centers in creating a multidisciplinary response to the jailed mentally ill. In 1993 and 1994, with $50,000 in seed money from MHA, four pilot Jail Mental Health Programs (predecessors to MCCJTP) were launched in Cecil, Charles, Frederick, and Wicomico counties. The pilots resulted in the creation of a system for providing case management services to mentally ill inmates.

The Mentally Ill in Maryland Jails

According to data maintained by the Maryland Mental Hygiene Administration, 1,682 jailed mentally ill individuals received MCCJTP services during 1996. The average daily jail population in the MCCJTP sites ranged from a low of 52 to a high of 1,162, with a median population of 237. The proportion of jailed individuals who were mentally ill varied considerably across the 18 jurisdictions. For instance, in the five jurisdictions visited by the author, prevalence estimates ranged from 8 to 21 percent.[a]

The following data from Frederick County, taken during a 1-day census in June 1997, indicate the prevalence of mental illness among the jailed population there. Of 341 inmates in the Frederick County Adult Correctional Center that day, 71 (21 percent) were diagnosed with 1 or more mental illnesses. Of those, 36 (50 percent) had a co-occurring substance use disorder.

Diagnosis	Diagnosed Jail Detainees	
	Number*	Percentage
Depressed or Bipolar Disorder	51	72
Schizophrenic Disorder	5	7
Psychotic Disorder	3	4
Other**	17	23

*Some individuals have multiple diagnoses.

** These include: antisocial personality disorder, attention deficit hyperactivity disorder, conduct disorders, dissociative disorders, eating disorders, intermittent explosive disorder, learning disorders, obsessive-compulsive disorder, and personality disorders.

Note

a. National estimates of the percentage of jail populations with serious mental illness (e.g., schizophrenia, bipolar disorder, severe, recurrent depression) range from 6 to 15 percent, depending on the study and definitions used. See Morrissey, et al., Editorial, "Jails and Prisons: America's New Mental Hospitals," *American Journal of Public Health* 85 (12) (December 1995): 1612.

MCCJTP Funding

MCCJTP combines Federal, State, and local funds to offer a mix of services within local detention centers and in the community. Current program funding includes:

- $900,000 in annual Mental Hygiene Administration (MHA) funds to hire MCCJTP case managers.
- $300,000 in annual Projects for Assistance in Transition From Homelessness (PATH)[a] funds for outreach, case management, mental health, and substance abuse services for homeless individuals with serious mental illness and/or co-occurring substance use disorders, and for parolees and probationers on intensive supervision caseloads.
- $340,922 in Edward Byrne Memorial State and Local Law Enforcement Assistance Program funds to provide substance abuse treatment services in conjunction with mental health services in seven county detention centers and in the community.
- $5.5 million from the U.S. Department of Housing and Urban Development (HUD) to provide Shelter Plus Care housing over a 5-year period (1996–2001).
- $6,557,719 in matching funds and services from jurisdictions participating in MCCJTP, $5.5 million of which supports the Shelter Plus Care housing program.
- Administrative and support services from participating agencies for which cost estimates are not available.

Note

a. PATH is part of the Mental Health Services Block Grant to the States that is overseen by Substance Abuse and Mental Health Services Administration's (SAMHSA's) Center for Mental Health Services. PATH provides a variety of treatment formula grant awards to the States for homeless people with mental illnesses and co-occurring substance abuse problems, including treatment, support services in residential settings, and coordination of services and housing. See "Sources for More Information" at the end of this report for contact information.

Within a short amount of time, those involved in the Jail Mental Health Program began reporting improved identification of the jailed mentally ill, enhanced communication between mental health and corrections staff, and reduced disruptions associated with mentally ill inmates (see "Screening Mentally Ill Offenders in Charles County," page 8).

Fourteen additional counties have since developed similar programs to respond to mentally ill offenders. Over time, the focus of the Jail Mental Health Program has expanded to include greater use of community-based services and diversion. In addition, mentally ill probationers and parolees have been added to the client base. The program's title was changed to the Maryland Community Criminal Justice Treatment Program in 1994 to reflect its broader scope.

Case managers, MCCJTP clients, and other consumers at Go-Getters, Inc., a psychiatric day treatment program in Wicomico County, MD, share free time between classes.

Key Features of Maryland's Coordinated Approach

Immediately after Ray Carver was referred for a mental health screening, the MCCJTP case manager reviewed his history of mental illness and referred him for medication. She counseled Ray throughout his stay at the detention center, and together they developed a treatment and aftercare plan for him that included taking his medication, participating in treatment for alcoholism, reinstating his Supplemental Security Income benefits, locating housing, and participating in the day program

Assessing Service Needs

From 1984 through the early 1990s, local task forces and MHA staff studied the capacity of existing service delivery mechanisms to meet the needs of mentally ill offenders and discovered the following:

- **Most detention centers had extremely limited access to mental health professionals.** Jail medical staff were generally not trained to address both the medical and psychiatric needs of inmates. If available, psychiatric services were limited to a few hours per week or month, when only the most severe cases could be evaluated. Jail officials also experienced considerable difficulty with the mental health system when trying to relocate individuals whose mental illness appeared to warrant admission to a State mental institution. Both in jail and community-based services were being compromised by the lack of proper staff to screen mentally ill offenders, provide other supportive services within jail, prepare discharge plans, and offer community-based followup.
- **Mentally ill individuals had a high rate of recidivism.** Mentally ill offenders appeared to return quickly to correctional settings at least in part because of the lack of appropriate aftercare planning and services in the community. In addition, many mentally ill offenders were homeless and/or had co-occurring substance use disorders that increased the likelihood of their return to jail.
- **Mentally ill offenders tended to cycle through a variety of criminal justice and psychosocial service settings, in part because of the lack of coordination among service providers.** A survey by MHA staff of 536 individuals housed in detention centers, State psychiatric hospitals, homeless shelters, and substance abuse clinics showed that during the previous 12 months, 54 percent had been in jail, 36 percent had received inpatient hospitalization, 35 percent had used an emergency shelter, and 33 percent had seen a substance abuse counselor.[a] Investigators concluded that better service coordination was warranted to reduce duplication in services, stabilize mentally ill offenders in the community, and prevent their return to jail.

These findings strongly suggested the need to design a program that would increase services for mentally ill offenders, coordinate services already in existence, and support mentally ill offenders in the community.

Note

a. Gillece, J., "An Analysis of Health, Criminal Justice, and Social Service Utilization by Individuals Hospitalized, Incarcerated, or Homeless," unpublished doctoral dissertation, College Park: University of Maryland, 1996: 52.

at Go-Getters, Inc., a local psychiatric rehabilitation center and partner agency of MCCJTP.

The case manager discussed Ray's criminal charges with his public defender, the assistant State's attorney, and the district court judge. Ray pled guilty and was sentenced to a year's probation. Several components of the treatment plan, which he signed in the presence of the judge, were included as conditions of Ray's probation.

Because he was homeless before his incarceration and willing to quit drinking and participate in daytime activities at Go-Getters, Inc., Ray qualified for housing assistance through the Shelter Plus Care grant awarded to Maryland's Department of Health and Mental Hygiene by the Federal Department of Housing and Urban Development. Prior to Ray's release, the MCCJTP case manager helped Ray complete an application for Shelter Plus Care housing, and a representative from Hudson Health Services, another partner agency of MCCJTP, located an apartment for Ray in a relatively low-crime area of town, just a few blocks from Go-Getters. The furnishings for Ray's apartment—a sofa, bed, table, and chair—were donated by local church and community organizations and moved to the apartment by two of the detention center's work release inmates.

On the day he was released from jail, Ray's MCCJTP case manager spent the day helping him get settled in his new apartment. Together, they stocked Ray's refrigerator, met with the psychiatrist at the County Health Center, and visited Go-Getters, where Ray was assigned a case manager.

Building on Research

During the past decade, a number of researchers have recommended strategies for responding to the needs of the jailed mentally ill, all of which have been carefully integrated into MCCJTP.

Specifically, MCCJTP's grounding principle—that communities must provide a continuum of care for mentally ill offenders—is consistent with 1990 research that concludes that the mental health needs of inmates must be viewed as a community problem requiring the involvement of an array of service providers in addition to detention center staff.[a]

Although sites around the Nation differ in their approach to such service coordination,[b] a 1992 review of research and practice recommended that the following key elements, which are central features of MCCJTP, be part of any multidisciplinary response to the jailed mentally ill:

- Interagency agreements.
- Consensus on defined goals.
- Delineation of responsibilities.
- Interagency communication.
- Cross-training.
- Ongoing program review.[c]

In a 1995 discussion of strategies for diverting the mentally ill out of criminal justice settings, researchers called for:

- Integrated services.
- Regular meetings of key agency representatives.
- "Boundary spanners" (individuals who can facilitate communication across agencies and professions) to coordinate policies and services.
- Strong leadership.
- Early identification of the mentally ill in correctional settings.
- Distinctive case management services.[d]

More recently, a 1997 study suggested that traditional jail-based mental health strategies should include court liaison mechanisms, pre- and postbooking diversion, and the use of community mental health services (e.g., university resources), especially in small jails.[e]

Some research suggests that services for the jailed mentally ill should also include:

- Screening, classification, and referrals.
- Crisis intervention.
- In-jail counseling.
- Discharge planning and community followup.
- Specialized services for subgroups of mentally ill offenders, such as those who are homeless and/or have co-occurring substance use disorders).[f]

Notes

a. Steadman, H.J. *Effectively Addressing the Mental Health Needs of Jail Detainees*, Washington, DC: U.S. Department of Justice, National Institute of Justice, 1990: 3.

b. Ibid., 3.

c. Landsberg, G. "Developing Comprehensive Mental Health Services in Local Jails and Police Lockups," in *Innovations in Community Mental Health*, ed. S. Cooper and J.M. Penner, Sarasota, FL: Professional Resource Press, 1992: 97-123.

d. Steadman, H.J., S.M. Morris, D.L. Dennis, "The Diversion of Mentally Ill Persons From Jails to Community-Based Services: A Profile of Programs," *American Journal of Public Health* (December 1995): 1631.

e. Steadman, H.J., and B. Veysey, *Providing Services for Jail Inmates With Mental Disorders*, Research in Brief, Washington, DC: U.S. Department of Justice, National Institute of Justice, April 1997.

f. Steadman, H.J., D.W. McCarty, and J.P. Morrissey, *The Mentally Ill in Jail: Planning for Essential Services*, New York: Guilford Press, 1989; Dvoskin, J., "Jail-Based Mental Health Services," in Steadman, *Effectively Addressing the Mental Health Needs of Jail Detainees*, 64-90; Landsberg, G., "Developing Comprehensive Mental Health Services in Local Jails and Police Lockups"; Center for Mental Health Services, *Double Jeopardy: Persons With Mental Illness in the Criminal Justice System*, Report to Congress, Washington, D.C.: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, February 1995; Abram, K., and L. Teplin, "Co-Occurring Disorders Among Mentally Ill Jail Detainees," *American Psychologist* (October 1991): 1042-1044.

For the first month after Ray's release, the MCCJTP case manager checked in on Ray several times a week. As Ray became more involved in community-based services, the MCCJTP case manager's involvement tapered off. She monitors Ray's progress with his case manager at Go-Getters and other service providers and is on-call in the event of a crisis.

As Ray's experience suggests, MCCJTP incorporates key features listed below and described more fully in the sections that follow:

- Local partnerships to aid mentally ill offenders.
- Support from State government agencies.
- A broad range of case management services for mentally ill offenders who are incarcerated or living in the community.
- Enhanced services for mentally ill offenders who are homeless and/or have co-occurring substance use disorders.
- Diversion strategies.
- Training for criminal justice and treatment professionals involved in the program.
- A commitment to program evaluation.

Local partnerships

Each MCCJTP program is guided by a local advisory board that assesses service needs, monitors program implementation, and investigates ways to expand program services. Although board membership varies across the counties, it generally includes representatives from the local detention center, as well as health and mental health professionals, alcohol and drug abuse treatment providers, public defenders, assistant State's attorneys, judges, parole and probation officers, law enforcement personnel, social service professionals, local hospital staff, housing specialists, mental health advocates, and consumers. Additional members are recruited as particular service needs (e.g., for diversion) are identified.

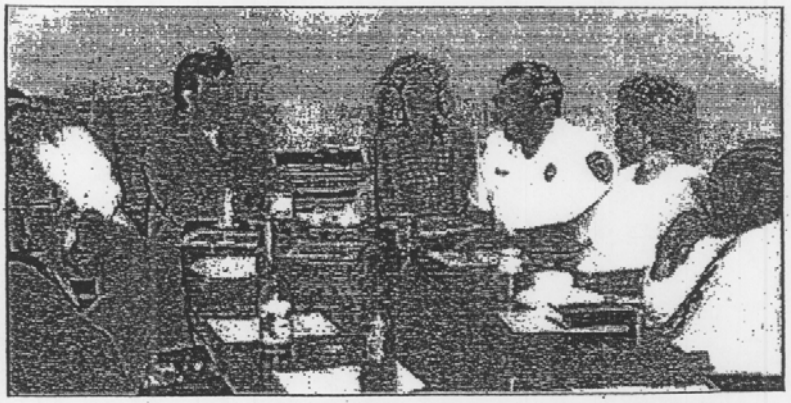
In most counties the advisory boards divide their time between reviewing specific cases and setting or refining policy. In most jurisdictions local health departments or related agencies coordinate MCCJTP and supervise the mental health staff assigned to the program. Other government agencies and private organizations have signed memorandums of understanding (MOUs) delineating their participation in local advisory boards and their willingness to provide services as appropriate.

These formal agreements are thought to be essential to ensure the smooth execution of local policies. In addition, working together to handle specific cases has reportedly been extremely beneficial to solidifying relationships among

Screening Mentally Ill Offenders in Charles County

When corrections officials in the Charles County Detention Center met with MHA staff to begin the county's Jail Mental Health Program pilot, they were confident that only three mentally ill individuals were housed in the jail. But screening by trained mental health staff resulted in 17 inmates being diagnosed as seriously mentally ill. Among them was an individual who was also deaf. Frustrated by his bizarre behavior, but unaware of his deafness, correctional officers had been speaking loudly to him for days and were becoming increasingly annoyed by his unresponsiveness. MHA staff were able to diagnose the inmate and, working with corrections staff, assist in relocating the individual to a secure mental health facility.

Months later, when the man again arrived at the jail, staff were prepared. The protocol that had been developed through the Jail Mental Health Program ensured that the inmate was identified quickly, placed on medication, moved swiftly through the certification process, and transferred to a State mental hospital.



Local and State officials convene the monthly meeting of the Task Force on Community Criminal Justice Treatment, the advisory council for Wicomico County's MCCJTP.

From SAMHSA, "An Overview of Mental Health and Substance Abuse Services and Systems Coordination Strategies, Section 1: Evidence-Based and Promising Practices"

Federal research and demonstration programs and the experience of hundreds of community-based providers have shown that the services described below help decrease psychiatric symptoms and substance use and increase residential stability for people with mental and addictive disorders. States and communities can adopt or adapt these practices to local needs.

Essential Service System Components

Evidence-Based and Promising Practices

Outreach and Engagement
- Meets immediate and basic needs for food, clothing, and shelter.
- Non-threatening, flexible approach to engage and connect people to needed services.

Housing with Appropriate Supports
- Includes a range of options from Safe Havens to transitional and permanent supportive housing.
- Combines affordable, independent housing with flexible, supportive services.

Multidisciplinary Treatment Teams/Intensive Case Management
- Provides or arranges for an individual's clinical, housing, and other rehabilitation needs.
- Features low caseloads (10-15:1) and 24-hour service availability.

Integrated Treatment for Co-occurring Disorders
- Features coordinated clinical treatment of both psychiatric and substance use disorders.
- Reduces alcohol and drug use, homelessness, and the severity of mental health problems.

Motivational Interventions/Stages of Change
- Helps prepare individuals for active treatment; incorporates relapse prevention strategies.
- Must be matched to an individual's stage of recovery.

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 with co-occurring mental disorders.

Self-Help Programs
- Often include the 12-step method, with a focus on personal responsibility.
- May provide an important source of support for people who are homeless.

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.

Prevention Services
- Reduce risk factors and enhance protective factors.
- Include supportive services in housing, discharge planning, and additional support during transition periods.

Other Essential Services

Primary Health Care
- Includes outreach and case management to provide access to a range of comprehensive health services.

Mental Health and Substance Abuse Treatment
- Provide access to a full range of outpatient and inpatient services, e.g., counseling, detox, self-help/peer support.

Psychosocial Rehabilitation
- Helps individuals recover functioning and integrate or re-integrate into their communities.

Income Support and Entitlement Assistance
- Outreach and case management to help people obtain, maintain, and manage their benefits.

Employment, Education and Training
- Requires assessment, case management, housing, supportive services, job training and placement, follow-up.

Services for Women
- Programs focus on women's specific needs, e.g., trauma, childcare, parenting, ongoing domestic violence, etc.

Low-Demand Services
- Helps engage individuals who initially are unwilling or unable to engage in more formal treatment.

Crisis Care
- Responds quickly with services needed to avoid hospitalization and homelessness.

Family Self-Help/Advocacy
- Helps families cope with family members' illnesses and addictions to prevent homelessness.

Cultural Competence
- Accepts differences, recognizes strengths, and respects choices through culturally adapted services.

Jail Diversion
- Features strategies to help divert people from jails and prisons into appropriate treatment.

Putting the Pieces Together

None of the services highlighted in this section is effective in isolation. Research and practice for more than a decade indicate clearly that, to be effective for people with serious mental illnesses and substance use disorders who are homeless, *the individual service components must be coordinated in a comprehensive, integrated system of care.* Integration is easier said than done. Fiscal, programmatic, and legislative constraints impact the ability of individual communities to achieve effective levels of integration.

www.MentalHealthCommission.gov

President's New Freedom Commission on Mental Health

Achieving the Promise: Transforming Mental Health Care in America

Executive Summary

Vision Statement

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports - essentials for living, working, learning, and participating fully in the community.

In February 2001, President George W. Bush announced his New Freedom Initiative to promote increased access to educational and employment opportunities for people with disabilities. The Initiative also promotes increased access to assistive and universally designed technologies and full access to community life. Not since the Americans with Disabilities Act (ADA) - the landmark legislation providing protections against discrimination - and the Supreme Court's *Olmstead v. L.C.* decision, which affirmed the right to live in community settings, has there been cause for such promise and opportunity for full community participation for all people with disabilities, including those with psychiatric disabilities.

On April 29, 2002, the President identified three obstacles preventing Americans with mental illnesses from getting the excellent care they deserve:

- Stigma that surrounds mental illnesses,
- Unfair treatment limitations and financial requirements placed on mental health benefits in private health insurance, and
- The fragmented mental health service delivery system.

The President's New Freedom Commission on Mental Health (called *the Commission* in this report) is a key component of the New Freedom Initiative. The President launched the Commission to address the problems in the current mental health service delivery system that allow Americans to fall through the system's cracks.

In his charge to the Commission, the President directed its members to study the problems and gaps in the mental health system and make concrete recommendations for immediate improvements that the Federal government, State governments, local agencies, as well as public and private health care providers, can implement. Executive Order 13263 detailed the instructions to the Commission. (*See the Appendix.*)

The Commission's findings confirm that there are unmet needs and that many barriers impede care for people with mental illnesses. Mental illnesses are shockingly common; they affect almost every American family. It can happen to a child,[a] a brother, a grandparent, or

a co-worker. It can happen to someone from any background - African American, Alaska Native, Asian American, Hispanic American, Native American, Pacific Islander, or White American. It can occur at any stage of life, from childhood to old age. No community is unaffected by mental illnesses; no school or workplace is untouched.

In any given year, about 5% to 7% of adults have a serious mental illness, according to several nationally representative studies.[1-3] A similar percentage of children - about 5% to 9% - have a serious emotional disturbance. These figures mean that millions of adults and children are disabled by mental illnesses every year.[1; 4]

President Bush said,

> "... Americans must understand and send this message: mental disability is not a scandal - it is an illness. And like physical illness, it is treatable, especially when the treatment comes early."

Over the years, science has broadened our knowledge about mental health and illnesses, showing the potential to improve the way in which mental health care is provided. The U.S. Department of Health and Human Services (HHS) released *Mental Health: A Report of the Surgeon General*,[5] which reviewed scientific advances in our understanding of mental health and mental illnesses. However, despite substantial investments that have enormously increased the scientific knowledge base and have led to developing many effective treatments, many Americans are not benefiting from these investments.[6; 7]

Far too often, treatments and services that are based on rigorous clinical research languish for years rather than being used effectively at the earliest opportunity. For instance, according to the Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, the lag between discovering effective forms of treatment and incorporating them into routine patient care is unnecessarily long, lasting about 15 to 20 years.[8]

In its report, the Institute of Medicine (IOM) described a strategy to improve the quality of health care during the coming decade, including priority areas for refinement.[9] These documents, along with other recent publications and research findings, provide insight into the importance of mental heath, particularly as it relates to overall health.

In this *Final Report...*

Adults with a serious mental illness are persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R *(Diagnostic and Statistical Manual for Mental Disorders)*[10], that has resulted in functional impairment[b] which substantially interferes with or limits one or more major life activities.

A serious emotional disturbance is defined as a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the DSM-III-R that results in functional impairment that substantially interferes with or limits one or more major life activities in an individual up to 18 years of age. Examples of functional impairment that adversely affect educational performance include an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory interpersonal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression; or a tendency to develop physical symptoms or fears associated with personal or school problems.[11]

Mental Illnesses Presents Serious Health Challenges

Mental illnesses rank first among illnesses that cause disability in the United States, Canada, and Western Europe.[12] This serious public health challenge is under-recognized as a public health burden. In addition, one of the most distressing and preventable consequences of undiagnosed, untreated, or under-treated mental illnesses is suicide. The World Health Organization (WHO) recently reported that suicide worldwide causes more deaths every year than homicide or war .[13]

In addition to the tragedy of lost lives, mental illnesses come with a devastatingly high financial cost. In the U.S., the annual economic, indirect cost of mental illnesses is estimated to be $79 billion. Most of that amount - approximately $63 billion - reflects the loss of productivity as a result of illnesses. But indirect costs also include almost $12 billion in mortality costs (lost productivity resulting from premature death) and almost $4 billion in productivity losses for incarcerated individuals and for the time of those who provide family care.[14]

In 1997, the latest year comparable data are available, the United States spent more than $1 trillion on health care, including almost $71 billion on treating mental illnesses. Mental health expenditures are predominantly publicly funded at 57%, compared to 46% of overall health care expenditures. Between 1987 and 1997, mental health spending did not keep pace with general health care because of declines in private health spending under managed care and cutbacks in hospital expenditures.[15]

In 1997, the United States spent more than $1 trillion on health care, including almost $71 billion on treating mental illnesses.

The Current Mental Health System Is Complex

In its *Interim Report to the President*, the Commission declared, "... the mental health delivery system is fragmented and in disarray ... lead[ing] to unnecessary and costly disability, homelessness, school failure and incarceration." The report described the extent of unmet needs and barriers to care, including:

- Fragmentation and gaps in care for children,
- Fragmentation and gaps in care for adults with serious mental illnesses,
- High unemployment and disability for people with serious mental illnesses,
- Lack of care for older adults with mental illnesses, and
- Lack of national priority for mental health and suicide prevention.

The *Interim Report* concluded that the system is not oriented to the single most important goal of the people it serves - the hope of recovery. State-of-the-art treatments, based on decades of research, are not being transferred from research to community settings. In many communities, access to quality care is poor, resulting in wasted resources and lost opportunities for recovery. More individuals could recover from even the most serious mental illnesses if they had access in their communities to treatment and supports that are tailored to their needs.

The Commission recognizes that thousands of dedicated, caring, skilled providers staff and manage the service delivery system. The Commission does not attribute the shortcomings and failings of the contemporary system to a lack of professionalism or compassion of mental health care workers. Rather, problems derive principally from the manner in which

the Nation's community-based mental health system has evolved over the past four to five decades. In short, the Nation must replace unnecessary institutional care with efficient, effective community services that people can count on. It needs to integrate programs that are fragmented across levels of government and among many agencies.

Building on the research literature and comments from more than 2,300 consumers,[c] family members, providers, administrators, researchers, government officials, and others who provided valuable insight into the way mental health care is delivered, after its yearlong study, the Commission concludes that traditional reform measures are not enough to meet the expectations of consumers and families.

To improve access to quality care and services, the Commission recommends fundamentally transforming how mental health care is delivered in America. The goals of this fundamental change are clear and align with the direction that the President established.

To improve access to quality care and services, the Commission recommends fundamentally transforming how mental health care is delivered in America.

The Goal of a Transformed System: Recovery

To achieve the promise of community living for everyone, new service delivery patterns and incentives must ensure that every American has easy and continuous access to the most current treatments and best support services. Advances in research, technology, and our understanding of how to treat mental illnesses provide powerful means to transform the system. In a transformed system, consumers and family members will have access to timely and accurate information that promotes learning, self-monitoring, and accountability. Health care providers will rely on up-to-date knowledge to provide optimum care for the best outcomes.

When a serious mental illness or a serious emotional disturbance is first diagnosed, the health care provider - in full partnership with consumers and families - will develop an individualized plan of care for managing the illness. This partnership of personalized care means basically choosing *who*, *what*, and *how* appropriate health care will be provided:

- Choosing which mental health care professionals are on the team,
- Sharing in decision making, and
- Having the option to agree or disagree with the treatment plan.

The highest quality of care and information will be available to consumers and families, regardless of their race, gender, ethnicity, language, age, or place of residence. Because recovery will be the common, recognized outcome of mental health services, the stigma surrounding mental illnesses will be reduced, reinforcing the hope of recovery for every individual with a mental illness.

In this *Final Report*...

Stigma refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses. Stigma is widespread in the United States and other Western nations.[16] Stigma leads others to avoid living, socializing, or working with, renting to, or employing people with mental disorders - especially severe disorders, such as schizophrenia. It leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking and wanting to pay for care.[5] Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment.

As more individuals seek help and share their stories with friends and relatives, compassion will be the response, not ridicule.

Successfully transforming the mental health service delivery system rests on two principles:

- **First, services and treatments must be consumer and family centered**, geared to give consumers real and meaningful choices about treatment options and providers - not oriented to the requirements of bureaucracies.
- **Second, care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience,** not just on managing symptoms.

Built around consumers' needs, the system must be seamless and convenient.

In this *Final Report*...

Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery.
Resilience means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses - and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members.

Transforming the system so that it will be both consumer and family centered and recovery-oriented in its care and services presents invigorating challenges. Incentives must change to encourage continuous improvement in agencies that provide care. New, relevant research findings must be systematically conveyed to front-line providers so that they can be applied to practice quickly. Innovative strategies must inform researchers of the unanswered questions of consumers, families, and providers. Research and treatment must recognize both the commonalities and the differences among Americans and must offer approaches that are sensitive to our diversity. Treatment and services that are based on proven effectiveness and consumer preference - not just on tradition or outmoded regulations - must be the basis for reimbursements.

The Nation must invest in the infrastructure to support emerging technologies and integrate them into the system of care. This new technology will enable consumers to collaborate with service providers, assume an active role in managing their illnesses, and move more quickly toward recovery.

The Commission identified the following six goals as the foundation for transforming mental health care in America. The goals are intertwined. No single step can achieve the fundamental restructuring that is needed to transform the mental health care delivery system.

Goals: In a transformed Mental Health System ...

Goal 1	**Americans Understand that Mental Health Is Essential to Overall Health.**
Goal 2	**Mental Health Care Is Consumer and Family Driven.**
Goal 3	**Disparities in Mental Health Services Are Eliminated.**
Goal 4	**Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice.**
Goal 5	**Excellent Mental Health Care Is Delivered and Research Is Accelerated.**
Goal 6	**Technology Is Used to Access Mental Health Care and Information.**

Achieving these goals will transform mental health care in America.

The following section of this report gives an overview of each goal of the transformed system, as well as the Commission's recommendations for moving the Nation toward achieving it. In the remainder of this report, the Commission discusses each goal in depth, showcasing model programs to illustrate the goal in practice and providing specific recommendations needed to transform the mental health system in America.

President's New Freedom Commission on Mental Health

Achieving the Promise: Transforming Mental Health Care in America

Goal 2 - Mental Health Care Is Consumer and Family Driven

Recommendations	**2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.** **2.2 Involve consumers and families fully in orienting the mental health system toward recovery.** **2.3 Align relevant Federal programs to improve access and accountability for mental health services.** **2.4 Create a Comprehensive State Mental Health Plan.** **2.5 Protect and enhance the rights of people with mental illnesses.**

Understanding the Goal

The Complex Mental Health System Overwhelms Many Consumers

Nearly every consumer of mental health services who testified before or submitted public comments to the Commission expressed the need to fully participate in his or her plan for recovery. In the case of children with serious emotional disturbances, their parents and guardians strongly echoed this sentiment. Consumers and families told the Commission that having hope and the opportunity to regain control of their lives was vital to their recovery.

Indeed, emerging research has validated that hope and self-determination are important factors contributing to recovery.[45; 46] However, understandably, consumers often feel overwhelmed and bewildered when they must access and integrate mental health care, support services, and disability benefits across multiple, disconnected programs that span Federal, State, and local agencies, as well as the private sector.

As the President said in his speech announcing the creation of the Commission, one of the major obstacles to quality mental health care is:

> "... our fragmented mental health service delivery system. Mental health centers and hospitals, homeless shelters, the justice system, and our schools all have contact with individuals suffering from mental disorders."

Consumers of mental health services must stand at the *center* of the system of care. Consumers' needs must drive the care and services that are provided. Unfortunately, the services currently available to consumers are fragmented, driven by financing rules and regulations, and restricted by bureaucratic boundaries. They defy easy description.

Program Efforts Overlap

Loosely defined, the mental health care system collectively refers to the full array of programs for anyone with a mental illness. These programs exist at every level of government and throughout the private sector. They have varying missions, settings, and financing. They deliver or pay for treatments, services, or other types of supports, such as housing, employment, or disability benefits. For instance, one program's mission might be to offer treatment through medication, psychotherapy, substance abuse treatment, or counseling, while another program's purpose might be to offer rehabilitation support. The setting could be a hospital, a community clinic, a private office, a school, or a business.

Many mainstream social welfare programs are not designed to serve people with serious mental illnesses, even though this group has become one of the largest and most severely disabled groups of beneficiaries.

A brief look at traditional funding sources for mental health services illustrates the impact of this overly complex system. The Community Mental Health Services Block Grant, funded by the U.S. Department of Health and Human Services (HHS) through the Substance Abuse and Mental Health Services Administration (SAMHSA), provides funding to the 59 States and territories. It is only one source of Federal funding that State mental health authorities manage. The funding totaled approximately $433 million in 2002,[47] or less than 3% of the revenues of these State agencies.[48]

But larger Federal programs that are not focused on mental health care play a much more substantial role in financing it. For example, through Medicare and Medicaid programs alone, HHS spends nearly $24 billion each year on beneficiaries' mental health care.[15]

Moreover, the largest Federal program that supports people with mental illnesses is not even a health services program - the Social Security Administration's Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs, with payments totaling approximately $21 billion in 2002.[49-51]

Other significant programs that are funded separately and play a role in State and local systems include:

- Housing,
- Rehabilitation,
- Education,
- Child welfare,
- Substance abuse,
- General health,
- Criminal justice, and
- Juvenile justice, among others.

Each program has its own complex, sometimes contradictory, set of rules. Many mainstream social welfare programs are not designed to serve people with serious mental illnesses, even though this group has become one of the largest and most severely disabled groups of beneficiaries.

If this current system worked well, it would function in a coordinated manner, and it would deliver the best possible treatments, services, and supports. However, as it stands, the current system often falls short. Many people with serious mental illnesses and children with serious emotional disturbances remain homeless or housed in institutions, jails, or juvenile detention centers. These individuals are unable to participate in their own communities.

Consumers and Families Do Not Control Their Own Care

In a consumer- and family-driven system, consumers choose their own programs and the providers that will help them most. Their needs and preferences drive the policy and financing decisions that affect them. Care is consumer-centered, with providers working in full partnership with the consumers they serve to develop individualized plans of care. Individualized plans of care help overcome the problems that result from fragmented or uncoordinated services and systems.

Currently, adults with serious mental illnesses and parents of children with serious emotional disturbances typically have limited influence over the care they or their children receive. Increasing opportunities for consumers to choose their providers and allowing consumers and families to have greater control over funds spent on their care and supports facilitate personal responsibility, create an economic interest in obtaining and sustaining recovery, and shift the incentives towards a system that promotes learning, self-monitoring, and accountability. Increasing choice protects individuals and encourages quality.

Individualized plans of care help overcome the problems that result from fragmented or uncoordinated services and systems.

Evidence shows that offering a full range of community-based alternatives is more effective than hospitalization and emergency room treatment.[18] Without choice and the availability of acceptable treatment options, people with mental illnesses are unlikely to engage in treatment or to participate in appropriate and timely interventions. Thus, giving consumers access to a range of effective, community-based treatment options is critical to achieving their full community participation. To ensure this access, the array of community-based treatment options must be expanded.

In particular, community-based treatment options for children and youth with serious emotional disorders must be expanded. Creating alternatives to inpatient treatment improves engagement in community-based treatment and reduces unnecessary institutionalization. These young people are too often placed in out-of-state treatment facilities, hours away from their families and communities. Further segregating these children from their families and communities can impede effective treatment.

Emerging evidence shows that a major Federal program to establish comprehensive, community-based systems of care for children with serious emotional disturbances has successfully reduced costly out-of-state placements and generated positive clinical and functional outcomes. Clinically, youth in systems of care sites showed an increase in behavioral and emotional strengths and a reduction in mental health problems. For these children, residential stability improved, school attendance and school performance improved, law enforcement contacts were reduced, and substance use decreased.[52]

Consumers Need Employment and Income Supports

The low rate of employment for adults with mental illnesses is alarming. People with mental illnesses have one of the lowest rates of employment of any group with disabilities - only about 1 in 3 is employed.[53] The loss of productivity and human potential is costly to society and tragically unnecessary. High unemployment occurs despite surveys that show the majority of adults with serious mental illnesses want to work - and that many *could* work with help.[54; 55]

Many individuals with serious mental illnesses qualify for and receive either SSI or SSDI benefits. SSI is a means-tested, income-assistance program; SSDI is a social insurance program with benefits based on past earnings. A sizable proportion of adults with mental illnesses who receive either form of income support live at, or below, the poverty level. For more than a decade, the number of SSI and SSDI beneficiaries with psychiatric disabilities has increased at rates higher than each program's overall growth rate. Individuals with serious mental illnesses represent the single largest diagnostic group (35%) on the SSI rolls, while representing over a quarter (28%) of all SSDI recipients.[49; 51]

People with mental illnesses have one of the lowest levels of employment of any group with disabilities - only about 1 in 3 is employed.

Though living in poverty, SSI recipients paradoxically find that returning to work makes them even poorer, primarily because employment results in losing Medicaid coverage, which is vital in covering the cost of medications and other treatments. According to a large, eight-State study, only 8% of those returning to full time jobs had mental health coverage.[56]

Recent Federal legislation has tried to address the loss of Medicaid and other disincentives to employment. For instance, the "Medicaid Buy-In" legislation allows States to extend Medicaid to disabled individuals who exit the SSI/SSDI rolls to resume employment, but many States cannot afford to implement Medicaid Buy-In. The Balanced Budget Act of 1997 allows States to extend Medicaid coverage to disabled individuals whose earned income is low, but still above the Federal Poverty Guidelines.

Another statutory reform - The Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999 - is problematic because its rules do not give vocational rehabilitation providers enough incentives to take on clients who have serious mental illnesses. Rather, these programs are more inclined to serve the least disabled - a process called *creaming*, in reference to the legislation's unintentional incentives for vocational rehabilitation providers to serve less disabled people rather than more disabled ones (the latter most commonly people with serious mental illnesses). One large study found that only 23% of people with schizophrenia received any kind of vocational services.[6] Since TWWIIA rewards only those providers who help their clients earn enough to no longer qualify for SSI, the bottom line is that most people with serious mental illnesses do not receive any vocational rehabilitation services at all.

Because they cannot work in the current climate, many consumers with serious mental illnesses continue to rely on Federal assistance payments in order to have health care coverage, even when they have a strong desire to be employed. Regrettably, a financial disincentive to achieve full employment exists because consumers lose Federal benefits if they become employed. Adding to the problem is the fact that most jobs open to these individuals have no mental health care coverage, so consumers must choose between employment and coverage. Consequently, they depend on a combination of disability income and Medicaid (or Medicare), all the while preferring work and independence.

For youth with serious emotional disturbances, the employment outlook is also bleak. A national study found that only 18% of these youth were employed full time, while another 21% worked part-time for one to two years after they left high school. This group had work experiences characterized by greater instability than all other disability groups.[57]

Other financial disincentives to employment exist as well, including potential loss of housing and transportation subsidies.

Over the next ten years, the U.S. economy is projected to grow by 22 million jobs, many in occupations that require on-the-job training.[58] With appropriate forms of support, people with mental illnesses could actively contribute to that economic growth, as well as to their own independence. They could fully participate in their communities. Instead, they are trapped into long-term dependence on disability income supports that leave them living below the poverty level.

A Shortage of Affordable Housing Exists

The lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for people with serious mental illnesses. Today, millions of people with serious mental illnesses lack housing that meets their needs.

The shortage of affordable housing and accompanying support services causes people with serious mental illnesses to cycle among jails, institutions, shelters, and the streets; to remain unnecessarily in institutions; or to live in seriously substandard housing.[59] People with serious mental illnesses also represent a large percentage of those who are repeatedly homeless or who are homeless for long periods of time.[60]

In fact, people with serious mental illnesses are over-represented among the homeless, especially among the chronically homeless. Of the more than two million adults in the U.S. who have at least one episode of homelessness in a given year, 46% report having had a mental health problem within the previous year, either by itself or in combination with substance abuse.[59] Chronically homeless people with mental illnesses are likely to:

- Have acute and chronic physical health problems;
- Use alcohol and drugs;
- Have escalating, ongoing psychiatric symptoms; and
- Become victimized and incarcerated.[61]

A recent study shows that people who rely solely on SSI benefits - as many people with serious mental illnesses do - have incomes equal to only 18% of the median income and cannot afford decent housing in any of the 2,703 housing market areas defined by the U.S. Department of Housing and Urban Development (HUD).[62] HUD reports to Congress show that as many as 1.4 million adults with disabilities who receive SSI benefits - including many with serious mental illnesses - pay more than 50% of their income for housing. [63]

Affordable housing programs are extremely complex, highly competitive, and difficult to access. Federal public housing policies can make it difficult for people with poor tenant histories, substance use disorder problems, and criminal records - all problems common to many people with serious mental illnesses - to qualify for Section 8 vouchers and public housing units. Those who do receive Section 8 housing vouchers often cannot use them because:

- The cost of available rental units may exceed voucher program guidelines, particularly in tight housing markets;
- Available rental units do not meet Federal Housing Quality Standards for the voucher program;
- Private landlords often refuse to accept vouchers; and
- Housing search assistance is often unavailable to consumers.

The lack of decent, safe, affordable, and integrated housing is one of the most significant barriers to full participation in community life for people with serious mental illnesses.

Tragically, many housing providers discriminate against people with mental illnesses. Too many communities are unwilling to have supportive housing programs in their neighborhoods. Since the 1980s, the Federal government has had the legal tools to address these problems, yet has failed to use them effectively. Between 1989 and 2000, HUD's fair housing enforcement activities diminished, despite growing demand. The average age of complaints at their closure in FY 2000 was nearly five times the 100-day period that Congress set as a benchmark.[64]

Just as the U.S. Supreme Court's *Olmstead* decision has increased the demand for integrated and affordable housing for people with serious mental illnesses, public housing is less available. Since 1992, approximately 75,000 units of HUD public housing have been converted to "elderly only" housing and more units are being converted every year, leaving fewer units for people with disabilities.[65]

Too few mental health systems dedicate resources to ensuring that people with mental illnesses have adequate housing with supports. These systems often lack staff who are knowledgeable about public housing programs and issues. Partnerships and collaborations between public housing authorities and mental health systems are far too rare. Highly categorical Federal funding streams (*silos*) for mental health, housing, substance abuse, and other health and social welfare programs greatly contribute to the fragmentation and failure to comprehensively address the multiple service needs of many people with serious mental illnesses.

Limited Mental Health Services Are Available in Correctional Facilities

In the U.S., approximately 1.3 million people are in State and Federal prisons, and 4.6 million are under correctional supervision in the community.[66; 67] Remarkably, approximately 13 million people are jailed every year, with about 631,000 inmates serving in jail at one time. The rate of serious mental illnesses for this population is about three to four times that of the general U.S. population.[68] This means that about 7% of all incarcerated people have a current serious mental illness; the proportion with a less serious form of mental illness is substantially higher.[68]

People with serious mental illnesses who come into contact with the criminal justice system are often:

- Poor,
- Uninsured,
- Disproportionately members of minority groups,
- Homeless, and

- Living with co-occurring substance abuse and mental disorders.

They are likely to continually recycle through the mental health, substance abuse, and criminal justice systems.[69]

As a shrinking public health care system limits access to services, many poor and racial or ethnic minority youth with serious emotional disorders fall through the cracks into the juvenile justice system.

When they are put in jail, people with mental illnesses frequently do not receive appropriate mental health services. Many lose their eligibility for income supports and health insurance benefits that they need to re-enter and re-integrate into the community after they are discharged.

Women are a dramatically growing presence in all parts of the criminal justice system. Current statistics reveal that women comprise 11% of the total jail population,[70] 6% of prison inmates,[71] 22% of adult probationers, and 12% of parolees.[72] Many women entering jails have been victims of violence and present multiple problems in addition to mental and substance abuse disorders, including child-rearing and parenting difficulties, health problems, histories of violence, sexual abuse, and trauma.[73] Gender-specific services and gender-responsive programs are in increasing demand but are rarely present in correctional facilities designed for men. Early needs assessment, screening for mental and substance abuse disorders, and identification of other needs relating to self or family are critical to effectively plan treatment for incarcerated women.

More than 106,000 teens are in custody in juvenile justice facilities.[74] As a shrinking public health care system limits access to services, many poor and racial or ethnic minority youth with serious emotional disorders fall through the cracks into the juvenile justice system. (*See Goal 4 for a broader discussion of mental health screening.*)

Recent research shows a high prevalence of mental disorders in children within the juvenile justice system. A large-scale, four-year, Chicago-based study found that 66% of boys and nearly 75% of girls in juvenile detention have at least one psychiatric disorder. About 50% of these youth abused or were addicted to drugs and more than 40% had either oppositional defiant or conduct disorders.

The study also found high rates of depression and dysthymia: 17% of boys; 26% of detained girls.[75] As youth progressed further into the formal juvenile justice system, rates of mental disorder also increased: 46% of youth on probation met criteria for a serious emotional disorder compared to 67% of youth in a correctional setting.[76] Appropriate treatment and diversion should be provided in juvenile justice settings followed by routine and periodic screening.

Fragmentation Is a Serious Problem at the State Level

State mental health authorities have enormous responsibility to deliver mental health care and support services, yet they have limited influence over many of the programs consumers and families need. Most resources for people with serious mental illnesses (e.g., Medicaid) are not typically within the direct control or accountability of the administrator of the State mental health system. For example, depending on the State and how the budget is prepared, Medicaid may be administered by a separate agency with limited mental health

expertise. Separate entities also administer criminal justice, housing, and education programs, contributing to fragmented services.

A Comprehensive State Mental Health Plan would create a new partnership among the Federal, State, and local governments and must include consumers and families.

The development of a Comprehensive State Mental Health Plan would create a new partnership among the Federal, State, and local governments and must include consumers and families. To be effective, the plan must reach beyond the traditional State mental health agency and the block grant to address the full range of treatment and support service programs that mental health consumers and their families should have. The planning process should support a respectful, collaborative dialogue among stakeholders, resulting in an extensive, coordinated State system of services and supports.

As States accept increased responsibility for coordinating mental health care, they should have greater flexibility in spending Federal resources to meet these needs. Using a performance partnership model, the Federal government and the State will negotiate an agreement on outcomes. This shift will then give States the flexibility to determine how they will achieve the desired outcomes outlined in their plans.

Aligning relevant Federal programs to support Comprehensive State Mental Health Plans can have the powerful impact of fostering consumers' independence and their ability to live, work, learn, and participate fully in their communities. (*See Recommendations 2.3 and 2.4.*)

Consumers and Families Need Community-based Care

In the 1999 *Olmstead v. L.C.* decision, the U.S. Supreme Court held that the unnecessary institutionalization of people with disabilities is discrimination under the Americans with Disabilities Act.[77] The Court found that:

> "...confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."

President Bush urged promptly implementing the *Olmstead* decision in his 2001 Executive Order 13217, mobilizing Federal resources in support of *Olmstead*. However, many adults and children remain in institutions instead of in more appropriate community-based settings.

On a separate topic, the General Accounting Office (GAO) recently issued a report that illustrates the tragic and unacceptable circumstances that result in thousands of parents being forced to place their children into the child welfare or juvenile justice systems each year so that they may obtain the mental health services they need. Loving and responsible parents who have exhausted their savings and health insurance face the wrenching decision of surrendering their parental rights and tearing apart their families to secure mental health treatment for their troubled children. The GAO report estimates that, in 2001, parents were forced to place more than 12,700 children in the child welfare or juvenile justice systems as the last resort for those children to receive needed mental health care treatment. Moreover,

these numbers are actually an undercount because 32 states, including the five largest, were unable to provide data on the number of children affected.[78]

According to the report, several factors contribute to the consequence of "trading custody for services," including:

- Limitations of both public and private health insurance,
- Inadequate supply of mental health services,
- Limited availability of services through mental health agencies and schools, and
- Difficulties meeting eligibility rules for services.

When parents cede their rights in order to place their children in foster care or in a program for delinquent youth, they may also be inadvertently placing their children at risk for abuse or neglect.[79] These placements also increase the financial burden on State child welfare and juvenile justice authorities. A more family-friendly policy must be found to remedy this situation.

Consumers Face Difficulty in Finding Quality Employment

Only about one-third of people with mental illnesses are employed, and many of them are under-employed.[53] For example, about 70% of people with serious mental illnesses with college degrees earned less than $10 per hour.[80] Overall, people with psychiatric disabilities earned a median wage of only about $6 per hour versus $9 per hour for the general population.[53]

Problems begin long before consumers enter the work force. Many individuals with serious mental illnesses lack the necessary high school and post-secondary education or training vital to building careers. A major study found that youth with emotional disturbances have the highest percentage of high school non-completion and failing grades compared with other disabled groups.[81]

Only about one-third of people with mental illnesses are employed, and many of them are under-employed.

Special education legislation - the Individuals with Disabilities Education (IDEA) Act - was designed to prepare school-aged youth to make the transition to the workplace, but its promise remains largely unfulfilled. Similarly, the Americans with Disabilities Act (ADA) has not fulfilled its potential to prevent discrimination in the workplace. Workplace discrimination, either overt or covert, continues to occur. According to surveys conducted over the past five decades, employers have expressed more negative attitudes about hiring workers with psychiatric disabilities than any other group.[82; 83] Economists have found unexplained wage gaps that are evidence of discrimination against those with psychiatric disabilities.[84]

The Use of Seclusion and Restraint Creates Risks

An emerging consensus asserts that the use of seclusion and restraint in mental health treatment settings creates significant risks for adults and children with psychiatric disabilities. These risks include serious injury or death, re-traumatizing people who have a history of trauma, loss of dignity, and other psychological harm. Consequently, it is inappropriate to use seclusion and restraint for the purposes of discipline, coercion, or staff convenience.

Seclusion and restraint are safety interventions of last resort; they are not treatment interventions. In light of the potentially serious consequences, seclusion and restraint should be used only when an imminent risk of danger to the individual or others exists and no other safe, effective intervention is possible. It is also inappropriate to use these methods instead of providing adequate levels of staff or active treatment.

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WILDER RESEARCH CENTER

SUMMARY

Background on chronic homelessness in Minnesota

Introduction

This fact sheet is based on personal interviews conducted with homeless adults and juveniles on October 24, 2000. It represents the most current data available on the characteristics of homeless persons in Minnesota. The next statewide study of homelessness will be conducted on October 23, 2003. Approximately three months following the completion of data collection, preliminary updated information on homelessness in Minnesota will be available. Both studies represent one-night snapshots of homelessness in our state.

Chronic homelessness

This fact sheet uses the following definition: a person who has been homeless for a period of 12 months or longer is defined as chronically homeless. Children in families who have been homeless for 12 months or longer are also defined as chronically homeless.

Survey facts

The Minnesota Statewide Survey conducted on October 24, 2000 identified 4,410 homeless adults and unaccompanied juveniles who were represented by personal interviews conducted in 288 locations throughout the state. With this group were 3,305 children age 17 or younger.

Of the adults and unaccompanied juveniles represented in the survey, 1,531 (35%) can be described as chronically homeless based on the above definition. This group was accompanied by 1,015 children (31% of the total children represented by the study).

Chronically homeless adults and unaccompanied juveniles

Of the 1,531 adults and unaccompanied juveniles identified as chronically homeless:

- 668 (44%) reported a serious or persistent mental illness
- 458 (30%) reported a chemical dependency problem
- 306 of these (20% of the 1531) reported a dual diagnosis of both mental illness and chemical dependency
- 667 (44%) did *not* have a serious or persistent mental illness or chemical dependency problem

Other conditions likely to affect chronic homelessness

It is believed that chronic health conditions, domestic violence, and criminal history are also likely to affect the length of time a person might be homeless. Of the 1,531 chronically homeless persons:

- 655 (43%) identified a chronic health condition, of whom 239 (16% of the 1,531) did not also have mental illness or chemical dependency
- 227 (15%) had a history of domestic violence, of whom 103 (7%) did not also have mental illness or chemical dependency
- 394 (26%) had a criminal history affecting their housing status, of whom 102 (7%) did not also have mental illness or chemical dependency.

Taking all three of these categories into account, survey results show that of the original 1,531 persons found to be chronically homeless, 348 (23%) have none of the five problems listed above (mental illness, chemical dependency, chronic illness, domestic violence or criminal history).

continued

Children

Of the 1,015 children in families headed by chronically homeless adults and juveniles, 362 (36%) lived with a parent with a serious mental illness, and 99 (10%) lived with a parent with a serious alcohol or chemical dependency problem. In addition, of children with chronically homeless families *without* mental illness or chemical dependency:

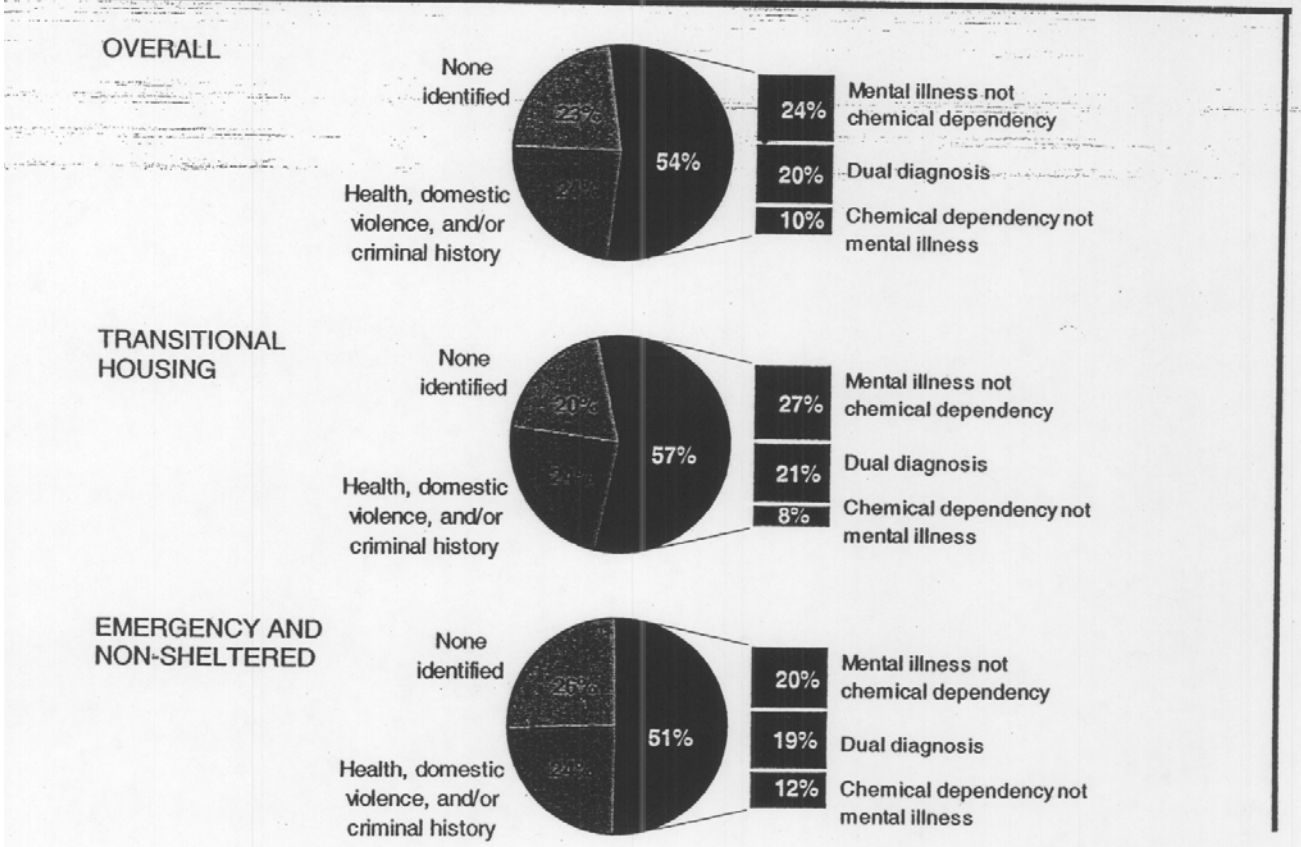
- 207 (20% of the 1,015) lived with a parent with a chronic health problem
- 164 (16%) lived with a parent who had been a victim of domestic violence
- 79 (8%) lived with a parent who had a criminal history

In all, 283 (28%) of the 1,015 children living in chronically homeless families were not affected by any of the five problem areas listed above.

Annual estimates

Attempts to use these data to produce annual estimates of the number of people experiencing chronic homelessness in Minnesota can only provide approximations. There is no reliable methodology for using cross-sectional data to produce annual population estimates. Wilder Research Center uses a conservative approach based on observed Ramsey County annual shelter usage. On this basis we estimate that the number of homeless persons over the course of a full year with any particular characteristic is likely to be at least twice the number of persons found with that characteristic on a single-night survey. Thus, the total number of chronically homeless adults in the year 2000 is estimated to be no fewer than 3,060 and the total number of chronically homeless children in these families would be no fewer than 2,030.

PREVALENCE OF MENTAL ILLNESS/CHEMICAL DEPENDENCY AND OTHER BARRIERS, BY HOUSING TYPE



	Overall		Transitional housing		Emergency and non-sheltered	
	N	%	N	%	N	%
Number homeless > 1 year	1,531	100%	792	100%	739	100%
Mental illness but not chemical dependency	362	24%	216	27%	147	20%
Chemical dependency but not mental illness	152	10%	65	8%	88	12%
Dual diagnosis	306	20%	167	21%	139	19%
TOTAL: Mental illness and/or chemical dependency	*820*	*54%*	*448*	*57%*	*374*	*51%*
Neither mental illness or chemical dependency	711	47%	344	43%	365	49%
Chronic health problems, domestic violence, and/or criminal history (and not mental illness or chemical dependency)	362	24%	186	24%	176	24%
None of these 5 problems identified	348	23%	158	20%	189	26%
Chronic health problems	655	43%	322	41%	333	45%
With mental illness and/or chemical dependency	416	27%	210	27%	206	28%
Without mental illness and/or chemical dependency	239	16%	112	14%	127	17%
Domestic violence*	227	15%	162	21%	65	9%
With mental illness and/or chemical dependency	124	8%	94	12%	30	4%
Without mental illness and/or chemical dependency	103	7%	68	9%	35	5%
Criminal history	394	26%	186	24%	207	28%
With mental illness and/or chemical dependency	292	19%	138	17%	154	21%
Without mental illness and/or chemical dependency	102	7%	48	6%	54	7%

***Notes:** Domestic violence percents shown as proportion of all homeless persons, not just of women. Percents may not total to 100 because of rounding.*

WILDER RESEARCH CENTER

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For more information please contact Ellen Shelton, 651-637-2470 or Greg Owen, 651-647-4612 at Wilder Research Center.
AUGUST 2003

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SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESS WORKING GROUP

Preparation for Meeting 2: Levels of Services and Supportive Housing Models

SUBCOMMITEE MEETING SUMMARY

August 13, 2003

Hosted by the Corporation for Supportive Housing, Hearth Connection and Supportive Housing Consortium. Those in attendance: Janel Bush, MN Department of Human Services; Steve Carlson, Mental Health Resources; Ken Cooper, Union Gospel Mission; Jonathan Farmer, Supportive Housing Consortium; Mary Hartmann, New Foundations; Jennifer Ho, Hearth Connection; Jane Lawrenz, Dakota County; Rhonda McCall, MN Housing Finance Agency; Emily Farah-Miller; MN Department of Human Services; Tonja Orr, MN Housing Finance Agency; Sue Watlov-Phillips Elim Transitional Housing, National Coalition for the Homeless; Christine Reller, Hennepin County; Cherie Shoquist, MN Housing Finance Agency; Barb Sporlein, St. Paul PHA; Diane Sprague, MN Housing Finance Agency; Kevin Turnquist, Hennepin County; and Rich Wayman, Streetworks.

Supportive housing links housing and supportive services to end homelessness and produce better health for families, unaccompanied youth and adults who do not have children with them. Supportive housing is for people who have long-histories of homelessness, complicated by mental illness, chemical dependency, chronic health concerns, including HIV and AIDS, low cognitive skills or traumatic brain injury, histories of abuse and trauma.

Supportive housing comes in many shapes and forms. It can take the form of any residential space, known or not yet conceived. In developing or operating any model, the local community—including people experiencing homelessness—must be involved, and costs and efficiencies must be taken into consideration.

With the proper supports, all of these models can be effective for people with the range of characteristics associated with chronic homelessness. Consumers have preferences along the continuum, including portability between options. Different models may prove to work better for different subgroups of people. Therefore, it is recommended that a plan to increase access to supportive housing invest in a range of options, paying attention to distribution of units along the continuum, and encouraging innovative design.

Shown here are the basic models. All of these housing configurations can be:

- Owned privately and leased as supportive housing, directly to the consumer or through a non-profit;
- Owned by a non-profit or public agency and used as supportive housing;
- Owned by the consumers themselves (though not a likely point-of-entry).

Consumers can live singly, or with others, and those others can be other consumers, or simply others in the community or in their lives. Therefore we see models of shared homes with multiple consumers and home-sharing between, say, the elderly and consumers.

	Scattered Site	Clustered or Mixed	Single Site
Single family homes, duplexes, townhomes, trailers, motor homes, etc.	√	√	√
Apartments	√	√	√
Single Room Occupancy (SRO) or rooming houses	N/A	N/A	√
Other, including farms, campsites, resorts, campuses etc.	N/A	N/A	√

Of note, buildings and/or providers may be licensed, which can be a bridge to mainstream funding. Examples include Board and Lodge and Foster Care.

In the same way that supportive housing has many structural forms, the service strategies employed in supporting people have multiple components, including the areas of support and the service philosophy that guides the approach.

Supportive services can be provided comprehensively by a single agency, or involve collaboration among multiple agencies, including mainstream service providers. Services can be located at a supportive housing site, or be portable. Services need to be flexible and available to people where they live, at the intensity level they want and need (which may vary over time). This may mean site-based programming at site-based housing, or a mix of services in home and at other service locations.

A plan for ending chronic homelessness needs to recognize that different supports are required for different people, or even for the same person at different times. Flexibility is paramount. Availability of a full continuum of supports, whether directly provided or coordinated is essential. The efficacy of different service approaches will be shown when people with long-histories of homelessness are attracted to, participate in and are stable in supportive housing. There is not a body of evidence on which housing and service models are most effective for this group of people, but the principles outlined here are promising approaches nationally.

Supportive services—for families, youth and adults without children with them—can include, but are not limited to:

- Outreach and engagement
- Housing- and tenancy-related support, including access to rental assistance
- Case management, assessment, service planning and coordination
- Independent living skills
- Assistance applying for other programs and benefits
- Employment, education and training

- Financial management
- Chemical dependency support
- Mental health and trauma-related support
- Domestic abuse, violence and safety planning
- Crisis planning and response
- Health care, including HIV/AIDS/STD education and support
- Criminal justice resolution and diversion
- Transportation
- Stress reduction
- Recreation, relationship skills and community and social supports
- Self-advocacy and community building

With families, there are some unique supports:

- Parenting
- Child safety, development, health and education
- Child care
- Respite
- Reunification (which may apply to youth as well)

Service approaches that can be used include:

- Housing first
- Housing ready
- Sobriety/Recovery
- Harm reduction
- Strengths-based or dream-based
- Permanent
- Transitional
- Voluntary
- Mandatory
- Low-demand
- Trauma-informed
- Cultural/Gender/Sexual orientation competency or focus
- Family/Group dynamics
- Consumer involvement
- Consumer run
- Client-centered

There are many service models, some as simple as having a staffed front desk or multidisciplinary teams, and there are programs like safe havens and lodges. In addition, there are some evidence-based techniques that can be used to deliver these services. Examples of these evidence-based practices include:

- Assertive Community Treatment
- Motivational interviewing
- Integrated treatment for MI/CD
- Psychosocial rehabilitation

- Therapeutic communities
- 12-step programs
- Solution-focused treatment

All of these should be enhanced by interagency service coordination and systems change efforts:

- Collaborative planning and monitoring
- Consolidated or coordinated financing
- Cross-training among agencies
- Designating point people
- Processes for conflict resolution
- Accountability mechanisms
- Evaluation, feedback and improvement processes

SUMMARY

1. Invest in a continuum of supportive housing models.
2. Offer access to a broad range of flexible supports.
3. Monitor who is succeeding.
4. Adapt mainstream programs to create, sustain and evaluate supportive housing.

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 2: Levels of Services and Supportive Housing Models

SUMMARY OF INFORMAL MEETINGS

In preparation for Meeting 2 of the Working Group on Supportive Housing, meetings were held between staff of the Department of Human Services, Department of Corrections, and the Minnesota Housing Finance Agency and the following organizations: Anishinabe Wakiagun, American Indian Housing Community Development Corporation, BDC Management, Catholic Charities, Churched United for the Homeless, Dakota County, Disability Law Center, Hennepin County, Minnesota Association of Runaway Youth Services, People Incorporated, RS Eden, Ramsey County, Runaway Homeless Youth Coalition, St. Stephen's, Streetworks, Union Gospel Mission, Veterans Administration, Wilder Foundation, and others.

Summary points on supportive housing models and best practices follow. Where possible, it is noted if more than one group made the same or similar comment.

CHOICE AND OTHER GENERAL COMMENTS

Maximize consumer choice and preference; need the entire range. (8)

- Needs vary for each individual. Need to work towards informed decisions with real options; people should not be placed in housing types they don't want to live in. Families need to be in charge of their own lives and choose the services they need when they are ready; some may view services as interference with life.
- Need housing and services. Do not need a program.
- Need housing before services.

Need nurturing mentors, volunteers, coaches, and success stories are important. (4)

- These help build relationships and engagement and trust.
- Need long-term support.

Services should be tied to the person, not to the unit. (3)

- Services are the challenge not the housing.

Must keep people housed no matter what. (4)

- Alternatives must be available for those who are unsuccessful in one model.
- Participation in services should not be a condition of maintaining housing; people should not have to "earn" housing.
- If psychiatric decompensation occurs, bring in more services rather than move individual.

HOUSING

Affordable stable housing is the key to success. (2)

The biggest gap in housing is high tolerance low expectation housing. (2)

Long-term housing fosters sense of community and long-term relationships. (2)

- For persons who chronically suffer from a mental illness, security, sense of community, chance to form ongoing relationships, and freedom from pressure of constantly moving is more important than treatment.
- People need a stake in the operation of their housing.

Location is key, near transportation and near services, near a drop in site. (3)

- If located in some neighborhoods, some people will never leave their apartment because they are terrified to.

Community space equals community. (3)

- Other strategies such as newsletter, shared kitchen, group activities can also build community.
- Group meetings are beneficial if even people don't like them, then they get to know each other and it helps make the building run smoother.
- Meeting or office space on site, may be crucial for some populations but most may not need or want it and in the long term will hate it – they feel watched.

Integration in the community is important. (4)

SMALL SINGLE SITE

Housing at 8-10 units, not more than 16 units are ideal for SPMI.

Less than 12 units, with off site services, provides long-term stability.

People need privacy, a door they can lock; own bathroom is preferable. (3)

Shared housing with private room is beneficial for some; only with right mix of people. (3)

Office to serve people in is helpful in congregate settings. (2)

MEDIUM SINGLE SITE

Intensive service models are expensive, need 18-20 units to make it work. (4)

People making their own choices are choosing intensive services or assisted living.

Best option for chronic alcoholics.

LARGE SINGLE SITE

Need to measure turn over and stability for residents in large apartment buildings. (3)

SROs

SROs are economically efficient from management standpoint and are inexpensive for residents. (2)

- Need observation of residents in order to have early notification of issues.

Right mix of disabled, low-income, and others is crucial. Times Square Apartments is a good example of the right mix. (2)

- SROs are ideal for people who have been on the street for a long time.
- Recommend small refrigerator and microwave in units. No stoves.
- Private bathrooms are preferable. (3)
- Shared common space and kitchens ok with the right mix of people. (3)
  Contrary view: Shared kitchens cause too much conflict. (1)

SCATTERED SITE

Scattered site is good for people who can function with minimal structure. (2)

People with serious mental illness are too isolated in scattered site housing. (2)

- People with MI overvalue negative experiences so do not put them in a position of failure with scattered site.

Scattered site would not work for chronic alcoholics; may work for recovering alcoholics. (4)

HARM REDUCTION

Need harm reduction models: (5)

- Safe havens or day centers with street outreach,
- Shower, laundry, storage, build engagement and outreach

Need safe havens specifically for youth. (2)

Harm reduction needs to include wet/dry housing. (5)

- Hennepin County Study shows system cost savings. (4)
- Need stealth services; may need to focus first on physical health.

A graduated (tiered) housing system works well that includes safe haven, short-term and permanent harm reduction housing and permanent supportive housing with the ability to go up and down the tiers depending on steps of progress. Include opportunities for people to leave and stay outside for a few days and come back, preferable to the same room. (4)

- Need low expectation high tolerance housing.
- Need psychologist or psychiatric nurse on site for the harm reduction model.
- Moving from the street into an apartment can be very overwhelming, management of space is overwhelming.
- A model that allows people to pay one day at a time is psychologically important.

SERVICES

A watchful eye who can recognize challenging circumstances at early stages is crucial. (6)

- Particularly for the chronic MI/CD population who is very vulnerable
- Traditional case management for MI can be too little too late.
- Crisis are not scheduled, need 24-hour availability.
- Need a critical mass for cost effectiveness.
- Preferable to on-site case management or resident coordinator.

Traditional case management broker model is inadequate; rehab model with hands-on direct provider of services is preferable. Need to avoid duplication of services. (2)

Resident coordinators provide advocacy, case management and referral to services. (2)

It is crucial to bring services to the person, often won't receive otherwise. (5)

- Psychiatric care, nursing services, and social work were specifically identified as needing to be brought to the individual. Medication, housekeeping, independent living, health services and possibly food were also specifically identified as needing to be on site.
- Evidence based treatment and measurable outcomes.

Life skills needed, particularly to build relationship and communication skills, because people stop maturing at age at which they start abusing drugs or alcohol. (3)

- Need supported work models, vocational supports, and employment opportunity helps break down barriers and isolation.
- There are not enough integrated treatment programs.
- Follow up after people are placed in housing.
- Level of services may not impact stability.

Up-front assessment and intensive services are important although costly and time (4)

intensive.

SERVICES FUNDING

MA to the person not the county.
Improve access to MA and SSI.
Representative payee may be necessary with SSI.
Identify areas of problems with state law that need to be changed to help fund supportive housing services.
Increase Community Alternatives for Disabled Individuals (CADI) waiver slots. CADI waivers were working.
ARMHS – separate and in addition to CADI waivers.
Meals can be an issue - MA does not pay for meals other than preparations.
Assertive Community Treatment.
MSA shelter needy is grossly underutilized.
MA reimbursable services - CADI Waiver, Personal Care Attendant (PCA) and Home Health Care.
Shelter Plus Care.
Group Residential Housing (GRH) Demonstration Project.
Targeted Case Management.
Many non-MA eligible people need intensive service teams.
Need to have a lump-sum for all services that are provided to the individual or family.

HOUSING FUNDING:

Need to change HUD policy excluding drug and criminal offenders.
Incentives for suburban communities to accept supportive housing.
Look at the issue of super majority for zoning.
Need shallow rent supports.
Bridges.
Housing Trust Fund.
Need tenant based and project based rental subsidies - priority to social service recipients.
Funding should be allocated to serve chronically homeless – it is a challenge to provide stealth services – community mental health, nurses, path workers – need to serve people in the field.

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SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 2: Levels of Services and Supportive Housing Models

SERVICE CHOICES AND HOUSING OPTIONS

Goal: Make available housing and service options that allow families and individuals who have experienced chronic homelessness to be successfully housed over the long-term.

Principles:

1. Maximize choice of housing and services for families and individuals; ensure flexible housing and service options that respond to need.
2. Encourage families and individuals to utilize services, but don't mandate services as a condition tenancy.
3. Utilize innovative practices that result in cost containment and use evidence-based models for services and housing that have demonstrated positive results.
4. Prioritize models that integrate families and individuals into communities, near public transportation and services.
5. Provide the necessary housing tenancy supports to find and maintain housing, a critical service need for people who have experienced chronic homelessness.

Target Population:

An individual or adult family member with: mental illness, chemical dependency, co-occurring mental illness and chemical dependency, chronic health conditions (including HIV/AIDS), cognitive limitations, domestic violence, abuse or neglect, or criminal history who has either lacked a permanent place to live continuously for a year or more, or has lacked a permanent place to live at least four times in the past three years, or prior to any incarceration or institutionalization.

Service Choices:

Types of services: information and referral, outreach and engagement, health related and home health services, alcohol and drug abuse services, mental health and counseling services, inpatient services, supportive case management services, intensive case management services, income management and support, residential treatment services, discharge planning, life skills, child care, education and training, employment, legal and transportation. *Ending Chronic Homelessness, Strategies for Action, Department of Health and Human Services, Report from the Secretary's Work Group on Ending Chronic Homelessness, March 2003.* Also, child protections services or correctional supervision may be required.

Housing Options:

Provide housing through a range of options: leasing rental units, rehabilitating existing units, and developing new units. All housing must be affordable. Types of housing: Scattered -site single family homes, townhouses, duplexes (may be shared) or apartments; clustered apartments; small single-site developments (4-12 units); medium single-site development (13-30 units); large single-

site apartment building (31+ units); single-site SRO: single room occupancy (bath, shared kitchen); or other housing types.

Recommendations on a range of service choices and an array of housing options for consideration by the Supportive Housing Working Group are organized separately for Families and for Individuals/ Unaccompanied Youth in three levels: (1) Outreach & Engagement, (2) Intensive Services and (3) Stabilization.

The following two tables provide an overview of service choices and housing options for families and for individuals/unaccompanied youth. The next tables provide more detailed information for each.

OVERVIEW: FAMILIES		
OUTREACH & ENGAGEMENT		
SERVICE CHOICES	**HOUSING OPTIONS**	**EXAMPLES**
Range of Services	Housing first, services second.	NA
INTENSIVE SERVICES		
SERVICE CHOICES	**HOUSING OPTIONS**	**EXAMPLES**
Range of Services See page 3	**Single Site –** Medium-Large development 16-36 units (up to 50 units) **Clustered Sites** - A number of single family homes, townhouses, duplexes or apartments in the same building or neighborhood **Scattered Site -** Single family homes, townhouses, duplexes or apartments	See page 3
STABILIZATION		
SERVICE CHOICES	**HOUSING OPTIONS**	**EXAMPLES**
Range of Services See page 4	**Single Site –** Medium-Large development 16-36 units (up to 50 units) **Clustered Sites** - A number of single family homes, townhouses, duplexes or apartments in the same building or neighborhood **Scattered Site** - Single family homes, townhouses, duplexes or apartments	See page 4

OVERVIEW: INDIVIDUALS / UNACCOMPANIED YOUTH		
OUTREACH & ENGAGEMENT		
SERVICE CHOICES	**HOUSING OPTIONS**	**EXAMPLES**
Range of Services See page 5	**Safe Haven/ Harm Reduction -** Drop in site with meals, shower, laundry, secure storage, phone, single rooms for single night, rooms with private bath **Scattered Site** - Single family homes, townhouses, duplexes or apartments	See page 5

INTENSIVE SERVICES		
SERVICE CHOICES	**HOUSING OPTIONS**	**EXAMPLES**
Range of Services See page 6	**Single Site –** Small development, 16 units or less or Medium-Large development 31 units or more **Clustered Sites** - A number of single family homes, townhouses, duplexes or apartments in the same building or neighborhood **Scattered Site -** Single family homes, townhouses, duplexes or apartments	See page 6

STABILIZATION		
SERVICE CHOICES	**HOUSING OPTIONS**	**EXAMPLES**
Range of Services See page 7	**Single Site –** Small development, 16 units or less or Medium-Large development 31 units or more **Clustered Sites** - A number of single family homes, townhouses, duplexes or apartments in the same building or neighborhood **Scattered Site** - Single family homes, townhouses, duplexes or apartments	See page 7

SERVICE CHOICES AND HOUSING OPTIONS

FAMILIES

INTENSIVE SERVICES

SERVICE CHOICES	HOUSING OPTIONS	EXAMPLES
Individualized plan of care that may include one or more of the following: Medical and psychiatric services Medication management and monitoring CD treatment and relapse prevention Integrated MH/CD services Independent living skills Crisis services and response Peer support services Transportation Employment, education and training Financial Management Assistance applying for benefits Legal services Community involvement Recreational activities Child related services: Parenting Child safety, development, Health and education Child Care Respite Reunification Services for children Housing tenancy support	**SINGLE SITE** Services on site: front desk, 1-2 office spaces for external providers, connection to crisis providers, dual diagnosis or CD treatment and relapse prevention, support groups, and possibly child care Considerations: - Smaller is better from a community building stand point, however, larger is better from the standpoint of development and operating cost efficiencies - Service economy of scale - Safe environment - Opportunity to see others succeed - Families may choose to leave community as they stabilize, or may wish to leave community due to issues with oversight **CLUSTERED SITES** Services to site: Assertive Community Treatment or case management, other services as needed, likely medical, dental and psychiatric services will need to be off site with staff, dual diagnosis or CD treatment and relapse prevention, support groups with child care and transportation Considerations: - Capture economy of service delivery with same benefits as scattered site **SCATTERED SITE** Services to site: Assertive Community Treatment or case management, other services as needed likely medical, dental and psychiatric services will need to be off site with staff, dual diagnosis or CD treatment and relapse prevention, support groups with child care and transportation Considerations: - Service delivery to unit may be inefficient and costly - Families may feel isolated - May not be appropriate immediately following treatment - Families remain in community as they stabilize	Portland Village, Minneapolis Perspectives, St. Louis Park New Foundations Crestview, East St. Paul Blue Earth County Hearth Connection Pilot NA Ramsey County Hearth Connection Pilot Blue Earth County Hearth Connection Pilot Wilder ROOF Project, Ramsey County

SERVICE CHOICES AND HOUSING OPTIONS

FAMILIES		
STABILIZATION		
SERVICE CHOICES	**HOUSING OPTIONS**	**EXAMPLES**
Ongoing support as determined on an individual level including one or more of the following: Medical and psychiatric services Medication monitoring as needed Relapse, crisis prevention and recovery maintenance Employment, education and training Community involvement Recreational activities Child related services Child safety, development, Health and education Child Care Services for children Housing tenancy support	**SINGLE SITE** Services on site reduced, off site as needed Considerations: - Smaller is better from a community building standpoint, however, larger is better from the standpoint of development and operating cost efficiencies - Reduction in services may inhibit the economy of scale - Stabilized families may provide hope and support to other families - Families may be resistant to change when they are otherwise ready to leave the community **CLUSTERED SITES** Services as needed Considerations: - Capture economy of service delivery with same benefits as scattered site **SCATTERED SITE** Services as needed Considerations: - Families are prepared to function in the community and identify and access services as needed	New Foundations Crestview, East St. Paul NA Wilder ROOF Project, Ramsey County

SERVICE CHOICES AND HOUSING OPTIONS

INDIVIDUALS / UNACCOMPANIED YOUTH		
OUTREACH & ENGAGEMENT		
SERVICE CHOICES	**HOUSING OPTIONS**	**EXAMPLES**
Initial Assessment: Consistent outreach worker or drop in center staff establish a trusting relationship On site assessment and services: psychiatric, chemical dependency, psychosocial/ functional, medical and suitable housing Crisis Intervention: Crisis plan and response Domestic abuse safety planningFlexible Funds to provide resources, food, clothing, Emergency Assistance, etc. Case Management/Service Coordination: Accessing benefits, assistance with completing applications, advocating for individual Medication management and monitoring Accompanying individual to appointments Independent living skills Supported work Youth need a one-to-one mentor Housing tenancy support	**SAFE HAVEN / HARM REDUCTION** On site services, assessment services, and front desk and/or security, highly tolerant property management, nurses or doctors in field or on site Considerations: - A tiered, or phased approach may be most appropriate to engage individuals who have MI/CD and have lacked housing for 12 months or more - Some benefit only by ability to commit to housing one night or one week at a time - Youth may need crisis intervention for basic needs, CD treatment - Creates a sense of community and reduces isolation **SCATTERED SITE** Services as needed provided on site or in the community, highly tolerant property management Considerations: - May not be appropriate without services in addition to tenancy supports if directly from street or shelter - Isolation	St. Columba Project H.O.M.E., Philadelphia Pathways, NYC

SERVICE CHOICES AND HOUSING OPTIONS

INDIVIDUALS / UNACCOMPANIED YOUTH		
INTENSIVE SERVICES		
SERVICE CHOICES	**HOUSING OPTIONS**	**EXAMPLES**
Individualized plan of care that may include one or more of the following: Medical and psychiatric services Medication management and monitoring CD treatment and relapse prevention Integrated MH/CD services for persons who have co-occurring disorders Independent living skills Crisis services and response Peer support services Transportation Employment, education and training Supported work Financial Management Assistance applying for benefits Legal services Community involvement Recreational activities Watchful eye (low level monitoring by on site staff) Housing tenancy support Youth need a one-to-one mentor	**SINGLE SITE** Services on site: front desk, 1-2 office spaces for external providers, connection to crisis providers, possibly dual diagnosis or CD treatment and relapse prevention, support groups Considerations: - Difficulty siting - Careful attention to the mix of residents - Licensing and registration **CLUSTERED SITES** Services to site: Assertive Community Treatment or case management, other services as needed likely medical, dental and psychiatric services, CD treatment and relapse prevention, will need to be off site with staff Considerations: - Capture economy of service delivery with same benefits as scattered site **SCATTERED SITE** Services to site: Assertive Community Treatment or case management, other services as needed likely medical, dental and psychiatric services, CD treatment and relapse prevention, will need to be off site with staff Considerations: - Service delivery may be inefficient and costly - Services delivered to meet needs of individual not the funding requirements	Anishinabe Wakaigun, Minneapolis Alliance Apartments, Minneapolis 7th Landing, St. Paul Community Involvement Program (CIP), Hennepin County Ramsey County Hearth Connection Pilot Stevens Court, Mental Health Resources, Minneapolis Ramsey County Hearth Connection Pilot Pathways, NYC

SERVICE CHOICES AND HOUSING OPTIONS

INDIVIDUALS AND YOUTH		
STABILIZATION		
SERVICE CHOICES	**HOUSING OPTIONS**	**EXAMPLES**
Services as Needed Ongoing support as determined on and individual level: Medical and psychiatric services Medication monitoring as needed Relapse, crisis prevention, and recovery maintenance Employment, education and training Supported work Community involvement Recreational activities Youth need one-to-one mentorship Watchful eye (low level monitoring by on site staff) Housing tenancy support	**SRO SINGLE ROOM OCCUPANCY** Private bath, shared kitchen Minimal service staff on site: front desk coverage and/or service coordinator, other services in the community possibly including CD recovery maintenance Considerations: - Difficulty siting - Careful attention to the mix of residents - Minimal rules for success **CLUSTERED SITES** Services as needed to site or in the community possibly including CD recovery maintenance Considerations: - Capture economy of service delivery with same benefit as scattered site **SCATTERED SITE** Services as needed to site or in the community possibly including CD recovery maintenance Considerations: - Stable housing in the community	American House Wilder Apartments at Snelling Community Involvement Program (CIP) Hennepin County Ramsey Hill, Mental Health Resources Pathways, NYC

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Models of Supportive Housing

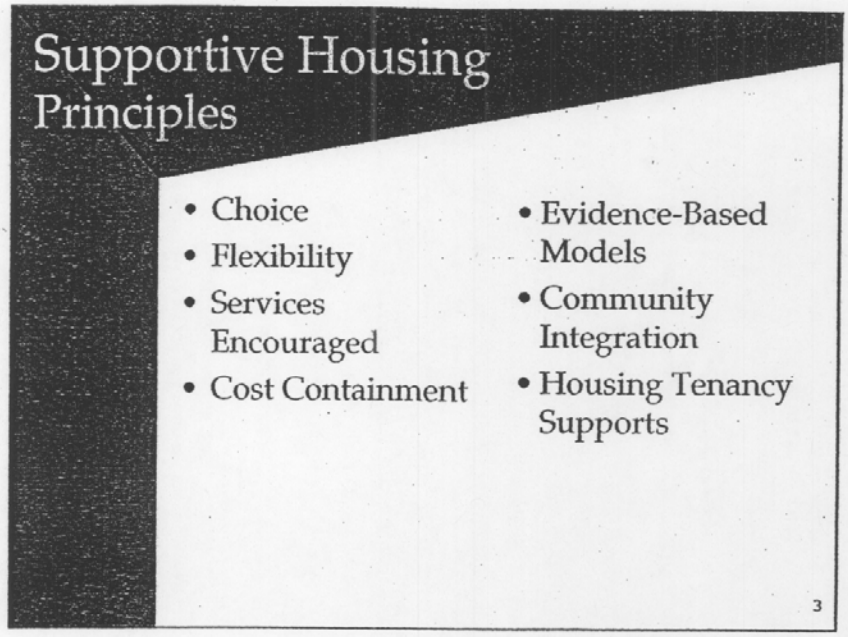
Working Group on Supportive Housing For Persons Experiencing Chronic Homelessness

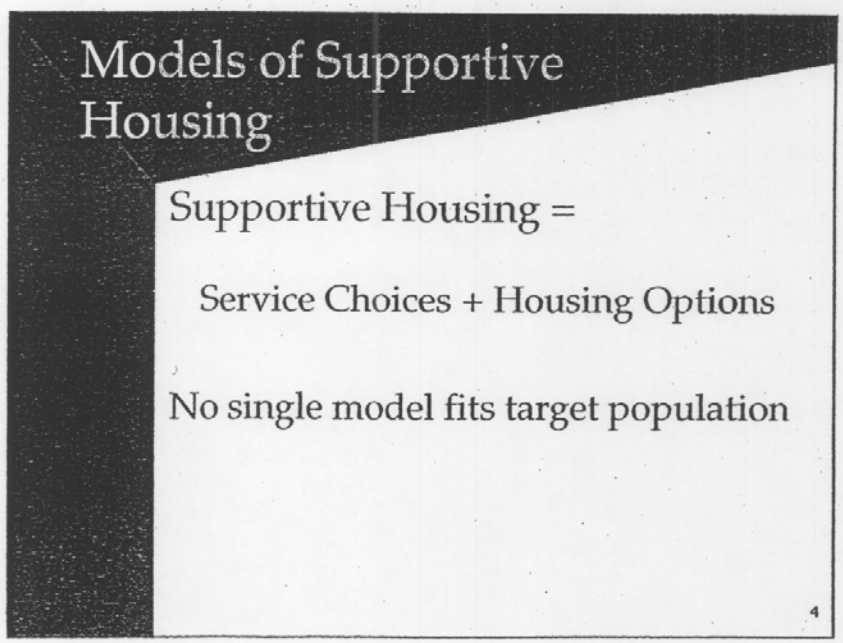
September 3, 2003

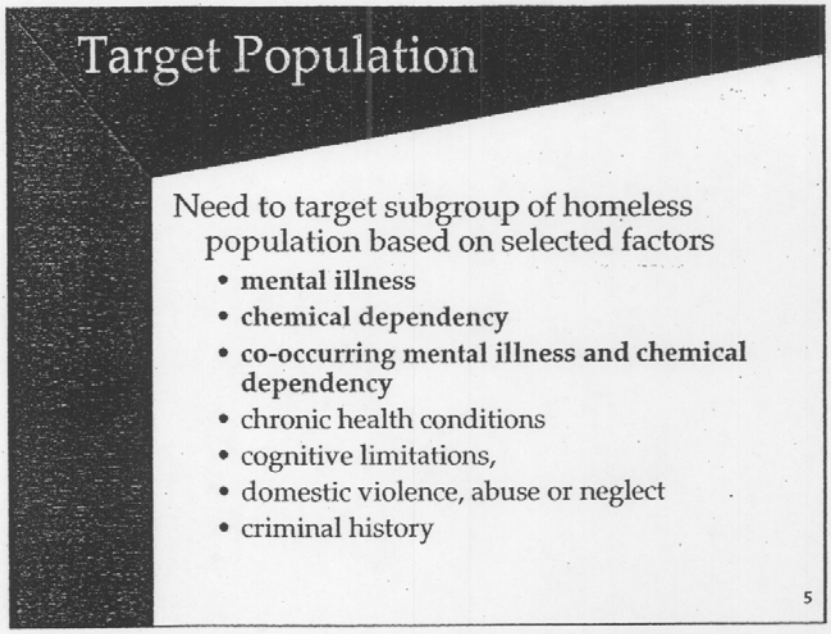
Supportive Housing Goal

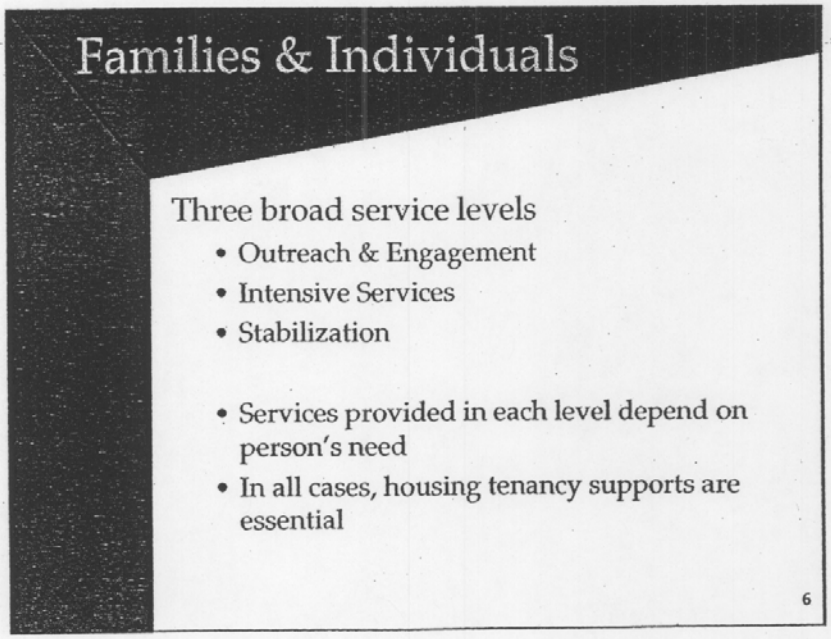
Make available housing and service options that allow families and individuals who have experienced chronic homelessness to be successfully housed over the long-term.

2


Supportive Housing Principles
• Choice
• Flexibility
• Services Encouraged
• Cost Containment
• Evidence-Based Models
• Community Integration
• Housing Tenancy Supports
3


Models of Supportive Housing
Supportive Housing =
Service Choices + Housing Options
No single model fits target population
4


Target Population
Need to target subgroup of homeless population based on selected factors
• mental illness
• chemical dependency
• co-occurring mental illness and chemical dependency
• chronic health conditions
• cognitive limitations,
• domestic violence, abuse or neglect
• criminal history
5


Families & Individuals
Three broad service levels
• Outreach & Engagement
• Intensive Services
• Stabilization
• Services provided in each level depend on person's need
• In all cases, housing tenancy supports are essential
6

Families- Outreach & Engagement

Housing First
Services Second

7

Families- Intensive Services

Service Choices

- Individualized plan of care including a full range of service choices
  - Intensive case management
  - Assertive Community Treatment

Housing Options

- **Single Site** – Medium-Large development 16-36 units (up to 50 units)
- **Clustered Sites** - A number of single family homes, townhouses, duplexes or apartments in the same building or neighborhood
- **Scattered Site** - Single family homes, townhouses, duplexes or apartments

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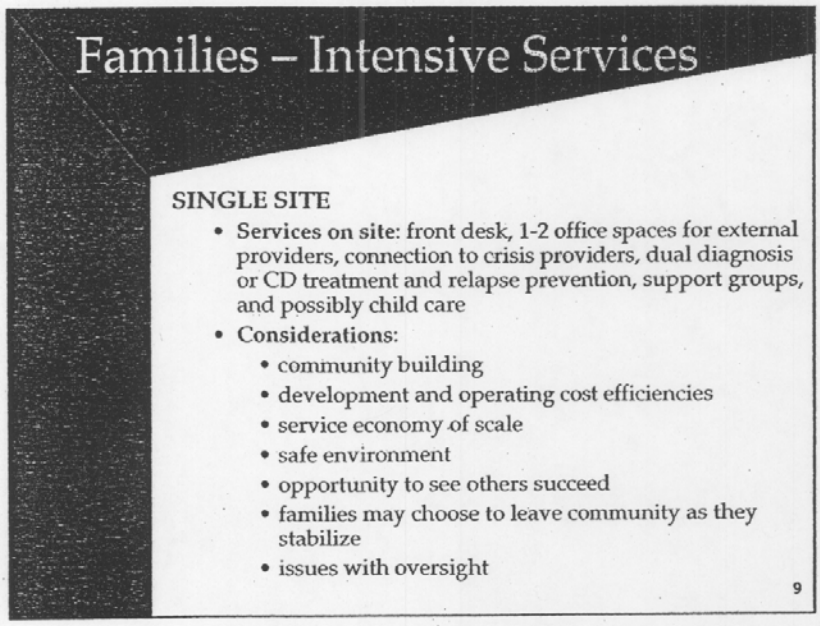
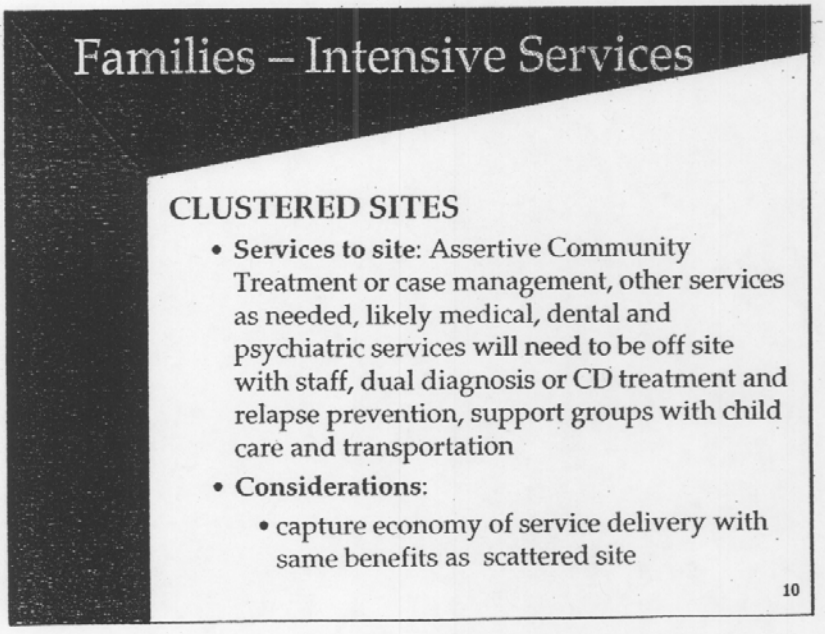
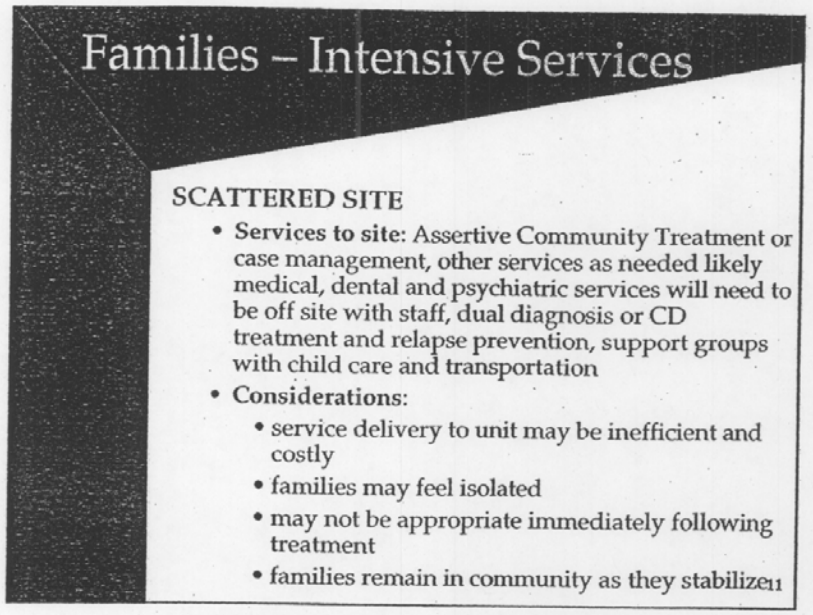
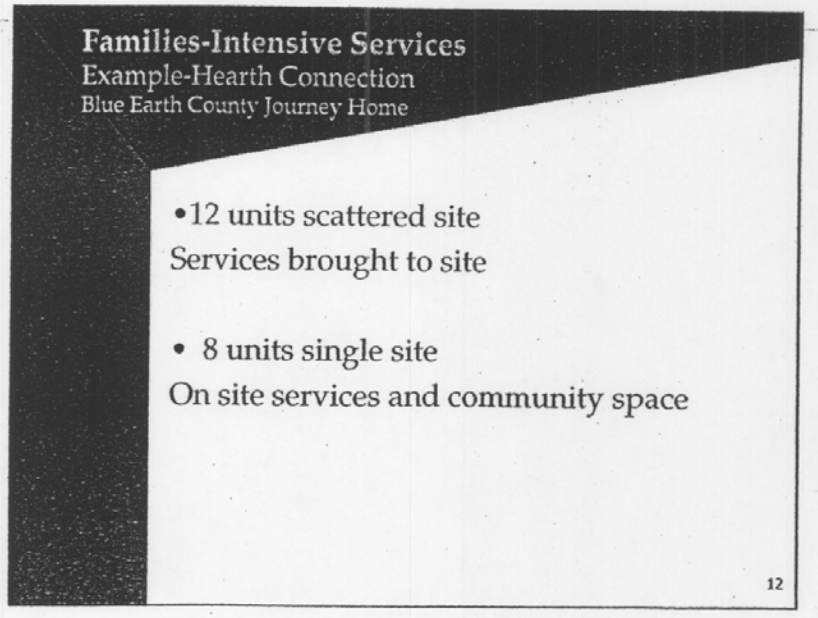
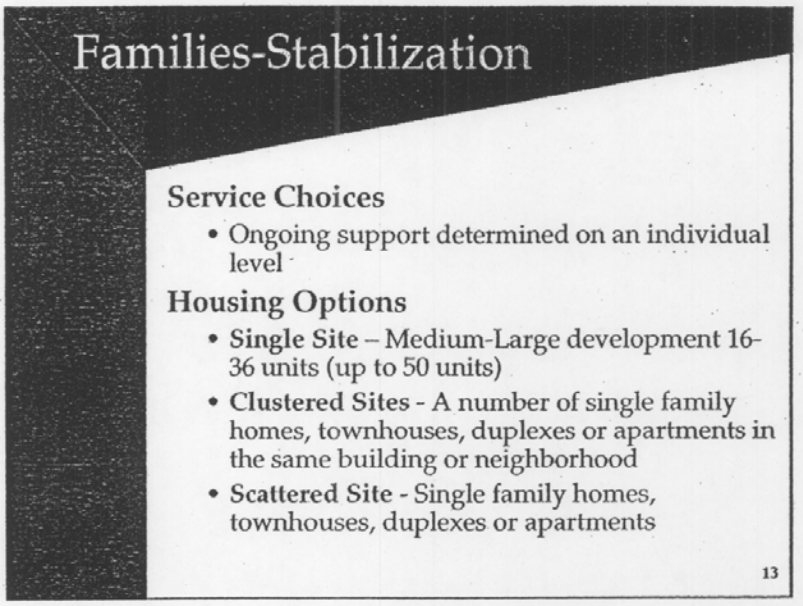

Families – Intensive Services
SINGLE SITE
• Services on site: front desk, 1-2 office spaces for external providers, connection to crisis providers, dual diagnosis or CD treatment and relapse prevention, support groups, and possibly child care
• Considerations:
• community building
• development and operating cost efficiencies
• service economy of scale
• safe environment
• opportunity to see others succeed
• families may choose to leave community as they stabilize
• issues with oversight
9


Families – Intensive Services
CLUSTERED SITES
• Services to site: Assertive Community Treatment or case management, other services as needed, likely medical, dental and psychiatric services will need to be off site with staff, dual diagnosis or CD treatment and relapse prevention, support groups with child care and transportation
• Considerations:
• capture economy of service delivery with same benefits as scattered site
10


Families – Intensive Services
SCATTERED SITE
• Services to site: Assertive Community Treatment or case management, other services as needed likely medical, dental and psychiatric services will need to be off site with staff, dual diagnosis or CD treatment and relapse prevention, support groups with child care and transportation
• Considerations:
• service delivery to unit may be inefficient and costly
• families may feel isolated
• may not be appropriate immediately following treatment
• families remain in community as they stabilize
11


Families-Intensive Services
Example-Hearth Connection
Blue Earth County Journey Home
•12 units scattered site
Services brought to site
• 8 units single site
On site services and community space
12


Families-Stabilization
Service Choices
• Ongoing support determined on an individual level
Housing Options
• Single Site – Medium-Large development 16-36 units (up to 50 units)
• Clustered Sites - A number of single family homes, townhouses, duplexes or apartments in the same building or neighborhood
• Scattered Site - Single family homes, townhouses, duplexes or apartments
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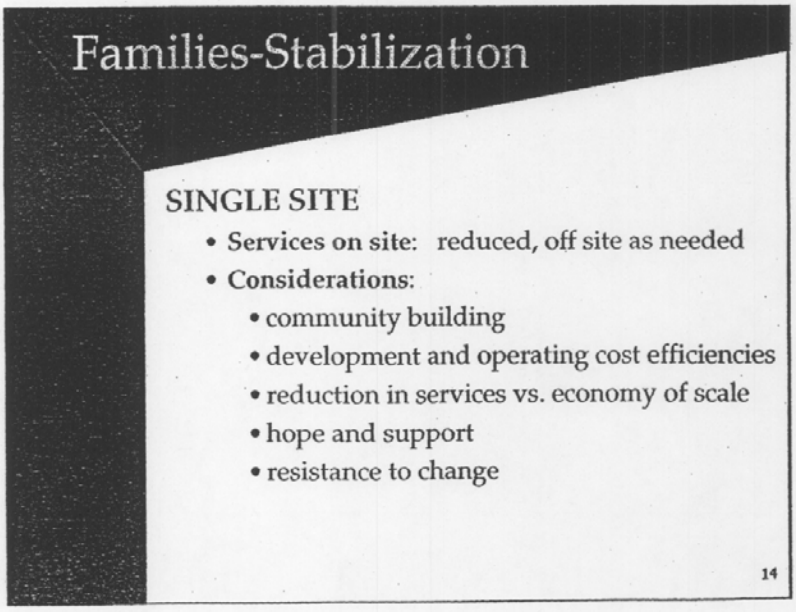
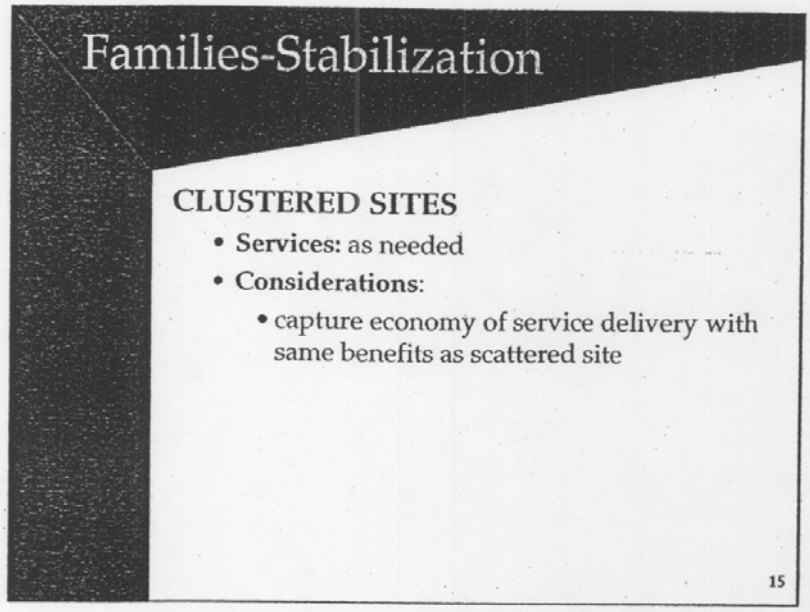
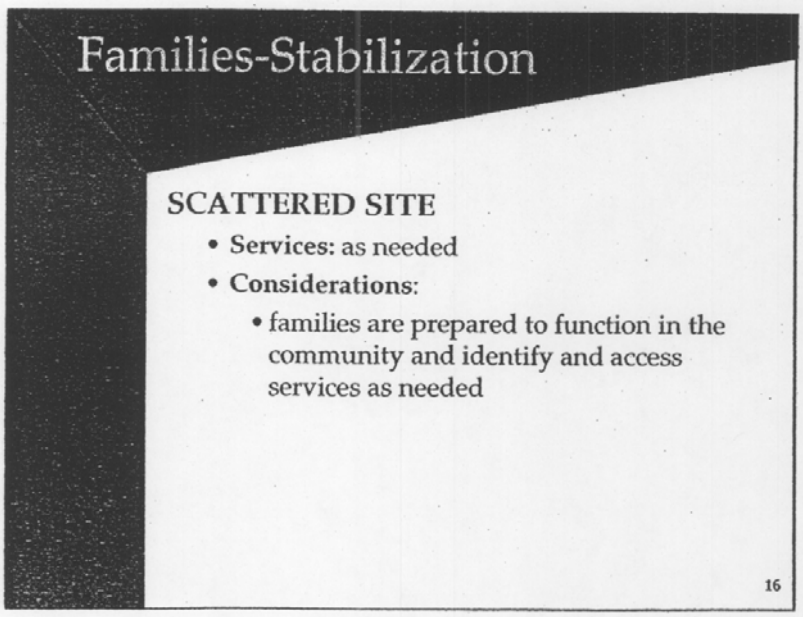
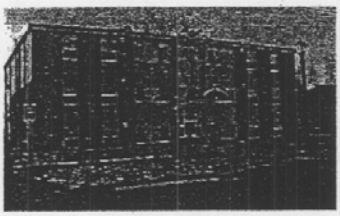

Families-Stabilization
SINGLE SITE
• Services on site: reduced, off site as needed
• Considerations:
• community building
• development and operating cost efficiencies
• reduction in services vs. economy of scale
• hope and support
• resistance to change
14


Families-Stabilization
CLUSTERED SITES
• Services: as needed
• Considerations:
• capture economy of service delivery with same benefits as scattered site
15


Families-Stabilization
SCATTERED SITE
• Services: as needed
• Considerations:
• families are prepared to function in the community and identify and access services as needed
16

Families-Stabilization
Example-New Foundations Crestview

- Single site apartments
- 31 units
- Comprehensive services on site available 24 hours



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Individuals- Outreach & Engagement

Service Choices

- Full range of service choices
  - Assessment
  - Crisis intervention
  - Case management/service coordination

Housing Options

- **Safe Haven/ Harm Reduction** - Drop in site with meals, shower, laundry, secure storage, phone, single rooms for single night, rooms with private bath
- **Scattered Site** - Single family homes, townhouses, duplexes or apartments

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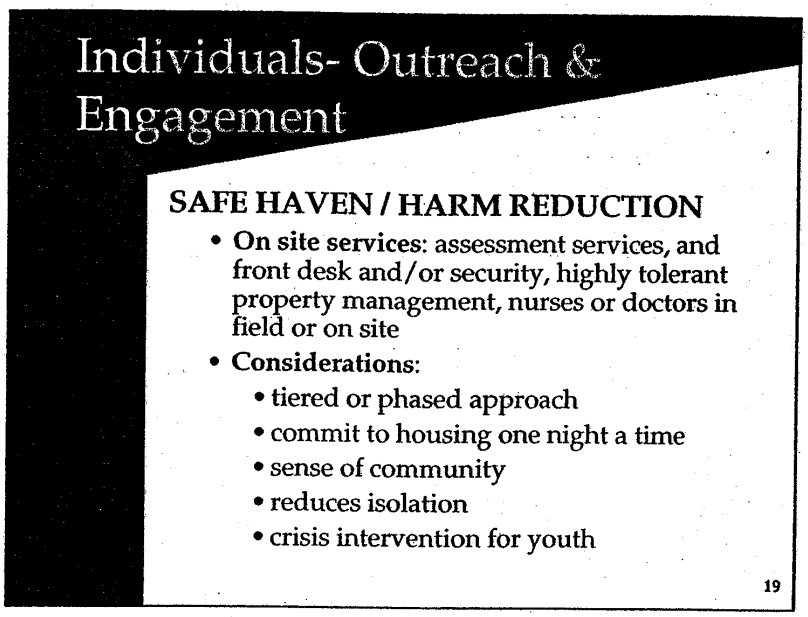
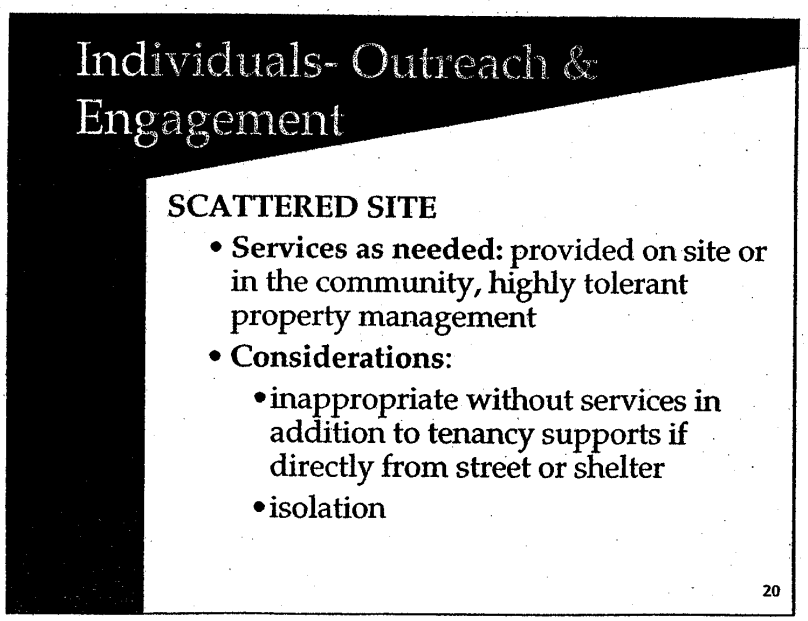
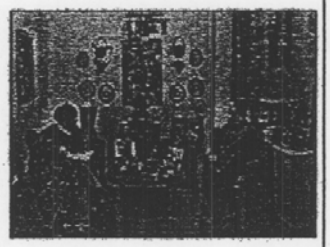

Individuals- Outreach & Engagement
SAFE HAVEN / HARM REDUCTION
• On site services: assessment services, and front desk and/or security, highly tolerant property management, nurses or doctors in field or on site
• Considerations:
• tiered or phased approach
• commit to housing one night a time
• sense of community
• reduces isolation
• crisis intervention for youth
19


Individuals- Outreach & Engagement
SCATTERED SITE
• Services as needed: provided on site or in the community, highly tolerant property management
• Considerations:
• inappropriate without services in addition to tenancy supports if directly from street or shelter
• isolation
20

Individuals-Outreach & Engagement
Example-Pathways to Housing, NY

- Independent scattered site
- 450 units
- Assertive Community Treatment (ACT)
- Employment Services



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Individuals- Intensive Services

Service Choices

- Full range of service choices
  - Assessment
  - Crisis intervention
  - Case management/service coordination

Housing Options

- **Single Site** – Small development, 16 units or less or Medium-Large development 31 units or more
- **Clustered Sites** - A number of single family homes, townhouses, duplexes or apartments in the same building or neighborhood
- **Scattered Site** - Single family homes, townhouses, duplexes or apartments

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Individuals- Intensive Services

SINGLE SITE

- **Services on site**: front desk, 1-2 office spaces for external providers, connection to crisis providers, possibly dual diagnosis or CD treatment and relapse prevention, support groups
- **Considerations**:
  - difficulty sitting
  - careful attention to the mix of residents
  - licensing and registration

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Individuals- Intensive Services

CLUSTERED SITES

- **Services to site**: Assertive Community Treatment or case management, other services as needed likely medical, dental and psychiatric services, CD treatment and relapse prevention, will need to be off site with staff
- **Considerations**:
  - capture economy of service delivery with same benefits as scattered site

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Individuals- Intensive Services

SCATTERED SITE

- **Services to site**: Assertive Community Treatment or case management, other services as needed likely medical, dental and psychiatric services, CD treatment and relapse prevention, will need to be off site with staff
- **Considerations**:
  - service delivery may be inefficient and costly
  - services delivered to meet needs of individual not the funding requirements

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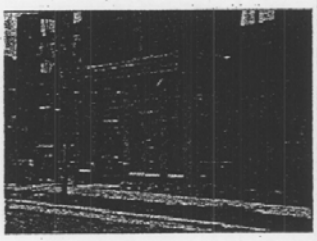
Individuals-Intensive Services
Example-Alliance Apartments

- Single site apartments
- 100 permanent units
- 24 transitional units
- On-site staff 8-12 hours/day



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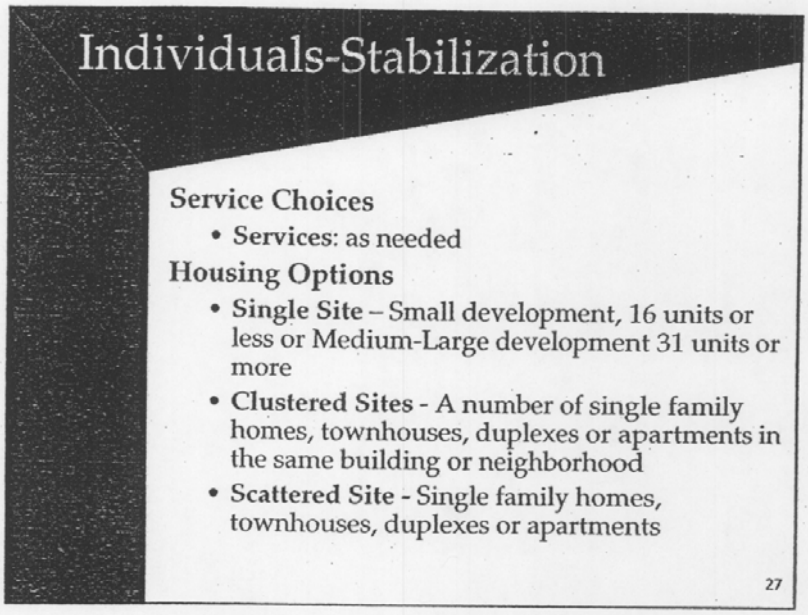
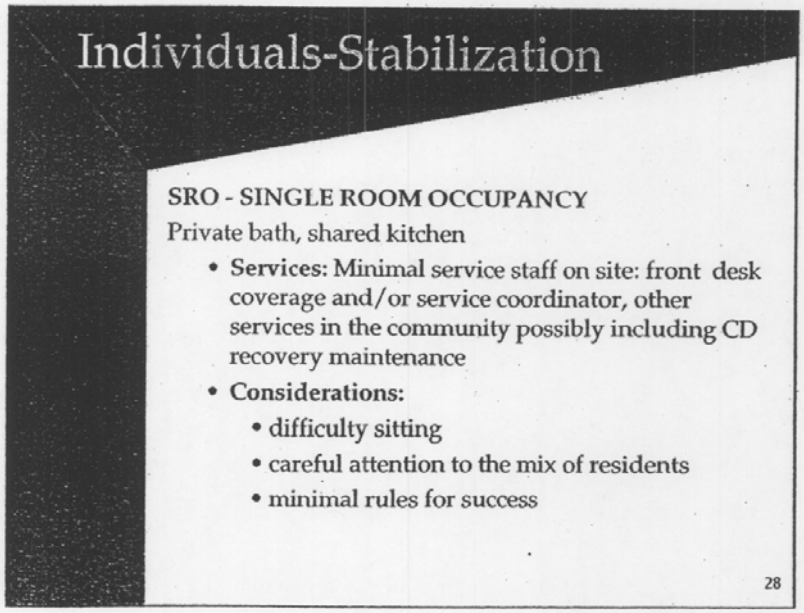
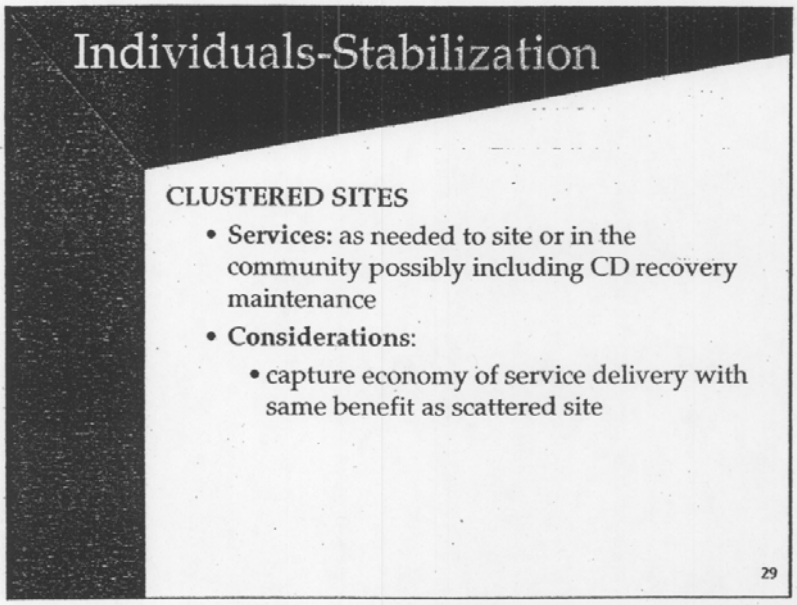
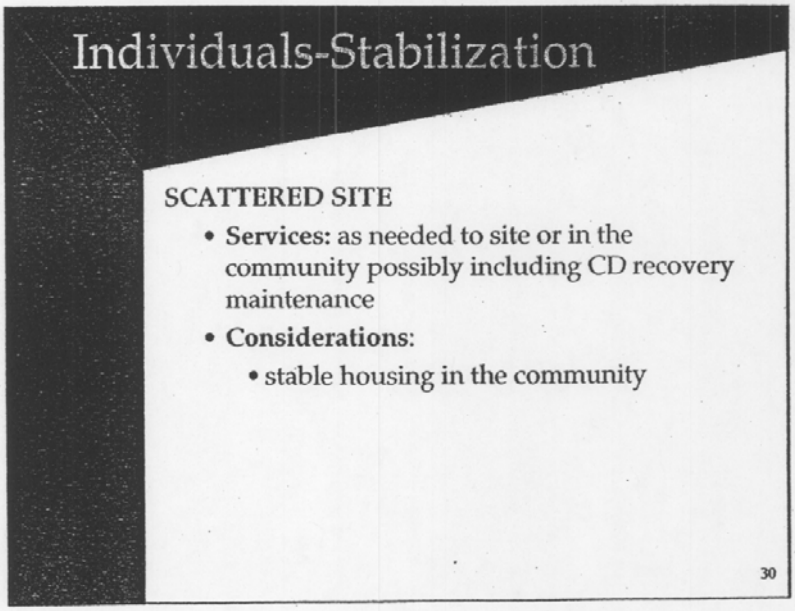

Individuals-Stabilization
Service Choices
• Services: as needed
Housing Options
• Single Site – Small development, 16 units or less or Medium-Large development 31 units or more
• Clustered Sites - A number of single family homes, townhouses, duplexes or apartments in the same building or neighborhood
• Scattered Site - Single family homes, townhouses, duplexes or apartments
27


Individuals-Stabilization
SRO - SINGLE ROOM OCCUPANCY
Private bath, shared kitchen
• Services: Minimal service staff on site: front desk coverage and/or service coordinator, other services in the community possibly including CD recovery maintenance
• Considerations:
• difficulty sitting
• careful attention to the mix of residents
• minimal rules for success
28

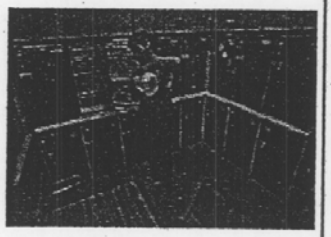

Individuals-Stabilization
CLUSTERED SITES
• Services: as needed to site or in the community possibly including CD recovery maintenance
• Considerations:
• capture economy of service delivery with same benefit as scattered site
29


Individuals-Stabilization
SCATTERED SITE
• Services: as needed to site or in the community possibly including CD recovery maintenance
• Considerations:
• stable housing in the community
30

Individuals-Stabilization

Example-Wilder Apartments at Snelling and American House

- Single Room Occupancy (SRO)
- 147 apartments
- On-site resident services coordinator



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Models of Supportive Housing

Discussion:

- Goal
- Principles
- Major Considerations

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SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 3: Gaps in Capital, Operating and Services Funding

MEETING SUMMARY

1. Welcome, Introductions and Overview

Assistant Commissioner Gomez, Commissioner Fabian and Commissioner Marx welcomed members and stakeholders. The first meetings set the context; these next meetings on funding require creativity. We need to construct this business plan with the assumption of no new forecasted revenue as we move forward.

2. Capital Funding for Supportive Housing

Commissioner Marx stated that an educated guess on capital costs would be 4,000 units of supportive housing at $150,000 per unit that would mean $600 million in capital costs. We don't have it and won't have it soon. MHFA is conducting sessions on how to increase efficiencies and reduce the costs of development in order to increase production. How do we bring some capital costs down?

Assistant Commissioner Bob Odman explained the cost of supportive housing has steadily increased over the last few years. Most has been large family housing, large units, and smaller developments with services. We need to find a way to bring these costs down. We do not have enough money to fund all the needs so we really need to focus on what we need, not necessarily what we want.

MHFA convened four meetings (two with staff, two with housing providers) to look at permanent supportive housing costs. We need to focus on: who are we serving, what is the size of chronically homeless families; where developments are located, what are the local community standards and building code requirements; what type of structure and how much service space is included; and how will it be funded. We also need to satisfy the requirements of all those coming to the table to provide money.

We came up with some recommendations: 1) establish a preference for existing rental housing, particularly housing with project based Section 8; 2) encourage adaptive reuse of existing structures (nursing homes, motels, hotels, etc.); 3) reduce size of units (more costs more) and amount of program space (use existing community program space in close proximity instead); 4) continue to review our own loan processing (time is money); 5) work with architects to develop standard plans to reduce design costs; 6) work with attorneys to get standardized documents. We need to consider the possibility of establishing cost limits. Continue the dialogue on an ongoing basis with all the partners in trying to find a way to end chronic homelessness. If we do lots of little things successfully, we can find ways to reduce costs.

3. Operating Funding for Supportive Housing

Assistant Commissioner Tonja Orr explained that even if we can get supportive housing built, there is still an operating deficit because the population we are serving does not have enough income to support it. We have to figure out a way to fill that deficit. Agency staff talked about what resources we have available that could be reallocated. Resources currently available are being well used. We will have to make some tough decisions about prioritizing this population over another already being served.

We have identified at least four sources of funding that could help with operating costs. None on their own could support the funding needed. Collectively, we could get a good portion funded.

The richest source is Section 8. It's federal money and it is the deepest subsidy (subsidizes the difference between what tenant can afford and actual costs of operating building to fair market rents). Currently, it's being well utilized. How do we incent housing authorities to project base their section 8 vouchers? We can look at things like the Challenge Fund and explore the possibility of giving them priority in accessing that money. We will look at other ways state agencies and others can provide incentive to housing authorities to use their Section 8 vouchers for supportive housing. Currently no housing authority has used the 20% maximum in project-based vouchers.

The Housing Trust Fund is a source. We also may have an opportunity to use federal HOME dollars for rental assistance. Currently, we don't do that. If we use some of the HOME dollars for rental assistance, we cannot continue to use it all for rental rehab. We also have some internal agency resources currently being used a lot for low and moderate-income rental housing. Will look at what extent we can reallocate resources for supportive housing. Some resources we've identified require some further exploration.

4. DHS Funding for People Living in Supportive Housing

Janel Bush reviewed the Department of Human Services Funding Catalogs. DHS funding covers all 3 categories - capital, operating and services. Categories – income supplement, community living supports, office of economic opportunities program, mental health funding, medical assistance (state plan programs, waivers, biggest source of funding for supportive services), chemical health (many federal program that do not allow chemical dependent) HIV/AIDS (administered by counties). We will continue to look at these programs. It is important to get specific about what providers and counties need. Think about funding as an opportunity, but be realistic. So much of funding is tied to the individual, not where they live. We will continue to discuss and dialogue as we go along.

5. Discussion on Housing and Service Gaps

Working Group Members expressed their ideas on funding strategies including: capital bonding, collaboration, leveraging, development cost reduction, operating funds, rental and income subsidies, services, and other issues and comments, including the need for additional resources. (See Observations, Ideas, Insights, and Comments on Housing and Service Gaps, which also includes Stakeholder comments.)

6. Discussion of Follow Up on Funding Issues for Next Meeting

Commissioner Marx thanked everyone for their time and insights. A sign up sheet for supportive housing tours is available. The November 18th meeting will focus on process and more funding decisions.

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SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 3: Gaps in Capital, Operating and Services Funding

HOUSING AND SERVICES GAPS

CAPITAL
(Costs associated with new construction, rehabilitation and other development costs)

1. **Limited funds for capital costs** of supportive housing.

OPERATING
(Costs of operating subsidy for revenue shortfall or costs unique of supportive housing)

2. **Inadequate individual income supplements/rental subsidies, or project-based operating subsidies** to pay for operating expenses in supportive housing programs. Even when an individual is receiving all available mainstream supports, their resources are often not adequate to pay for community-based supportive housing without an additional subsidy. A corollary is limited funds for operating cost/rental subsidies for project-based supportive housing.

3. **Inadequate start–up funds** for operating and services in new supportive housing programs/settings.

OUTREACH AND ENGAGEMENT
(Locate, build trust, and assist persons experiencing chronic homelessness)

4. **Lack of special outreach, engagement** and support for mainstreaming activities, including discharge planning, for the chronically homeless.

5. **Unfocused efforts and limited funds to increase eligibility** determinations for this population for SSI or other programs to increase mainstreaming.

6. **Insufficient capacity and funds to perform MI evaluation and diagnosis** before MA eligibility is determined.

SERVICES
(Medical, social, employment and housing support services)

7. **Lack of service coordination** and integrated case management models and funds to serve persons experiencing chronic homelessness. ("Front desk" seen as one solution to the problem of connecting the resident with available services.) Coordination models should include "housing tenancy supports."

8. **Inadequate or unstable funding for "front desk services"** in some supportive housing settings. (Types and levels of service need to be identified.) Ways to stabilize this funding even as resident needs change or they move out.

9. **Lack of chemical dependency case management** for the non-MA eligible.

10. **Prescriptive funding that does not allow for "other costs," e.g. one-time, surprises, transportation, etc.** Numerous federal and state restrictions on service and income funding streams drive some of this dilemma.

STATE OF MINNESOTA

Office Memorandum

Date: September 25, 2003

To: Interagency Supportive Housing Working Group Staff
Department of Corrections
Department of Employment and Economic Development
Department of Human Services
Minnesota Housing Finance Agency
(See attached list)

From: Commissioner Kevin Goodno, Department of Human Services
Commissioner Joan Fabian, Department of Corrections
Commissioner Tim Marx, Minnesota Housing Finance Agency

Subject: October 7 Interagency Meeting on Long-Term Homelessness

Thank you for all of your hard and creative work in support of the Working Group on supportive housing for the long-term homeless. The first two meetings of the working group have been successful and demonstrated that this effort has broad support and interest. We now have a good working definition of the long-term homeless population and an understanding of the array of housing and service approaches that are available to end their long-term homelessness. The remaining meetings on funding strategies and an interagency process for awarding funding are critical to the success of the working group and our goal to develop a "business plan" to end long-term homelessness to present to the Governor and the legislature. As you know, the Governor's strategic planning process has highlighted ending long-term homelessness as a key goal for the Administration.

Identifying funding streams and establishing an interagency process are items on which the state agencies involved are uniquely qualified to provide leadership. We believe it will be helpful for key staff involved from the agencies and the Governor's office to discuss and develop a plan for resolving these issues prior to the next meeting of the working group. For this reason, we have scheduled an interagency working meeting on **Tuesday, October 7, from 1:30 p.m. to 4:30 p.m. at the Minnesota Housing Finance Agency.**

This interagency working meeting has two principal purposes. First, as indicated, to discuss the funding and interagency process issues. A detailed outline of funding and process issues is attached for this purpose. Second, to review a draft outline of the overall final report due in February to the Governor and the legislature so that we have a common understanding of the major issues that need to be addressed. A draft outline is also attached.

The interagency working group that has been meeting regularly on Mondays will be responsible for developing the final agenda and planning for the October 7 meeting. We hope that these materials and additional preparation based on them will provide the basis for a productive meeting on October 7.

Finally, we want to thank you for all of your hard work and patience on this project as we try to meld the housing, human service, and corrections approaches into a seamless system that serves our most vulnerable. Moving forward on a major initiative like this given the funding constraints and other challenges is a daunting task. Success would truly mean reform and system change, and serve as a national example of how to address a complex social issue in new, creative, and cost-effective ways. We have confidence that if we are persistent and build upon the good work that has been done we can meet, if not beat, the expectations of the Governor and the legislature.

Attachments

cc: Ward Einess, Office of the Governor

Attachment 1

Interagency Funding and Process Outline
Interagency Working Group on Long-Term Homelessness
Outline for October 7, 2003 Interagency Meeting

1. **Supportive Housing Activities.** There are three general categories of activities for which funding is necessary for successful supportive housing for the target population. A detailed listing for each general category should be developed.

   A. Capital costs - the bricks and mortar of a supportive housing project (including common or service space), whether new construction, acquisition, or acquisition and rehabilitation;
   B. Operating costs – the costs of maintaining the property (taxes, insurance, utilities, maintenance, reserves, any debt service); and
   C. Support services – the health care, case management, life skills, employment and training services and specific housing support services.

2. **Assess Existing Funding, Eligibility, and Delivery Capability.** We will identify which government funding sources are currently available to cover the costs of the three categories of activities, what system is in place to deliver those services, and whether there is sufficient existing funding. This should provide us a "universe" of currently available services, potentially available funding, and provide a listing of the funding and service delivery gaps for the purpose of developing strategies for addressing those gaps. See numbers 3 and 4 below.

3. **Assessment and Analysis of Funding and Delivery Gaps.** Based on the assessment of the universe of funding sources for the three categories of activities, several questions should be asked to help identify potential "gap filling" strategies. These questions include:

   A. Funding constraints. If a funding source is not available for a particular activity, what state law, rule, or policy or federal law or regulation restricts the use of funds from being used for that activity? Does this differ for any subset of the target population?

   B. Eligibility constraints. If a service or activity is determined to be appropriate and necessary for a particular subset of the targeted population and funding for the activity is available but the subset of the targeted population is not eligible for the funding, what state law, rule, or policy or federal law or regulation that restricts the use of the funds for that activity? Does this differ for any subset of the target population?

C. Delivery constraints. Is there current capacity in the system to provide the target population the level of each activity that is needed?

4. **Development of Service Eligibility and Funding "Gap Filling" Strategies.** Strategies should be developed that will "stretch" the identified resources and expand eligibility in all three categories of activities as much as possible. We should be practical and strategic about this so as to maximize the opportunity to serve as many individuals in the target population as possible as soon as possible. Included in this discussion should be establishment of a timeframe in which agreed upon strategies will be pursued and when a favorable outcome might be expected.

There are a number of specific items that have been discussed in this area:

A. Service Efficiency - How can services be coordinated to ensure that they do not duplicate or overlap one another because of multiple funding sources for services? Would better coordination result in fewer overall services being provided (and therefore reduced expense) while achieving acceptable outcomes?

B. Housing Support Services - How can the specific service of housing support – the front desk service and /or the facilitator for issues between the tenant and the landlord, including initially securing the housing and possibly co-signing the lease - be funded? Are there alternatives to the front desk or watchful eye? To what extent can human service or other funding, which typically follows the individual, be "stretched" to pay for the operating or service elements of a supportive housing project so that even when the tenant leaves, the supportive housing and services continue to be available for others?

C. Medical Assistance - Eligibility for MA seems to be a key to securing services. What strategies should be pursued to improve access to this program for the chronically homeless? Can the process for presumptive eligibility for MA be better utilized?

D. SSI - What can be done to increase positive SSI eligibility determinations for this population in order to increase available income for housing? Are there other income supports that can be made available to the chronically homeless?

E. Funding Limitations and New Resources - The business plan should assume that we will maximize federal resources, but that there will be no new "unforecasted" revenue available in the short-term through FY 05. However, if there is a potential funding source the use or expansion of which would

have revenue implications, such as lifting the cap on additional CADI waivers, that source should be identified for consideration and the business plan should address how the non-federal share or additional state costs might be met.

F. Accounting for Savings in Fiscal Notes – As part of a funding strategy, how do we communicate the extent to which, taking a global view, costs may be offset by savings to other budget areas, including institutional care, more expensive acute care, child welfare, and local government costs such as detox and police. Do we have sufficient data now to re-examine some of the forecast assumptions related to potential cost savings as a result of stable housing and supportive services as compared to the costs of institutional and/or acute care and crisis services? What additional data needs to be collected or examined to develop cost savings estimated and what is a realistic timeframe for doing so? This may be an issue that we will not be able to consider fully at the October 7th meeting, but will need to address before the final recommendations are made.

G. Working Relationship With Counties - Counties are both a funding source and a deliverer of services. How do we include the counties in our business plan? How can funding and services be better coordinated with the counties? Are there services the counties do not deliver now that are needed or services that they do now deliver, but would be better delivered in a different manner?

H. Capital Cost Efficiencies - Based on current and potential future estimates of the number of households and people in the target population (2000 Wilder estimate is 3000 households and 5000 total population), we need a range of estimates for potential future capital needs and potential capital funding sources. As part of this, we need ideas from the MHFA about potential capital cost containment initiatives that might be employed.

I. Delivery Capacity – To the extent there will be increased demand for each of the three activities to provide appropriate supportive housing for the target population, it will have to be determined whether the current delivery systems are adequate and, if not, what strategies should be employed to provide adequate delivery capacity.

Through this process, we may be able to identify one or more groups within the target population for whom the fewest "fixes" to the various systems are necessary for us to be able to provide supportive housing. The business plan would identify these groups as a priority for the first strategies we pursue and for new supportive housing.

5. **Business Plan and Implementation**. The analysis above should form the basis for a preliminary estimate of the phasing of the implementation of the business plan over the next several years. The business plan needs a start date, some flexible target dates, and a sensitivity analysis or description of factors that would cause those dates to move, e.g. increase in target population, decreased availability of funding, etc.

6. **Interagency Process**. Some concrete recommendations on an interagency process are necessary. The agencies will implement the business plan primarily through our local government and nonprofit providers. We will need some type of interagency system to solicit, review, fund, monitor, and evaluate supportive housing that is developed consistent with the plan and make necessary mid-course corrections. Criteria or guidelines should be developed on capital costs, the appropriate service mix (e.g. "front desk", use of common space, use of assertive community treatment, etc.) for various segments of the target population. As discussed at the last working group meeting, it is likely that there will need to be a significant effort at outreach to the long-term homeless population and a "tiered" approach to providing permanent housing. This outreach will likely need to be funded. A variant of the MHFA "super RFP process" for supportive housing might be an option, with a separate and distinct tract and funding sources for supportive housing. We should discuss whether this process should be formalized by statute or rule.

Attachment 2

Draft Outline of Report
Interagency Working Group on Long-Term Homelessness

I. Review of charge and purpose of report

"2003 legislation charged a working group to advise the commissioners on a host of issues. The commissioner's must report to the legislature on the activities of the working group and recommend next steps to address the problem of long-term homelessness."

II. Review of the working group's activities

A. Narrative of the focus population (those experiencing chronic homelessness).
- *(Legislative charge to working group #1)*
- Operationalized definition, appropriate for use by Wilder in tracking numbers.
- Itemization of the indicators we will use to measure the state's progress in reducing the number of people experiencing chronic homelessness.

B. Narrative of the supportive housing models that work to stabilize this population.
- *(Legislative charge to working group #2)*
- Research citations will be included for those models that are evidence-based.
- Models may be organized around different populations (ie: families, individuals)

C. Analysis of existing funding streams, gaps, and strategies to address the gaps.
- *(Legislative charge to working group #3, 4, 6, 7)*
- Chart funding streams with narrative foot notes listing what they do and can buy in which circumstances and for whom. Organization of categories will be:
  1. Capital
  2. Operating
     Rental subsidies
     Income subsidies (e.g. SSI)
  3. Services

- List of changes that could be made to funding streams to better accommodate this population, remove barriers and improve coordination of funding, including estimated cost-savings to offset potential new operating or service dollars. (Both '04 and long-term or more complex options).
- Strategies to efficiently utilize and combine capital, service and operations funding to serve particular segments of the long-term homeless population based on their unique needs

D. Narrative of the crucial elements of an interagency decision-making process.
- *(Legislative charge to working group #5)*
- Who needs to be at the table?
- What should the parameters of an RFP process be?
- What funding elements need to be in place to solicit solid, viable project proposals?
- What other policy design elements are necessary—e.g. outreach to the long-term homeless population, ongoing evaluation of projects underway.

III. Commissioners' recommendations (business plan) *(Legislative charge to commissioners)*

A. A proposed interagency decision-making process
- Gathers expertise in capital, operating and services funding
- Identifies the criteria the group should use in soliciting and judging proposals
- Identifies the resources available to distribute to promising projects via an RFP process

B. Potential changes to existing funding streams and regulations
- Licensing/registration
- Funding streams
- More refined process for documenting savings?

C. Recommended Implementation Plan
- Strategy for initial portion of targeted population
- Phase-in strategy for remainder of population
- Description of factors that could affect phase-in
- Other

Interagency Staff for Supportive Housing Working Group

Kevin Goodno, Commissioner, Department of Human Services
Joan Fabian, Commissioner, Department of Corrections
Tim Marx, Commissioner, MN Housing Finance Agency

Sharon Autio
Minnesota Department of Human Services

Kathy Bique
Minnesota Department of Employment and Economic Development

Janel Bush
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Diane Sprague
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Minnesota Housing Finance Agency

Date: October 15, 2003

To: Supportive Housing for Persons Experiencing Chronic Homelessness Working Group

From: Bob Odman, Assistant Commissioner, Multifamily

Phone: 651-296-9821

Subject: Cost Containment of Supportive Housing

The enclosed outline provides a list of considerations to be taken into account when developing permanent supportive housing and deciding what measures might be taken to achieve the most cost effective alternative to meet the need of housing chronically homeless households. After convening two meetings with Agency staff and two meetings with professionals actively engaged in the design, construction, development, financing and operation of supportive housing, the following are recommendations of measures the Minnesota Housing Finance Agency and its funding partners should take to house the maximum number of households the most cost effectively consistent with meeting the divergent needs of chronically homeless households.

- Establish a preference for the use of existing multifamily rental housing as opposed to new construction.
- Encourage the integration of chronically homeless households into existing MHFA financed multifamily rental developments, particularly, project based Section 8 housing.
- Encourage the adaptive reuse of nursing homes, hotels, and motels for housing single persons when economically feasible.
- Reduce the size of new construction housing units and program space.
- Continue to review the underwriting process to streamline and expedite loan processing.
- Work with MHFA architects and client architects to develop standard, replicable plans that can be constructed cost effectively and reduce design costs.
- Work with MFHA assigned Attorney General Staff and partner and client attorneys to implement the use of standard benchmark legal documents to expedite closing process and reduce legal fees.

- Conduct annual cost containment roundtable discussions at the Working Together Multifamily Conference.
- Use durable, cost effective materials to reduce long term operating costs.
- Work with contractors, architects, attorneys, accountants, providers, and funders on an ongoing basis to look for ways to control and reduce costs.

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 3: Gaps in Capital, Operating and Services Funding COST

COST CONTAINMENT CONSIDERATIONS OUTLINE

1. **Who will be served**
   a. Singles
   b. Families
   c. MI, CD
   d. How many?

2. **Where**
   a. Open land
   b. Urban core
   c. Suburban
   d. Greater Minnesota
   e. Public transportation access
   f. Distance to services.

3. **What**
   a. New construction or existing residential
   b. Apartments
   c. Townhouses
   d. Single family detached
   e. Existing project based Section 8 developments
   f. Adaptive re-use
   g. Industrial – lofts
   h. Commercial – conversion of office space
   i. Motels/hotels
   j. Nursing homes
   k. Schools
   l. Convents/rectories
   m. How big?
   n. Number of housing units
   o. Square footage of units
   p. There appears to be consensus that we can realize some real savings through the reduction in the size of supportive housing units.
   q. Only have one bathroom per unit in family units
   r. How durable?
   s. Long-term maintenance and operating considerations
   t. How attractive?

u. Do you have program space on site?
v. How much?
w. What uses?

4. How

a. How much money is available and who has the money?
b. What restrictions are attached to the money?
c. What approvals are required?
d. Neighborhood
e. Municipal
f. Funder
   - Capital
   - Service
   - Operating
g. Do we have cost limits?
h. Total cost
i. Our share
j. Competitive construction contract bids versus negotiated contracts.
k. Design build versus engineered.
l. How can soft costs be reduced?
m. How can total development process be expedited?
n. What can MHFA and funders do?
o. What can others do?
p. Form groups of architects, contractors, and owners to review and share best practices for cost reduction.
q. MHFA consider taking more informed risks on new materials, technology, and building processes.

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 3: Gaps in Capital, Operating and Services Funding

COST CONTAINMENT MEETINGS
September 18 and 26, 2003

MEETINGS SUMMARY

In Attendance: David Carlson (Watson-Forsberg Co.); Terri Cermak (Cermak Rhoades Architects); Kirk Fadner (Collaborative Design Group); David Forsberg (Watson-Forsberg Co.); Bill Hickey (Collaborative Design Group); Rich Kiemen (KM Building Co.); Marv Kotek (Frerichs Construction); Peter Kramer (Roark Kramer Kosowski Design); Tom Schirber (Wilder); Jim Solem (CURA – U of M)

Dick Brustad (Community Housing Development Corporation)
Cynthia Lee (Minneapolis CPED)
Ellen Hart Shegos (Hart Shegos and Associates)
Trisha Kauffman (East Metro Women's Council)
Pam Zagaria (Family Housing Fund)
John Duffy (Duffy Development)
Warren Hanson (Greater Minnesota Housing Fund)
Carolyn Olson (Great Metropolitan Housing Corporation)
Gary Peltier (St. Paul PED)
Joe Errigo (CommonBond)
Eric Grumdahl (Hearth Connection)
Darlene Johnson (Housing Coalition St. Cloud)
Dan Cain (RS Eden)
Mari Moen (Corporation for Supportive Housing)

MHFA: Han Lee, Tim Marx, Julie Ann Monson, Jerry Narlock, Bob Odman, Tonja Orr, Cherie Shoquist, Bruce Watson, Marcia Kolb, Rhonda McCall

How can we contain/reduce the cost of supportive housing for families and individuals? Is program space needed on site? If so, how much? Should we provide one housing unit with 30-year durability versus two units with shorter-term durability?

One Good Idea:

Development and Construction

- Need more money on the front end.
- Streamline legal work in addition to closing documents, eliminate half the due diligence lawyers, problematic mosaic to put together a deal.
- Public bidding.
- Education of contractors.
- Quicker closings.
- Replicate good projects – best practices.
- Smaller units, less amenities, reduce use of garages, number of bathrooms.
- Nominal efficiencies – it all comes down to the number of square feet and the ratio of community space.
- Durability. Focus on quality materials. Cut costs on design not materials.
- Vinyl instead of carpet.
- Technology related to cost savings.
- Modular housing.
- Modular design if appropriate and durable.
- Experience with modular homes – costs $10,000 more than stick built.
- Do not create cookie cutter supportive housing with public housing stigma.
- Designs that use less materials and re-use materials.
- Value engineering, size of units, consistent floor plans, standardized exteriors costs less than reinventing the wheel, share good ideas.
- Reexamine city requirements regarding code politics, extra costs, etc.
- If standardize, need to include city inspectors. Could inspectors and structural engineers approve four at once?
- Converted units, vacant nursing homes, rural motels.
- Purchase airspace above parking lots.
- Engage labor-trade (example: free labor for ice castle).
- Caution – cut costs still deliver quality projects.
- Life cycle costs, funding to maintain products 25 years down the road, remodeling costs part of product.
- Encourage using existing housing stock and project based Section 8.
- Rental housing with services.
- Vacancies – some areas have plenty of apartments, need combination Bridges, Section 8 voucher with support services.
- Shared houses and living spaces in rural areas.
- Families better in neighborhoods, smaller developments.
- Recently policy emphasis that fewer units provide a better quality of life - can't tell quality of life difference between 168 unit and 12 unit buildings with same management, if the efficiency is in a larger development pursue it.
- If take kitchens out of units, disqualify for support services, CADI waivers etc.

- Kitchen/bathrooms different level of need depending on level of self-sufficiency. After 60 days sobriety, need higher level of privacy as move towards self-sufficiency.

Service Space
- Plan for program space in conjunction with broader community and community resources.
- Set aside one unit for program space that is a residential unit to be available if needs change over time.
- Need to consider staff program space and recreation program space.
- Cost savings of program space determined by population.
- Need design for family space. Better utilize space (example: Winnebago).
- Better to have a community room for families.
- Program space based on need, need services day-to-day or once a week?
- Healthcare services space should not take $200,000, the cost of a unit.
- Economy of scale ratio of program space to number of units, under 20 units drives costs way up.

Services
- Population is not homogeneous. Mixed populations need different types of housing. Differences (ex. Alliance and Anishinabe Wakiagun with chronic alcoholics) determine level of services.
- On-site services make all the difference. Much higher success rates in on-site, congregate settings than in scattered site.
- Not in agreement on best practices - different populations served by different practices.
- Who are the people we want to serve and what are their needs?
- Providers need to come to table with a plan for services. Providing services does not necessarily mean you need more money.
- Combined staff.

Planning and Politics
- Convince politicians can support developments and be reelected and that neighborhoods not have increased crime. Involve DHS and DOC (funding).
- Siting and better community process.
- Political and neighborhood groups with veto power delay.
- Collaborative costs, spread around, streamline funding.
- Most cost effective to build good housing and programs.
- Need to know where needs are around state.

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Minnesota Housing Finance Agency Survey

Name of Organization__9 of 19 surveys returned_____

Name of Contact_____

Phone _____

E-mail_____

Governor Pawlenty and MHFA Commissioner Marx have established the goal of ending chronic homelessness. To facilitate the achievement of this goal, the Minnesota Housing Finance Agency multifamily staff will be exploring a variety of housing models, strategies and programs. One existing model that appears to be successful is to integrate a few chronically homeless households in each of a variety of buildings located in close proximity to services with service providers working with property managers and building owners to assure that needed services are provided to the tenant. The service provider/case manager will also work with the property manager to resolve any problems that may arise as a result of the tenancy.

We are considering providing a priority in the awarding of our funding for developments willing to make a percentage of the units in a development available for occupancy by persons or households who are chronically homeless.

Key characteristics of homeless persons are an individual or adult family member with:
Mental illness,
Chemical dependency, or
Dual diagnosis of mental illness and chemical dependency;
and
who has either been homeless continuously for a year or more,
or has had at least four episodes of homelessness in the past three years,
excluding periods of incarceration or institutionalization.

We would appreciate it if you would answer the following questions:

1. Do you have past or present experience housing tenants who were previously chronically homeless? If so, what was your experience? Was/is it a successful experience? **5 of 9 respondents had experience, 4 did not. One of five with experience, reported the experience was successful. Four had mixed experience - some successes, some failures.**

2. Would you be willing to agree to make a percentage of units in a mixed income development available to chronically homeless households? If so, what percent of the units would you be willing to make available? **5 would be willing to house chronically homeless in a mixed income development, 4 might be willing to do so. 4 thought the percentage should be 5% or less; 3 thought 5-10%; one thought 15-20%; and one 50%.**

3. If you answered yes to the second question, how long would you be willing to make such a commitment? **2 for 5 years or less; one for 5-7 years; one for 10 years; one for 15 years; and three for 15 years or more.**

4. What, if any, incentives would be needed for you to house, or continue to house, chronically homeless households?
    a. **One- no incentives**
    b. **Three- fund total capital cost – no amortizing debt**
    c. **Seven - Low rents and necessary services**
    d. **Two – management fee increase.**

5. Do you have any recommendations as to how we can end chronic homelessness?
    a. **Need funding for services**
    b. **More capital cost funding**

6. Comments, questions, or concerns?
    a. **Should units be furnished**
    b. **Need rental assistance vouchers**
    c. **Need service staff**
    d. **Training and support for property managers needed.**

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Safe Homes, Safe Communities

a focus group report on offender housing

Minnesota Department of Corrections

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www.doc.state.mn.us
March 2001

This document will be provided in alternative format upon request.

Executive Summary

"The bottom line is that we need to cultivate relationships to help offenders get housing. This is labor-intensive work, but the results are tremendous in keeping offenders out of prison."

Housing for offenders? This is not a topic that immediately engenders broad-based empathy or a call to action. Housing shortages abound, particularly affordable housing units. Why should policymakers pay special attention to housing difficulties experienced by offenders? Simply put, the answer is public safety.

Offenders released from jails and prisons are increasingly finding that they cannot gain access to suitable housing. The result? They sleep in cars, find emergency housing along with more vulnerable populations, cohabitate with other felons in substandard housing, or live a vagrant lifestyle, from friend to friend until their welcome runs out. The label of "offender" is often synonymous with a "scarlet letter" as they are branded as a poor risk to accept on a rental lease. Instead of a welcome mat, they encounter barriers that deliver a message that they are shunned from gaining access to housing units. And case workers report that many offenders are subsequently being revoked and returned to incarceration. State or county residential care is much more expensive than community care or self-sufficiency, and these offenders will eventually be released again.

Approximately 3,800 inmates are released from Minnesota prisons each year and many more from county jails. As a society, we have two choices: 1) Allow offenders to be subject to inadequate or substandard housing conditions, insurmountable access at an increased public safety risk, or a revolving door in and out of jails and prisons at an increased cost to the taxpayer; or 2) create reasonable pathways for offenders to find suitable housing and corresponding support services so they can gain self-sufficiency and a restored sense of hope.

This report represents a beginning step toward finding solutions that work, both for the offender and his/her family as well as the public at large. The reader will not find a "breakthrough" strategy in the recommendations, but there are important first steps that will hopefully lead to solutions that bring long-term and meaningful change.

Focus Groups

As a result of increasing concerns expressed by corrections professionals over the inability of offenders to acquire adequate housing, the Minnesota Department of Corrections (DOC) held four focus group sessions over the fall of 2000. Each session was attended by over 60 city, county, and state officials along with case managers, housing advocates, and service providers. Concerns spanned the entire state and encompassed urban, rural and suburban features. The summary below describes the group's findings and recommendations.

Focus Group Findings

- The lack of access to appropriate housing for offenders results in diminished public safety.
- While public concern about housing for offenders is understandable, offenders evoke a level of concern among communities and property managers that makes access to housing almost insurmountable.
- Helping systems do not always coordinate or communicate with each other. Sometimes policies and practices by one agency cancel the efforts of another.
- Specialized offender housing is not geographically disbursed appropriately. There is excessively high concentration in some areas and unavailability in others.
- Given public sentiment often predisposed against housing offenders in their communities, creative solutions are necessary.
- The objectives of correctional halfway houses should be clarified and contract administration altered accordingly.
- The highest priorities around housing services for offenders are, in order of priority:
  - — Guaranteed emergency bed access
  - — Transitional housing
  - — Supportive housing
  - — Access to market rate and affordable housing
- Housing placements upon release from prison could be improved with changes at the correctional institution.

DOC Recommendations

- Improve system coordination/communication and focus on offender housing needs by establishing an interagency work group to:
  - — Review, coordinate, and recommend appropriate changes in policies and practices.
  - — Assist and inform referral and direct-care professionals of existing housing.
  - — Conduct a statewide summit with regional work teams.

- Increase public awareness of the issue of offender housing.

- Increase rental placements by building upon existing housing interventions proven to be effective. Do this by:
  - — Developing how-to packets, offender-provided certification training programs, and a centralized listing of housing options for access by probation officers and housing case managers.
  - — Increasing housing service contracts.
  - — Issuing exploratory community-driven Requests for Proposals to encourage innovative housing options for offenders with the greatest needs.
  - — Training probation officers.
  - — Reducing probation officer caseloads.

- Explore short-term emergency sex offender housing options until a more permanent solution can be found.

- Assess the social and health needs of the offender population to develop a more thorough and complete understanding of their housing and service needs.

- Set aside corrections funding to create a supply of supportive housing units (new and existing) for offenders.

- Improve DOC transitional services for prison releasees by:
  - — Beginning release planning earlier in the process. Release planning should begin at intake, with intense planning moved to six months before release instead of the current four-month mark.
  - — Ensuring that each releasing facility has a special needs unit or other trained staff to assist inmates who are mentally ill or mentally delayed to develop appropriate release plans.
  - — Conducting a discharge mental health assessment on every offender identified with a major mental illness prior to release from the institution. Assessment results should be used to address the transition plan and the information transferred to the field agent.
  - — Ensuring that offenders requiring psychotropic medication are provided with an appropriate supply at release and that they have access to follow-up health care services. Set up a process for monitoring the taking of medication as part of the release plan.
  - — Ensuring that, whenever possible, the offender identifies a local case manager(s) to assist with transitional issues upon release.
  - — Extending the identification card pilot projects beyond the pilot sites.
  - — Examining DOC policies to determine how to encourage more long-term involvement between inmates and the community that will continue after release. Programs such as AMICUS and Prison Fellowship could be expanded.
  - — Reviewing DOC policies on halfway houses including clarification of roles and outcomes desired, funding options that better match service levels desired, and length of stay.
  - — Holding an annual planning session with prison case workers and probation officers to coordinate policy, identify problems and solutions, and improve transition from institution to field services and vice versa.
  - — Conducting a listening session with vendors who serve offenders of color to determine how to best provide transitional services that are comprehensive, supportive, and culturally-specific.
  - — Conducting "transition fairs" at each medium-custody facility to provide information on available housing, employment, and other community services.

Solutions lie largely at the community level. This is where the largest number of offenders are supervised by community agents; agencies that can lend support, planning and services are based; and volunteers needed to support local efforts live. That is not to say that state agencies shouldn't play an important role. State agencies can and should reexamine policies, coordinate statewide strategies, help seek funding, and provide technical assistance so that local planning efforts can succeed. It is the DOC's intent to put these recommendations in action by collaborating with other state agencies, county personnel, the private sector, and service providers.

DOC Recommendations

Recommendation 1: Improve system coordination/communication and focus on offender housing needs by establishing an interagency work group to:
— Review, coordinate, and recommend appropriate changes in policies and practices.
— Assist and inform referral and direct-care professionals of existing housing.
— Conduct a statewide summit with regional work teams.

"When you return home from prison you are not emotionally or psychologically ready to walk the streets."

— Review, coordinate, and recommend appropriate changes in policies and practices.

An interagency work group should be established to identify policy and practice issues that inhibit the ability of the offender to gain access to suitable housing and programs that might increase the chance for offenders to retain their rental unit (such as crisis care services). If an existing interagency group could expand its focus to include correctional issues, creating an additional work group can be avoided. The work group should adopt a "One Door, No Wrong Door" approach to its work. The goal should be to reduce finger-pointing, ease bureaucratic rules, streamline processes, and align funding streams to ensure that offenders can access suitable and appropriate housing. It should also consider any possible legislative action that might provide incentives or remove disincentives for property manager liability to rent to an offender. The work group should examine legislative and policy barriers initially put in place for the public interest that have created secondary and harmful consequences to successful mainstreaming and determine if some of these should be altered or removed. Finally, it should develop a model of continuum of housing services and an action plan to accomplish the goal of meeting offender housing needs.

At a minimum, agencies that make up the work group should consist of federal, state, county, and local officials and include representatives from corrections, human services, mental health, chemical dependency, private vendors, housing, law enforcement, veterans, and victims. It should be noted that a number of interagency efforts have been put in place in recent years with limited success. This recommendation should be implemented only after an analysis of those efforts is completed and a determination made on how to ensure that this effort succeeds. Among other topics noted above, this group should explore the concept of tying service funds to capital projects.

— Assist and inform referral and direct-care professionals of existing housing.

It was clear through focus group discussions that few service sectors had a comprehensive knowledge of the housing subject. Many were missing information that would be valuable in their effort to serve those in need. For example, many of those in attendance were unaware of the following opportunities to assist with housing:
— SMERT (State Medical Review Team) funds. The Department of Human Services has a budget called SMERT that can be accessed for disability services. Local agencies should learn more about this program and seek reimbursement to assist with mental health or other disability-related services.
— Shelter Plus Care certificates. These housing certificates are available for individuals with severe and persistent mental health needs and who are homeless. They are similar to Section 8 certificates but require a service funding match.
— Medical assistance (MA) and general assistance medical care (GAMC) funds. For example, a program called Rehab Options is available through MA. These funds could be accessed to expand services, but Minnesota is not currently accessing them.
— Mental health initiatives. Local case workers can enhance the linking of their client needs, including housing, with these mental health initiatives (pilot projects now underway) as a means of gaining intensive mental health services.

In addition, following are examples of some of the housing programs addressing homelessness:
— Emergency Shelter Grant Program
— Family Homeless Prevention and Assistance Program
— Federal Emergency Food and Shelter Program
— Supportive Housing Program
— Transitional Housing Program
— Emergency Services Program
— Affordable Rental Investment Fund
— Foreclosure Prevention Program
— Housing Trust Fund
— Education for Homeless Children and Youth
— Battered Women's Program
— Homeless Youth Program

— PATH (Project for Assistance in Transition from Homelessness)
— Statewide Plan for Housing Persons with HIV/AIDS
— Bridges
— Crisis Housing Assistance Fund

It is recommended that the work group develop informational materials to better inform case managers and correctional administrators of funding and service options available to assist with housing.

— Conduct a statewide summit with regional work teams.

It is recommended that the work group sponsor a housing summit for correctional staff and stakeholders. The summit would be designed to encourage the development of local needs analysis and action plans to improve access to suitable housing for offenders. To accomplish this, it is recommended that each invited jurisdiction bring a diverse team of policymakers to the summit. A separate DOC team made up of prison case managers should be invited as well. Field visits to housing projects including supportive housing should be part of the summit. Selected offices in the work group should be made available to provide follow-up technical assistance to local teams.

Recommendation 2: Increase public awareness of the issue of offender housing.

"The availability of housing that most people can afford has been steadily declining, but within the past two years, it's reached crisis proportions." Kit Hadley, Minnesota Housing Finance Commissioner, The Minnesota Housing Crunch

Public support for policies or funding necessary for offenders to access suitable housing is perceived to be weak. This may be due to an assumption that access would be costly to taxpayers and that it would increase the risk to their safety. It is possible that some of the public attitude may be that poor housing options are a natural consequence of criminal acts and such access barriers should not be removed.

However, there is a great deal of information that would be instructional to the public. For example, offenders without suitable housing are believed to be more likely to reoffend. And the costs associated with housing assistance are considerably lower than those that result from consequences of living in unsuitable environments. Until public opinion supports housing assistance for offenders, it is doubtful that there will be sufficient political will to make these services a priority.

It is recommended that the DOC work closely with other agencies such as the Minnesota Housing Finance Agency and the Corporation for Supportive Housing to inform the public about offender housing issues. This information should include data that indicates how to best use public funds to prevent more substantial long-term costs.

The public awareness project should be preventive in nature. For example, given the need to preserve the limited but valuable service of halfway houses, stronger public support would provide some immunity from the "one bad case" that could threaten public support for all halfway houses. According to the Massachusetts Housing and Shelter Alliance, Massachusetts saw a drop of pre-release beds from 688 in 1992 to 206 in 1999, and halfway house beds dropped from 240 in 1989 to a mere 30 in 2000. The reason? Willie Horton. The massive negative publicity and political fallout that came from the murder and conviction resulted in a decrease of these transitional beds.

Recommendation 3: Increase rental placements by building upon existing housing interventions proven to be effective. Do this by:
— Developing how-to packets, offender provider certification training programs, and a centralized listing of housing options for access by probation officers and housing case managers.
— Increasing housing service contracts.
— Issuing exploratory community driven Requests for Proposals to encourage innovative housing options for offenders with the greatest needs.
— Training probation officers.
— Reducing probation officer caseloads.

"When you push people out of a decent housing arrangement, they end up where you don't want them."

—Developing how-to packets, offender-provided certification training programs, and a centralized listing of housing options for access by probation officers and housing case managers.

Case managers, probation officers, and offenders could benefit from easy-to-use packets of information and a listing of viable rental options to decrease the likelihood of housing rejection and forfeiture of application fees. The packets should contain practical do's and don't's. Centralized listings of accessible rental properties can reduce the frustration in finding housing and increase the opportunity for an ongoing relationship with referral sources.

Effective housing advocates use various techniques to increase the chance that their clients will gain access to rental units. These tips could be highly useful to probation officers and case managers who deal with housing issues on a regular basis. In addition, the Attorney General's office produces a brochure entitled *Landlords and Tenants: Rights and Responsibilities.* This informational brochure helps tenants and landlords understand the laws and responsibilities that come with renting.

Hard-to-house applicants could benefit from attending a series of classes on how to find and retain rental property. These classes provide them with a certification that they present to the property manager which gives the manager some assurance that the tenant understands their responsibilities as a renter. For example, the Family Housing Fund has provided certification training for tenants, and a Tenant Training and Certification Program has been developed by RHAM (Rental Housing Alliance of Minnesota). In addition, the Minnesota Public Housing Authority has a renter's education program initiated by Holman Decree which is used in conjunction with the Section 8 program and teaches skills used to search for housing. The RHAM training certification program outline includes topics such as:

— Housing search preparation
— Application process and fees
— Interviews and first impressions
— Telephone etiquette
— Security deposit
— Budgeting and spending styles
— Landlord/tenant rights and responsibilities
— Lifestyles, guests, and pets
— Housekeeping
— Giving proper written notice

It is recommended that the work group produce examples of these suggestions for summit team participants. Local teams could develop their own version of the information and techniques for use in their area.

— Increasing housing service contracts.

Some of the best success stories came from housing advocates who provide services for hard-to-house individuals. Two distinct program examples include the ROOF programs operated by Wilder and St. Steven's Housing Services. They understand property manager concerns and seek to address them through information and guarantees of quick responses or financial reimbursement if damages occur.

It is recommended that local and state agencies consider entering into or expanding existing housing advocacy contracts for the hard-to-place offender. Whether this solution is appropriate should be assessed at a local level. The summit will provide additional information and awareness to assist local policymakers in determining the full extent of the need and whether funding can be acquired.

— Issuing exploratory community-driven Requests for Proposals (RFPs) to encourage innovative housing options for offenders with the greatest needs.

Focus group participants expressed some optimism toward newer, more unique community-driven efforts that might be considered unproved but promising in promoting stable housing and other support services for offenders. In particular, restorative justice projects such as Circles of Support (operated out of Toronto and more recently in Olmsted County) engage the community in supporting and holding the offender accountable. A network of community members offers assistance in helping the offender in a variety of areas including housing.

Some of these RFPs could address specific offender populations that are facing unique problems such as female offenders (including those leaving federal institutions), juveniles seeking independent living, and sex offenders.

It is recommended that the DOC work with other state agencies to find a way to fund an exploratory RFP process to learn how new, innovative, community-driven support systems can assist offenders with housing needs

and reduce their risk of reoffending. An evaluation process should be included as part of the RFP.

— Training probation officers.

Successful efforts by probation officers and housing case managers are marked by the establishment of trusting relationships with rental agency staff and property managers. The probation officer is in the best position to inform the property manager of the applicant's profile and circumstances (with a data privacy release) and to intervene quickly if a problem arises. The probation officer can ensure the offender will abide by agreed conditions and monitor and enforce them. Some examples of these agreements include:
— No drinking or drug use;
— Curfew;
— No loud parties;
— Payment of rent on time;
— Immediate removal should the agreement be violated.

The relationship between the offender, supervising agent, and property manager provides some immediate benefits to the manager. Some of these include the manager not incurring the expense of ongoing advertisement if the supervising agent can keep the unit full and not needing to intercede with eviction.

In addition, the timing of the housing request can be important. For example, sex offenders who are in treatment or aftercare at the time they are searching for housing stand a better chance of "getting a break." Attendance at treatment means that the property manager has another set of intercessors should the offender not cooperate. It also provides more assurance that the offender is seeking help, thereby reducing their at-risk profile.

— Reducing probation officer caseloads.

In order for the probation officer to act as an effective liaison with the property manager, officers must have caseloads that are of reasonable size. Ongoing attempts are being made through legislative funding (case/workload reduction) to bring caseloads closer to a standard size; however, funding to-date (i.e., $17 million from 1994 to 2000) has only reduced caseloads from an average of 111 for adult agents in 1994 to 108 in 2000 due to the increased number of probationers.

Lower caseload sizes allow the probation officer to assist the offender in finding and retaining housing and establishing relationships with housing managers. Many offenders face relapse with chemical dependency or mental illness. When these illnesses cycle up, community-based support can assist the offender in gaining stability and retaining housing. Even simple tasks such as filling out forms and responding to mail can be taxing to one in the throes of an illness. The related energies required to cope can render an offender incapable of focusing his/her attention. Overworked probation officers do not have time to garner community support necessary to assist these individuals at the time of greatest need.

It is recommended that the DOC continue seeking funding to bring probation caseloads within minimum standards for effective supervision.

Recommendation 4: Explore short-term emergency sex offender housing options until a more permanent solution can be found.

"By labeling sex offenders, we have created pariahs who are banished from nearly all communities. This has made placement, reintegration, and supervision impossible and has consequently impaired public safety."

Although small in number compared to other crime categories, sex offenders in need of emergency housing consume a significant amount of attention and conflict. Given community notification procedures, offenders are often on the verge of being released from prison only to have their residential placement fall through. Sex offenders have responded by sleeping in their cars, correctional offices, motels, and other creative but unsuitable living arrangements due to these last-minute changes in plans.

Potential long-term solutions to the issue of housing for sex offenders will take years to put in place. In the meantime, it is recommended that the DOC develop an emergency backup plan. One idea considered was that of placing trailers on prison grounds. Community sentiment, removing pressure on the county of responsibility, potentially causing a "stacking up" of trailer beds, and creating a high concentration of sex offenders creates concern with this solution. The concerns expressed over this and similar solutions demonstrate the level of difficulty in resolving this problem.

Another potential short-term solution suggested was to reconstruct how halfway house placements are made. For example, a "continued jurisdiction" arrangement could be established whereby an offender can be pulled back into the residential placement for a period of time (e.g., 90 days) if the community living arrangement falls apart. If set up properly, this extended jurisdiction could be acted on without a formal revocation or restructure.

A combination of solutions will likely be necessary. Some of them could include set-aside halfway house beds, creating more incentives by providing higher compensation rates, and purchasing time-limited emergency beds with selected property managers. Focus group members clearly advised against the creation of housing dedicated only to level 3 sex offenders due to real and perceived safety and public support concerns. However, some members expressed support for the waiving of community notification requirements when the offender is in a highly structured living environment. If successful in their supervision and treatment plans over a two to four-year period, their ability to get their risk level dropped and mainstream back to the community would be enhanced.

Recommendation 5: Assess the social and health needs of the offender population to develop a more thorough and complete understanding of their housing and service needs.

"When you put an ex-shark in with sharks, he/she will revert to a shark."

While offender housing needs are pronounced, data is missing on the number of housing units needed, for which targeted populations, and the location. Some of the most promising solutions to effective transition and stable housing are expansion of supportive housing and halfway residential care. These solutions are more meaningful if they can be distributed throughout the state to handle rural and urban needs and not burden disproportionately any one community. Supportive and halfway houses offer a flexible range of options for the populations they could serve ranging from prison releasees to probationers to special needs offenders no longer on supervision in the key housing areas (emergency, transitional, short and long-term).

A common theme that emerged from all focus group conversations was that a significant portion of offenders is dealing with a complex range of social, health and behavioral health issues. Women whose children are in foster care during their imprisonment, inmates with long histories of alcohol and drug abuse, and people afflicted with chronic mental illness are some of the more prominent conditions that must be addressed upon an inmate's release. For an offender with special needs, appropriate housing alone will not usually result in a successful reintegration into the community. Instead, these offenders require a flexible array of support services along with access to adequate housing to ensure a crime-free and productive life in the community.

A lesson learned from the focus groups was that the DOC can and should play an important role in helping to shape an appropriate housing and service infrastructure for offenders in the community. To do this, however, the DOC needs to have a more precise understanding of the needs and characteristics of its inmate population. More complete knowledge about the offender's work and medical history, family situation, and ties with treatment or service providers would help the DOC shape its strategy for engaging the housing and service sectors.

For instance, with better information the DOC could align the current portfolio of halfway house beds to serve groups of offenders who would benefit most from a short-term, highly structured residential setting. Moreover, with more sophisticated information the DOC would be in a better position to determine whether additional halfway house beds are needed and where these beds should be located.

Another advantage with having a more complete understanding of an offender's experiences and circumstances before prison and upon release is that the DOC could help shape the type of housing and service settings that are expected to improve an offender's chances for success in the community. For instance, there is growing evidence that supportive housing can facilitate an offender's re-engagement with society. And there are some significant efforts underway to increase the number and type of supportive housing units in Minnesota. The DOC would be in a stronger place to help advance this work and negotiate set-asides of new units if it had a more detailed understanding of the size and characteristics of the inmates who are being released to the community.

These housing options, however, take significant effort, finances, and collaboration to initiate. Agencies need to work closely with local communities to build support and to find funding both for construction as well as ongoing, onsite support services.

A number of factors must be considered to determine whether additional halfway house beds are needed and how many. For example, in at least one state a judge found that the state was liable for not providing sufficient housing. The Wisconsin Department of Health and Family Services was found in contempt by a judge for not providing a halfway house for sex offenders and was fined $1,000 per day. In this case, the offender was being detained unconstitutionally because the department had not been able to find the housing he needed for his release.

Focus group participants favored a distributive model that would place correctional housing in each region of the state. At the very least, this model would help address the overwhelming need to find emergency housing, particularly for sex offenders required to undergo a community notification process. It could also provide housing designed to provide specific supportive services for special needs populations. Some city officials urged a solution that would take local government officials out of the public hearing and siting process when the state determines that a particular housing project to serve offenders is in the public's best interests.

Recommendation 6: Set aside corrections funding to create a supply of supportive housing units (new and existing) for offenders.

"Supportive housing seems to me to be such an ingeniously sensible idea and to be so skillfully carried out by the Corporation for Supportive Housing that I look forward to the day when not only will the program be replicated in cities all around the country, but that the very thinking behind it will have spread as well." Alan Alda, actor/writer/director, former Rockefeller Foundation board member

At the focus group meetings, corrections professionals reported being very satisfied with their supportive housing experiences. They note the following benefits of supportive housing:

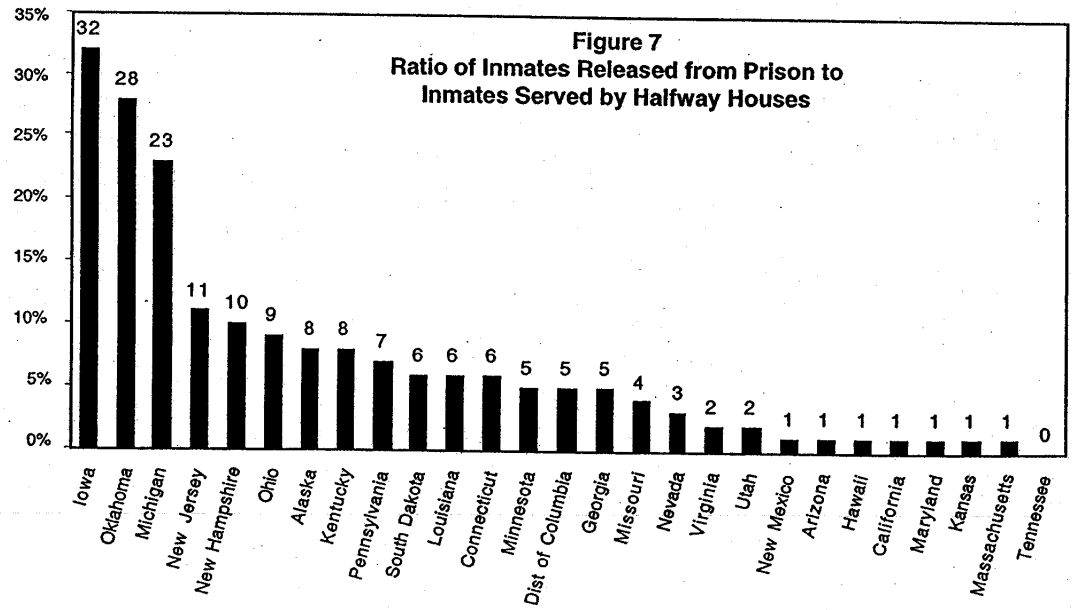

Figure 7
Ratio of Inmates Released from Prison to Inmates Served by Halfway Houses

Source: Minnesota Department of Corrections Research/Evaluation and Sex Offender/Chemical Dependency Services Units

- Highly structured and "structure breeds success" with the kind of offenders in need of this kind of housing.
- Affordable.
- Creates a positive community experience for the offender.
- Increases accountability due to the case management and structure and reduces opportunities for the offender to find cracks to slip through and excuses for lack of follow-through.
- Allows an offender to establish a positive rental and employment history which affords the opportunity to eventually move to market rate housing.
- Provides immediate access to supportive staff when there is an urgent need or can prevent a minor issue from becoming a crisis.
- Fosters independence, self-sufficiency, and confidence.
- Increases the opportunity for employment since it decreases distractions, provides a phone number and address, and allows for job networking among other residents and staff.
- Reduces hopelessness.
- Provides linkages between the offender and the community.
- Increases community understanding of the offender and decreases stereotypes. Some of this occurs through the process of gaining community support for supportive housing, personal contact with the offender, and care given to the property by the offender.

For supportive housing to be accepted and effective, it requires a strong, healthy community as a partner. Communities that do not acknowledge a role in helping others find supportive housing will be a hindrance to the effort.

Although supportive housing can work for all offenders, its existing models tend to work better with offenders who have matured and are willing to make the program work. Typically this includes offenders who are in their upper 20s or older and who are more aware and sensitive to others' privacy needs.

Access to supportive housing is a problem, primarily due to the limited number of available units. Current units are more available to the single adult than to youth or those with families. There are also long waiting lists (usually ranging from three to six months, with some up to a year). In rural areas, the access problem is exacerbated by not having the economy of scale to create and operate supportive housing units. Many rural-based offenders are placed in supportive housing in the metro area. Funders are also reluctant to accept hard-to-serve populations (e.g., sex offenders, those with mental illness, etc.). The following obstacles create additional barriers to securing housing placement:

- Income level.
- Teenager(s) in the family.
- Family size (more than two kids, and in need of three or more bedrooms).
- Two-parent household or male-led household.
- Those with previous unlawful detainers (or eviction actions) which stay on one's record forever, even if lost rent or damages were paid.

Most supportive housing programs will consider all offenders for placement on a case-by-case basis with the exception of two populations: level 3 sex offenders (due to the community notification requirement) and arsonists.

As described earlier, emerging evidence and the focus group summaries highlight the value of and need for an increased supply of supportive housing in Minnesota. Although more information about the DOC's inmate population (particularly those with special needs) must be compiled, most people in the field agree that the post-release success rates for a significant portion of offenders would improve if more affordable housing with a flexible array of support services was made available.

One way for the DOC to help spur development in this area is to establish a supportive housing incentive fund that would be used to gain access to existing units and fund the creation of new units of supportive housing. This fund would be used to supplement the operating and service costs associated with providing supportive housing to offenders, especially those who appear to be at greatest risk of failing in the community because of their history with mental illness and/or substance abuse.

The DOC could use these funds to ensure access to units, thereby reducing the challenge of finding appropriate housing for and connecting offenders with necessary support services. In addition, the DOC could tie its funding to a set of conditions that would help ensure that the funds are maximized and that other key sectors are involved with supporting the offender in the community. For example, the DOC could:

- Require supportive housing sponsors who receive financial assistance from the DOC to meet a set of key

outcomes. Namely, the DOC would expect every offender to be housed in a stable and safe setting, that appropriate services are offered, and that the offender is reengaged in the community in a positive way.

- Require project sponsors to leverage other funds (at least a two-to-one match; $2 from other sources for every DOC dollar) for the housing and services that are to be delivered to the offender.
- Require that the sponsors maintain data and information about the offenders being served so that a formal and thorough evaluation of the value and effectiveness of supportive housing for offenders can be completed.

The proposal would start with an initial level of funding for the incentive fund and increase the amount of funds as additional revenue sources are identified and as the effectiveness and value of this approach are verified through an evaluation.

Recommendation 7: Improve DOC transition services for prison releasees

"The state has really stepped up to the plate and taken an unbelievable amount of leadership. Governor Ventura has proposed to spend $82.5 million on affordable housing initiatives. I think that has to pass. But this is not a problem that can be solved by the state alone." Kit Hadley, Minnesota Housing Finance Agency Commissioner, The Minnesota Housing Crunch

— Beginning release planning earlier in the process. Release planning should begin at intake, with intense planning moved to six months before release instead of the current four-month mark.

— Ensuring that each releasing facility has a special needs unit or other trained staff to assist inmates who are mentally ill or mentally delayed to develop appropriate release plans.

— Conducting a discharge mental health assessment on every offender identified with a major mental illness prior to release from the institution. Assessment results should be used to address the transition plan with the information transferred to the field agent.

Part of the assessment should screen for mental health supportive living eligibility. Inmates with a serious mental illness (such as schizophrenia, bipolar, major depressive disorder) may qualify for services under Rule 79 if they've been hospitalized within the past year or if they've been housed in a special needs unit. If eligible, the county is responsible for providing a social services caseworker who will assist the inmate with housing, medication, food, etc. Funding is to cover all related costs, including housing.

— Ensuring that offenders requiring psychotropic medication are provided with an appropriate supply at release and that they have access to follow-up health care services. Set up a process for monitoring the taking of medication as part of the release plan.

Providing an appropriate supply of medication is dependent on many factors. Currently, DOC policy only calls for a seven-day supply, the rationale being that an offender might use a larger supply to overdose or use in another inappropriate manner. While a more ample supply appears warranted, it would be more judicious to make decisions on a case-by-case basis, making sure that some case manager is aware of the related issues and ensures proper filling and monitoring of medication.

— Ensuring that, whenever possible, the offender identifies a local case manager(s) to assist with transitional issues upon release.

— Extending the identification card pilot projects beyond the pilot sites.

— Examining DOC policies to determine how to encourage more long-term involvement between inmates and the community that would continue after release. Programs such as AMICUS and Prison Fellowship could be expanded.

— Reviewing DOC policies on halfway houses including clarification of roles and outcomes desired, funding options that better match service levels desired, and length of stay.

— *Holding an annual planning session with prison case workers and probation officers to coordinate policy, identify problems and solutions, and improve transition from institution to field services and vice versa.*

— *Conducting a listening session with vendors who serve offenders of color to determine how to best provide transitional services that are comprehensive, supportive, and culturally-specific.*

— *Conducting "transition fairs" at each medium-custody facility to provide information on available housing, employment, and other community services.*

The recommendations in this section were identified by focus group participants as key factors in the offender's success at community reintegration. Because most of the participants were community-based advocates, service providers, and referral sources, they were able to identify what actions taken by institutional staff were the most helpful as inmates leave correctional facilities and enter communities.

Progress Made on Recommendations

The DOC has a transition committee in place and many of the recommendations have been or are in the process of being implemented or expanded. Some of the changes include:

- The state identification card pilot project at the Minnesota Correctional Facility-Faribault has been implemented. There is discussion underway with the Department of Public Safety to expand this project to other correctional facilities. In addition, initial discussion is occurring on the possibility of incorporating the driver's license examination process as part of the project.

- DOC policy states that offenders are to be given a minimum of seven days medication and a 30-day prescription for refills. Offenders who are currently taking psychotropic mediation are referred by Health Services to the psychiatrist for a prescription. While psychiatrists routinely encourage offenders to make arrangements with a psychiatrist in the community for follow-up care, additional monitoring is warranted to ensure the prescription is filled and medication taken, when deemed necessary. Additional follow-up services would be helpful to address the cost of filling the prescription and monitoring medication.

- Transitional opportunities for offenders include workforce centers, INVEST programming (such as work skills, interviewing techniques, interpersonal skills, community resource options, educational and employment opportunities, and financial aid), housing referrals, and child support consultation. Offenders are also given information to help them understand the release process. While these services are helpful, ongoing intensive case management upon release is crucial to help the offender apply these skills.

- Current DOC policy under "interpersonal associations and sexual misconduct between staff and offender" stipulates that "employees, volunteers and independent contractors will not maintain any interpersonal association with current offenders, their family members or with former offenders of any jurisdiction or their family members unless specifically approved." The department is working towards changing the language of the policy to enhance community support resources.

- The facility health services administrator and mental health services directors are developing a "transfer health care summary" form to be used at all institutions. Offenders' specific health concerns will be identified. Case managers will assist the offenders in enrolling into MA, GAMC, or MinnesotaCare before release so they will be better financially prepared to pay for medications and health care.

- Prison Fellowship is developing a mentor program for offenders. It will be available in all institutions.

The DOC should continue its work in improving the areas noted under this recommendation section.

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 4: Interagency Decision Making Process and Criteria for Funding

MEETING SUMMARY

Welcome, Introductions and Overview

Commissioner Marx, Assistant Commissioner Gomez and Commissioner Fabian thanked members and stakeholders for attending the meeting during National Homeless Awareness Week. Commissioner Marx reviewed the planned meeting agenda to discuss funding strategies of each department, the interagency decision-making process, and the draft outline of the report.

Update on Housing and Service Funding Strategies

Department of Human Services:

Assistant Commissioner Gomez stated that the Department of Human Services (DHS) is concentrating on a broad array of services and programs, looking at possible changes in funding priorities, services and programs that could be directed to certain populations.

In supportive housing projects, there is usually a piece that cannot be funded by any sources that DHS has. It would be useful to have flexible funds. This is a big challenge. Our programs are extremely categorical and all kinds of legal requirements are attached to them. We think we can find some limited amounts of funds that could at least be in a pool to provide flexible, wraparound opportunities.

Strategies may include: promoting best practices to the counties; funding for permanent supportive housing for Rule 36 facilities for people with mental illness; conditional use of the MSA shelter needy provision; broadening the definition of housing with services in GRH that addresses chronic homelessness to provide income to an individual; convert some housing subsidies that are now a part of the monies that go to the mental health initiative ($1,330,000) to support and target homeless people; target PATH ($460,000 state dollars) to chronic homeless in Clay, Hennepin, St. Louis, and Ramsey counties; looking at Safe Haven programs; reviewing chemical dependency proposals and promulgating Rule 31 to allow case management costs to be eligible for payment under the program; employment services for MFIP families; work with counties on child protection; and add new resources to support SSI eligibility efforts.

Department of Corrections:

Commissioner Fabian stated that the Department of Corrections (DOC) is looking at corrections compliance and what can be done with transition and housing. There is an untapped resource using offenders on their way out of prison on work crews to do maintenance on tax-forfeited properties or building prefabricated homes.

Minnesota Housing Finance Agency:

Commissioner Marx introduced potential strategies including setting priorities for the awarding of capital funding; creating a threshold service funding plan; leveraging other funding; assessing the costs of program space and unit size; and looking at accessing agency resources in order to provide operating cost subsides. The Minnesota Housing Finance Agency (MHFA) is prepared on a short-term basis to get as many units out providing housing for long-term homeless as possible. We are looking at this as an opportunity to sit down with federal programs with the goal of ending long-term homelessness as well and say where we need help. We are prepared to put resources (capital and operating) on the table, but cannot fund over long-term, need to see everyone involved over the long-term.

Interagency Decision Making Process

Commissioner Gomez reviewed potential decision-making processes in terms of funding of supportive housing and also in terms of a process for input into policy and advice necessary throughout life of these projects.

Discussion on Draft Outline of Report

Members reviewed a draft of the report outline. Members and stakeholders were encouraged to submit additions to the outline, comments, and questions to Cherie Shoquist at MHFA, Janel Bush at DHS and Bill Donnay at DOC.

Discussion of Follow Up on Strategies for the Next Meeting

Commissioner Marx ended by stating that this will be a busy month as we proceed to draft the report, please contact us with your comments on the report. Thank you for your participation.

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SUPPORTIVE HOUSING FOR PERSONS
EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 4: Interagency Decision Making Process and Criteria for Funding

OBSERVATIONS, IDEAS, INSIGHTS, AND COMMENTS
ON HOUSING AND SERVICE GAPS

The following is a summary of comments made by Working Group Members and written comments made by Stakeholders in attendance at the October 15th Working Group Meeting.

Gaps in Capital Funding

Bonding

- Bonding provides an excellent opportunity to spread out the capital costs. We need a large request that capitalizes on this opportunity.

- The idea of selling state GO bonds is the best idea, it spreads the cost of capital facilities over the life of these projects versus being financed all up front.

- Bonds are a sterling idea, never been a better time.

- Is there a way to connect state bonding with the insurance model?

- Marry GO bond funding with Low Income Housing Tax Credits (LIHTC).

- The advocate community has endorsed this notion of using GO bonds for capital costs. Scale it to a level feasible to attain. It has to be married to great cost reduction ideas and criteria. If GO bonds don't get us there all the way, the community can help realign resources more toward supportive housing even if it means less workforce housing. Capital costs issues are easier to align and resolve.

- One homeless group cannot be pitted against another. Our message must be inclusive of all populations and not reduce the resources currently being used to help others experiencing homelessness. This should also apply to bonding. Bonding that is flexible for a broad continuum of housing to save people experiencing or at risk of experiencing homelessness.

Collaboration and Leveraging

- Make sure HUD McKinney Vento Homeless Assistance dollars are fully accessed across the state for supportive housing. In some areas of the state McKinney funds are not even applied for.

- Seek support by local jurisdictions and cities to realign use of Community Development Block Grant (CDBG) to support capital and possibly operating costs. CDBG is under-utilized for affordable housing (especially in Minneapolis).

- Look at how other states use CDBG to fund supportive housing.

- Incentives for developers and local communities to include supportive housing as a part of new development.

- Create regional funders councils so that as projects are getting funded by one source, the funders can come together to talk about where there are gaps in funding and who has the resources that can help alleviate the gaps. Similar model to the Ramsey and Hennepin Funders Councils. It would make sense to do this by Continuum of Care regions, with one in the metro area.

Cost Containment/Reduction in Development Costs

- Cost containment philosophy can become rigid. It is cost effective to develop, cost intensive to maintain.

- Support quality material choice to increase long-term durability of housing created. Less cost over life of building (30 years). More local support potential (neighborhood politics).

- Reduction in program space is a concern.

- Look at reusing or redesigning existing buildings. May help with siting.

- Reuse of existing buildings is a good idea.

- DOC workforce is a captive audience. What pieces can they contribute? Could they make doors, etc. and be partners to rehab houses? What partnerships could we establish in building to reduce the cost? (DOC is looking down these lines. Senator Neuville is working on constructing a building at Faribault where inmates could put prefab houses together. Already working with unions and other systems. $70,000 pre-fab homes, inmates construct and deliver. Do have partnership that builds about 120 houses a year all over state. Doing more in Greater Minnesota.)

Gaps in Operating Funding

Rental Subsidies

- The operating cost solution is to have project based Section 8 certificates. Strongly suggest use of federal versus state or local funds. A barrier has been federal officials in Washington have to approve on case-by-case basis on project basing in an impacted area. Need greater cooperation from local public housing authorities and local HUD office in figuring out ways to attach Section 8 vouchers to projects. HUD Washington will at times overrule decisions. Perhaps find a way to bring this key issue to republican leaders attention. Need a political strategy to end homeless in 10 years. Making the decision locally regarding project basing Section 8 is the biggest, easiest single thing we can do.

- On the operating side, the rental assistance disadvantage is that a good number of people who are chronic homeless aren't going to be eligible for Section 8. What we need is the housing, the rental assistance for this population.

- Project based concerns with some restrictions in population we are looking at (example – CD, criminal).

- Need to take a look at project based Section 8, it is the long-term solution for service providers also trying to provide housing. Have to project out 15 years how fund this project. Reiterate the idea of priority being education, need to remember housing is healthcare, is education.

- Section 8, the housing choice voucher is an opportunity and challenge. It is the deepest subsidy and federal and mainstream resource. Flexible in a way (general occupancy, mixed income deals). Could be more flexible, some confusion, some local discretion as to how these programs are run. One challenge is the trade off for local HRA without new vouchers - advocate for new, incremental vouchers. Project based assistance was not meant to do supportive housing in terms of HUD silos.

- 98% of Section 8 is utilized according to the local HUD office. Utilization rates have come up dramatically – we are not getting new incremental vouchers. Make a choice when already serving, who are you going to say no to? Need incremental funding from Congress and a commitment. There isn't a burning commitment to the fact that homeless is a huge problem for suburbia. Need to work on the sense of awareness.

- Assess each Section 8 voucher and USDA RD Rental Assistance units to prioritize the use of this assistance. If an individual only uses a small portion of the total assistance available for Section 8 rental assistance unit, then replace the unit with a state RA unit to free up the federal RA/Section 8 to provide a larger amount to a more "needy" individual.

- Asset test all people receiving assistance so those with a good asset base are not consuming a subsidized unit that could be available to a person with less resources.

- Force PHA's to use 20% of funds toward project-based assistance.
- Larger PHA's created for general occupancy, but trying to reach specialized population. As an agency, have difficulty making decisions where there would continue to be a concentration, need geographic distribution and choice in both housing and services. Work with cities in helping them manage and convert Section 8 to project based. There are trade offs. Vacancy grows and utilization rate increases as we divert resources from waiting list, then people are not being served.
- Push for Continuum of Care regions to plan and initiate Shelter Plus Care proposals (federal money which is under-utilized in Minnesota).
- Each Continuum of Care group submit a HUD Shelter Plus Care application to address homelessness for a new program or increase a project.

Income Subsidies

- Free up Group Residential Housing (GRH) dollars for additional rent assistance.
- Intrigued about ways around targeting individuals - GRH. Let them contract to a greater extent.
- Do not underestimate importance of people having a stable income in their lives. Many are certifiably disabled. Simple thing we could do. SSI applications are complicated (federal) as they want to be sure people do qualify. Problem – disorganized behavior, cannot follow up with this application. Federal officials don't have a choice but to deny. It is labor intensive. Once this is resolved make sure people who are eligible are entitled to those benefits. Good step to begin to introduce stability in the lives of people.

Gaps in Services Funding

- Address the long-term commitment for housing and the year-to-year commitment to services.
- Remember the intake side, there needs to be a better case management system available right away.
- A central place instead of many to figure out what to do, how to house a client. Could we combine those resources to have a central place questions could be answered and paperwork can be done?
- Operation costs decrease with stable, consistent volunteer base. Seek commitment from faith communities to establish a volunteer bank for housing support and specific projects.

- Outcome measurement of how individual setting is working versus community setting – very important in making a commitment. Needs to be some consensus so people making project based decisions are making the right ones.

- Double the Bridges funding and extend it to other people chronic homeless who are beyond MI.

- Have PATH staff do MA billing and thereby increase the number across the state.

- Reduce county match requirement to 25% for contracting out access to MA waiver funds (particularly child welfare targeted case management) used to provide support services for supportive housing. 50% is to onerous for counties to bear in current economy.

- The funding catalog is the most comprehensive listing ever seen of all different program funds from DHS, thank you. Add opportunity column to this chart. Pick out 3-4 of these areas that would be helpful to us. GRH dollars would be one, Rule 36 restructuring, challenges serving people already in those facilities but will allow do community supports really want. Different philosophy about where people individually should be making choices. What are the best choices – individual or group sites. Get data out there and see there is some progress. Pick 3-4 issues on DHS list to really dig into and work on.

- There has to be clarity within the human service funding community about whether they really support supportive housing or not. To provide money for supportive services you need dollars. Two problems: 1) so much of human services funding comes from these categorical streams; and 2) people in hierarchy don't believe in supportive, single site housing. When projects have problems with service funding, the question is asked, is it because DHS can't help or is it that they don't believe in it or won't help?

- Block granting. Could you bundle funding and attach it to the building as long as you maintain certain thresholds of occupancy and assess occupants on an individual basis? Could you streamline a lot of paperwork and process and stabilize supportive services?

- Need to know more about DHS funding and its flexibility. Inflexibility now as to who can use it. No free lunch.

- Service providers have to be the key. Does not work to partner only with building people and developers – poor match. Key to making it work is the service side.

- Service providers know how to do this stuff, don't need to identify models, just need the housing. Service and operating agreements for 15 years.

- Property owners are going to be held liable for activity in which no one goes to jail. Services – need plan to address commitment.

- Focus resources on discharge planning so no one is released from corrections, discharged from hospitals/Rule 36/CD programs into homelessness. This will require advocacy for housing placement, public benefits, income supplements, etc.

- Streamline pre-certification diagnostics and process for SSI eligibility – adult rehab option.

- Service funding commitments need to occur earlier in the process. The development timeline demands that developers define their project and target population at least three years before the doors will actually open for rent-up. Coordinate better with service funders along the way but without clear and reliable service funding commitments, what often occurs is a project that promises to capital funders to serve a specific population (along with architectural drawings appropriate for that population, perhaps neighborhood conversations, etc), and then the service funder will say, we have no money left so why not serve these folks (with green hair) instead -- or worse, "we simply have no money, good luck". Obviously service funding has constraints including annual budget appropriation processes but some type of commitment from service funders seems reasonable. At a minimum, if a project serves a priority population for the county or DHS or whomever, then they will commit to figuring out the funding for the project once it wades its way through the years of capital fundraising.

- More flexible Medicaid waivers. The state has the opportunity to legislatively create waivers that would target supportive housing tenants and potentially even be shaped to provide single site based services. We should do it.

- This is a good time to purse waiver option housed in community housing versus an institution. Medicaid dollars - there is a lot to be understood about local match.

- Most counties identify many different organizations that provide housing. It is so fragmented. Need additional resources; there are a significant amount of resources at our fingertips through efficiency. Know the in's and out's of all those resources to get to what we need done. All types of pots, please recognize that we can be creative, DHS can say our current way of funding and providing services is this – but question could we also do this?

- Best practices committees. Counties do not understand homelessness, supportive housing. Best practices a way by which to educate and inform counties. Issues between rural and urban exist. All these levels and labels of workers – intent is good, but what about cost.

- Why could housing not be part of treatment? Restricted for some reasons thus far. Population we want to help and serve is often ineligible. Remove some of those barriers if we are going to help. Need to educate and assist, formulate a way to show why they need to care about it. Service standpoint, funding mechanisms individual based – yes, but also problematic based (i.e. mental health).

- Undermining some things already in place by changing Emergency Assistance to county-based assistance.

Other Ideas, Issues, Comments

- Truth except for a few times when there's been a crisis, housing is not viewed by the public as a very important issue (and therefore, not by the politicians). Find a message that is so compelling that it ranks up with nursing homes, ethanol and education. Part of message about homelessness. There is a real consensus that there's something wrong with people being homeless. Nowhere near the same consensus with supportive housing; many don't know what that is. Be careful that homelessness is the problem people really want to do something about. Pay attention to the homeless issue. Accept the fact it probably will take a decade. Housing tries to do far too many things with too few resources. Need a message and consensus among ourselves as to what our priorities are, we have to prioritize. Chronic homeless really is a key issue, makes more sense to solve that issue than some others. Limit the agenda so we really can.

- Develop a business plan through a strategic collaboration of business, government, philanthropy and faith-based sector. Access funds through faith institutions.

- Need to realize that not just politicians, but own communities and neighborhoods need to be on board.

- Prioritize (similar to Family Homeless Prevention and Assistance Program) users and consumers of supportive housing.

- Homeownership programs, training, write-offs are the trade-off. This is the market issue not housing for people in poverty.

- Supportive housing provided by a property management consortium which contracts with private market landlords for siting.

- More partnerships with community land trusts, Habitat for Humanity, non-profits.

- Induce businesses to come to Minnesota (job zones). A legislator mentioned what if we developed supportive housing zones.

- Talk to homeless about what kind of housing they want to live in.

- States and counties to engage in data collection. Worked on methodology to crunch the data. Similar method could be applied to those successfully served.

- Corporate sponsorship.

- Promote moderate-income housing to encourage a movement from subsidized elderly housing to free up units.

- Seek cooperation with state realtors to identify local sites and buildings which could be converted to supportive housing.

- Seek corporate sponsorship. Governor should convene a corporation roundtable on workforce housing.

- Look at non-traditional housing options for single adults (rooming houses, hotels, hostel models).

- Strategic, methodical and stricter enforcement of fair housing laws so that projects can quickly and efficiently do adaptive re-use of hotels, nursing homes, etc.

- Zoning and local government regulations really has to be addressed. What do the cities want and how can we help them get that. Someone at federal level needs to be brought on board to make it happen at the federal level.

- Problems caused by fighting neighborhoods, communities limits locational choice, delays increase costs, and reinforces the wrong idea that neighbors can choose their new neighbors based on income, race, disability, etc.

- NIMBY attitudes cost time and money. We need to bring the Attorney General and Legal Aid to the table to ensure that strict enforcement of Fair Housing laws are applied to supportive housing developments. The approach needs to be strategic, coordinated and methodical and should reinforce and publicize basic principles such as the fact that neighbors are not legally empowered to approve or disapprove projects at ALL and certainly not based on family size, income, race, or disability. We have had projects delayed for literally years while neighbors coerce politicians to stall or disapprove projects because they don't like the people or disability of its future tenants. This is simply illegal and we should be aggressive and united in saying so each time it occurs. These delays mean increased legal fees, increased construction costs (inaccurate construction estimates because of delays), and can threaten other already committed money from private sector when the project doesn't move forward in a timely way.

Additional Resources

- Seek greater support from federal representatives and senators to increase housing support. (Get the federal government back in the business of funding housing.)

- If nobody allocates new money, they are not taking it seriously. How can you end something when you're not willing to put funds toward it?

- Need to recognize that at the end of the day, new money will be needed. All the cost reduction and reallocation steals from the low wage working poor to fund projects for extremely poor working poor homeless population.

- Deed tax mortgage interest cap.

- Non-profits pay property taxes on supportive housing. No property tax on nonprofit supportive housing.

- It's disingenuous to say we plan to end chronic homelessness without additional state financial support. The governor and state legislature need to increase funding.

- Look at expanding tax credits like 4D (more incentive for landlords to have corrections people and others).

- New taxes needed.

- License plates sold for environmental funds (voluntary revenue). Community land trust model – homeownership somewhere off in the future – can that concept be applied to a larger scale on a multifamily housing level?

- Fees – could we have a hotel tax?

- Add a real estate recordation fee exclusively for supportive housing development fund for a limited number of years (say 10). The Coalition on Housing and Homelessness in Ohio, Ohio CDC Association, LISC and other housing and community providers were successful in doubling real estate recordation fees, generating an estimated $90 million in dedicated housing funds over the next two years.

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Service Funding Survey Summary

This survey was sent to Working Group Members and Stakeholders that provide services and housing support services. A summary of the 24 responses received follows.

How do you integrate county service funding into supportive housing?

1. Do you have contracts with the county for services, for how long, for what services or programs?
   Intensive case management and Non-intensive case management
   Adult Rehabilitative Mental Health Services (ARHMS)
   Community Alternatives for Disabled Individuals (CADI)
   Community Support Services (CSP)
   Targeted case management
   Assertive Community Treatment (ACT)
   Parenting support services
   Group Residential Housing (GRH) and Group Residential Housing Demonstration

2. **What county service programs are most useful?**
   Financial Assistance, Emergency Assistance (EA)
   Medical Assistance, CADI
   Mental and chemical health assessment, treatment and case management
   Intensive case management
   Assisted living plus
   Daycare assistance
   Food support

3. **What county service programs are most restrictive?**
   Adult Rehabilitative Mental Health Services (ARHMS)
   Community Alternatives for Disabled Individuals (CADI)
   Targeted case management
   Support services funds
   Accessing MA waiver reimbursement to fund services for supportive housing
   All, if chemical dependency

4. **What service funding are you unable to access? Why?**
   MA and SSI – First diagnosed with CD instead of MI
   Harder now that GAMC is no longer available
   Veterans health care benefits
   No funding for non-custodial fathers with criminal history
   No funding for property management

5. **Who do you serve primarily?**
   MI, CD, co-occurring, female victims of family violence, people with disabilities, individuals and families with low-incomes

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Supportive Housing for Persons Experiencing Chronic Homelessness WORKING GROUP

Meeting 4: Interagency Decision Making Process and Criteria for Funding

INTERAGENCY DECISION MAKING PROCESS FOR FUNDING SUPPORTIVE HOUSING

The Working Group is required by its enabling legislation to "...propose a formal inter-agency decision-making process and plan for funding supportive housing proposals." The process and plan will direct state-level efforts long term. The decision-making process may focus on policy issues, on operational issues and project selections, or on both levels. Approaches for how the interagency process could be structured and how projects selections could be handled follow. How do we ensure that people who currently experience long-term homelessness or have recently experienced long-term homelessness are part of the process?

Some Financing/Project Selection Models

Super RFP Process. MHFA and the state's other major affordable housing capital funders have operated a one-stop, consolidated "Super Request for Proposals" process for a number of years. It funds both supportive and conventional housing projects. All proposals currently submitted compete for a single pool of funds. This approach could be retained or a designated amount of capital funding – some percentage up to nearly or all available funding -- could be set aside for projects targeting chronically homeless households. The capital funding partners now jointly select projects. Depending on the inter-agency decision-making arrangement chosen, the other state agencies could be brought into the selections process as voting or non-voting members.

MHFA's "MARIF Program" offers an example here. MHFA received state appropriations to design and operate a program financing units for households receiving Minnesota Family Investment Program assistance – the "Minnesota Affordable Rental Investment Fund/MARIF." MARIF covered 100% of a unit's capital costs ("fast-track" production), avoiding the delays otherwise experienced when securing funds from multiple sources. MHFA sought active participation by DHS both in designing the program as well as in project reviews.

Alternate Super RFP process. A separate, parallel selections process and funding allocation could be set up in conjunction with the Super RFP to concentrate on supportive housing projects. It could continue being administered by MHFA and the other major capital funders, or depending on the inter-agency decision-making approach selected, the other state agencies could become participants as well.

Funding Block Grant. A designated amount of Super RFP funding would be turned over to the chosen inter-agency decision-making body for operating an entirely separate supportive housing application and selections processes.

Funders' Councils. Organize regional Funders' Councils to expedite securing resources for filling project development gaps. These would be similar to the Councils now operating in Hennepin and Ramsey Counties. The state's Continuum of Care regional boundaries could be used; the activity could be incorporated into existing Continuum of Care responsibilities or separate, targeted work groups organized for this purpose.

Some Policy/Implementation/Advisory Group Models

Supportive Housing Working Group. A freestanding body similar to the existing Working Group would be established in statute. Agency commissioners would serve as joint chairpersons, or the Minnesota Housing Finance Agency (MHFA) commissioner would take on the responsibility. As with the Working Group, additional members would be selected to represent a range of appropriate sectors (i.e., housing and service providers, counties, housing authorities, developers and other business interests, philanthropic organizations, and others). The respective state agencies would commit staff for performing background analysis and research as well as operational support; a variation would be for one agency to provide the majority of operational support.

Agencies' Sub-Cabinet. State agency commissioners would form the decision-making council. The agencies would commit staff for performing background work, and they either would share in providing operational support or one agency would take on the majority of the responsibility. A variation would be to organize an advisory group to the Sub-Cabinet with representation from the various sectors.

Office for Ending Homelessness. A separate administrative unit would be established to focus implementation efforts. It could be freestanding, linked to MHFA or another agency, or connected to the Governor's Office. It would have its own director. It could be given unique powers including the ability to temporarily waive agencies' rules or statutory provisions in order to better promote development.

Interagency Task Force on Homelessness. The role of the Interagency Task Force could be redefined to provide direction on supportive housing policy and assistance with project selections in addition to it's other responsibilities coordinating state programs related to homelessness.

This existing Task Force has operated since 1990. MHFA was given statutory responsibility then to coordinate all state agencies' services and programs related to homelessness; the other agencies were responsible for furnishing assistance as requested. Members currently include the Departments of Health, Human Services, Corrections, Employment and Economic Development, Public Safety, Veterans, Metropolitan Council and the MHFA; the HUD Area Office also attends. Prime responsibilities include providing technical support to regional Continuum of Care coalitions and their efforts to obtain HUD-McKinney-Vento Homeless Assistance funds, and selecting and monitoring projects funded through MHFA's Family Homeless Prevention Assistance program.

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

DRAFT OUTLINE OF REPORT

This is an initial draft outline of the Commissioners' report and business plan on supportive housing for long-term homelessness. It does not indicate that final policy or funding decisions have been made. It is an opportunity to review the draft outline and to offer suggestions for inclusion in the Commissioners' report to the legislature by February 2004.

Report Structure:

Letter to Governor and Legislature from the Commissioners
Executive Summary
Report
Bibliography and sources
Appendix and supplementary materials from meetings

Report Outline:

I. REVIEW OF CHARGE AND PURPOSE OF REPORT

The 2003 Minnesota Legislature charged the working group to advise the commissioners on a host of issues. The commissioners must report to the Legislature on the activities of the working group and recommend next steps to address the problem of long-term homelessness.

A. Context

1. Place the goal of ending long-term homeless in context of entire homelessness issue. Admit focus on chronic or long-term homelessness is not solving the entire problem of homelessness.
2. Ending long-term homelessness and reforming government systems, not just adding more funding to existing systems.
3. Recognize how poverty impacts homelessness.
4. Acknowledge trade-offs.
5. Highlight federal policies – consistency with Federal Interagency Council to End Chronic Homelessness.
6. Summarize front door to back door strategies – supportive housing most promising approach to end long-term homelessness. (Not abandoning prevention and stabilization).

7. Enunciate policy for the long-term homeless of "housing first" to treat mental illness, treat chemical dependency, reduce recidivism, assist public safety, lead to better outcomes.
8. Recognize prior work upon which this effort is built.

B. Vision and Goal

1. State vision to end homelessness.
2. State goal of ending homelessness by 2009. (Recognize as an aspirational goal based on ability to change systems, obtain funding, and the change in the number of long-term homeless between the 2000 and 2003 Wilder survey).

II. DESCRIPTION OF LONG-TERM HOMELESSNESS

The working group shall determine the key characteristics of individuals and families experiencing long-term homelessness for whom affordable housing with links to support services is needed. ***(Legislative charge to working group #1)***

A. Wilder numbers of persons experiencing chronic/long-term homelessness

1. 2003 Wilder Survey numbers and characteristics (data will not be available until late January/early February 2004).
2. Geographic distribution.
3. Footnote use of HMIS data.

B. Key characteristics of persons experiencing chronic/long-term homelessness

1. Context – Why identify key characteristics?
   a) Not an eligibility criteria, an understanding of population needs in order to develop the plan for housing and services. None of these characteristics are weighted more heavily than others.
   b) What are barriers beyond poverty and funds for housing?
   c) Emphasize length of homelessness over diagnostics.
   d) Focus on populations with greatest barriers.

2. An individual, unaccompanied youth, or family with children who has either lacked a permanent place to live continuously for a year or more, at least four times in the past three years, or prior to any incarceration or institutionalization.

and may have
mental illness,
chemical dependency, or
co-occurring mental illness and chemical dependency.

Additional characteristics may include: domestic abuse and neglect, criminal history, cognitive limitations and chronic health conditions (including HIV/AIDS), among others.

C. Cost of chronic homelessness

1. Culhane findings.
2. Wilder Survey information and analysis.
3. Cost savings type research and data. Include information on the costs of homelessness to the individual and society in child protection, schools, emergency rooms, detox, jails, institutions, shelters, etc.
4. National data – Connecticut, New York, Philadelphia.
5. Local data – Portland Village, Anishinabe Waukaigan, Hearth Connection

III. SUPPORTIVE HOUSING MODELS

The working group shall identify a variety of supportive housing models that address the different needs of individuals and families experiencing long-term homelessness. ***(Legislative charge to working group #2)***

A. Supportive Housing

1. The case for supportive housing – cost/benefit analysis.
2. Discussion of models and evidence which supports them.
3. Minnesota's current supportive housing experience and history, number of projects, financing, etc.
4. Indicate the challenges that have prevented a "system" from supporting this information.

B. Make available housing and service options that allow persons who have experienced chronic homelessness to be successfully housed over the long-term.

1. Principles.
   a) Maximize choice of housing and services for families and individuals; ensure flexible housing and service options that respond to need.
   b) Encourage families and individuals to utilize services, but don't mandate services as a condition tenancy in all cases.
   c) Utilize innovative practices that result in cost containment and use evidence-based models for service and housing that have demonstrated positive results.
   d) Prioritize models that connect families and individuals in communities, near public transportation and services.
   e) Provide the necessary housing tenancy supports to find and maintain housing, a critical service need for people who have experienced chronic homelessness.

C. Estimated Need

1. Propose numbers and types of supportive housing units and types of supportive service needs for the identified population.
2. Include estimated per unit cost based on MHFA data:
   Construction, rehabilitation
   Family housing, individual housing
   Scattered site, single site
   SRO with or without bath and kitchen in unit
3. Are there significant cost differences?
4. Create a table of estimated need.

D. Housing Options: Housing First

1. Individuals
   a) Safe haven
   b) Scattered site
   c) Clustered site
   d) Single site – including SRO

2. Families with children
   a) Scattered site
   b) Clustered site
   c) Single site

E. Service Choices: Provide Necessary Services

(Content will be added per discussion from Meeting 2).

IV. CAPITAL, OPERATING AND SERVICES FUNDING GAPS

Determine the existing resources that may fund these models for families and individuals who are experiencing long-term homelessness. Identify the gaps in capital, operating, and service funding that affect the ability to develop supportive housing models. ***(Legislative charge to working group #3 and #4)***

A. Funding Issues: Gaps and Broad Strategies = A Funding "Vision"

1. Recognize that there is little likelihood of major new funding in short-term; but identify potential future funding sources that could make sense over time.
2. This is a more general discussion; specific "business plan strategies" come later.
3. Review of each cost category: sources and uses and major strategies for savings, gap filling, etc. from our existing work plus some others.
4. Set forth some principles.
   a) Maximize federal funds and flexibility.
   b) Service and capital efficiency.
   c) Services follow person.
5. Identify broad strategies.
   a) Maximize access to resources (such as SSI)
   b) Target existing programs
   c) Block granting of service funding for long-term homeless

B. Capital Funding

The bricks and mortar of a supportive housing project (including common or service space), whether new construction, acquisition, or acquisition and rehabilitation.

1. Reduce development costs.
   a) Reduce size of units, reduce service space (appropriately with careful planning).
   b) Consider existing rental housing.
   c) Encourage adaptive reuse of existing structures.
   d) Review loan processing.
   e) Standardize legal documents.
   f) Develop standard design plans.
2. Funding.
   a) Housing Trust Fund
   b) Housing Tax Credits

c) MHFA – Agency resources
d) HUD Supportive Housing program
e) State General Obligation Bonds
f) Philanthropic funds

C. Operating Funding

The costs of maintaining the property (taxes, insurance, utilities, maintenance, reserves, any debt service).

1. Rental subsidy.
   a) Use existing project based Section 8 and public housing.
   b) Housing Trust Fund
   c) MHFA – Agency resources
   d) HUD Supportive Housing program, Shelter Plus Care and Section 8 SRO moderate rehabilitation
   e) Incentive for mixed income development projects to include supportive units.
2. Income.
   a) SSI outreach
      (i) improve existing county SSI outreach work – system change coordinate with local Social Security Administration
      (ii) fund new SSI outreach work for long-term homeless – HOPE
      (iii) improve SSI reinstatement upon release from correctional institutions
   b) GRH
   c) Bridges (requires additional funding)

D. Support Services Funding

The healthcare, case management, life skills, employment and training services and specific housing support services necessary to support stable housing.

(Content will be added).

V. FUNDING STRATEGIES

A. Identify priorities in each area to pursue based on promise of short-term funding; list others either because they cost money or will take time to resolve.

B. Make case for flexible fiscal notes given potential cost savings.

C. Place holder for miscellaneous issues such as siting issues; the need to collaborate with delivery partners and local governments on incentives for localities to site.

D. Planning link to continuum of care planning and the Metro Regional Council to End Homelessness, use continuum of care to maximize HUD capital, operating and service funding.

E. Commit state funding as a "challenge" for federal funding.

VI. INTERAGENCY DECISION MAKING PROCESS

Propose a formal, interagency decision making process and a plan to fund supportive housing proposals based on the agreed upon criteria, with the goal of maximizing access to funding for the capital, operating and service costs of supportive housing proposals either scattered site or project based. ***(Legislative charge to working group #5)***

Describe the decision making process. (List of options below.)

Obtain input and feedback from people who are experiencing long-term homelessness currently or have recently experienced long-term homelessness.

A. Some Operating, Financing, and Project Selection Models

1. Super RFP process
2. Alternative Super RFP process; or
3. Funding Block Grant
4. Funders' Council
5. Integrate ongoing evaluation of strategies for people experiencing long-term homelessness

AND/OR

B. Some Policy, Implementation, or Advisory Group Models

1. Supportive Housing Working Group
2. Agencies' Sub-cabinet
3. Office for Ending Homelessness; or
4. Interagency Task Force on Homelessness

VII. COMMISSIONERS' RECOMMENDATIONS (BUSINESS PLAN)

The plan must include an estimate of the statewide need for supportive housing, an estimate of necessary resources to implement the plan, and alternative timetables for implementation of the plan and propose changes in laws and regulations that impede the effective delivery and coordination of services for the targeted population in affordable housing.

A. Phase I – Three to Five Years.

1. Targeted population.
   a) Priority for key characteristics?
   b) Will long-term homelessness "tenure" be a priority?
   c) Substantial risk of chronic homelessness also a priority?

2. Supportive housing.
   a) (See estimated need section III, C)
   b) Unit goals and capacity.
   c) Cost estimate ranges for each need.

3. Sources of funding by each type of funding need.
   (See funding section IV, A, B, C and D)

   a) General:
      (i) state bonding of $4 million or more for FY 04-05.
      (ii) make some assumptions regarding service and operating based on short-term implementation of various strategies
      (iii) develop an overall cost/uses mix
      (iv) cost estimates for a unit number goal over three years for each cost – capital, operating, services
      (v) develop overall sources mix for each cost based on this unit goal as above (e.g. who pays in what proportion between government, non-profit and charitable organizations, local government)
      (vi) identify the gaps; what we are working on with potential sources being additional MHFA agency resources, foundation resources, federal resources, continued progress on service funding, better fiscal climate will make available funds based on demonstrated cost savings, etc.

b) Resource Analysis
   a. DHS resource analysis
   b. DOC resource analysis
   c. MHFA resource analysis
   d. Other resources

B. Phase II – Long Term

Filling difference between phase I and the end; less detail; need to monitor progress and see results of 2006 Wilder survey.

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Man, woman apparently beaten to death in Duluth

Larry Oakes
Star Tribune Northern Minnesota Correspondent
Published 10/31/2003

DULUTH -- For at least 15 years, Donald Erwin Smith's permanent address was all of downtown Duluth, his friends say.

He ate at the Union Gospel Mission or the Damiano Center's soup kitchen. When he wasn't drunk, he sometimes slept in the 40-bed shelter run by a coalition of churches. Sometimes he shared an apartment with some other men, but he didn't like staying there because they got violent when they were drunk.

So Smith, 48, often drank himself to sleep in his "camp" -- a tent and pile of blankets under a pedestrian bridge where homeless people congregate, between Interstate Hwy. 35 and Railroad Street.

Sometime Wednesday, a woman apparently joined him.

Shortly before midnight, police responding to a 911 call found their bodies there. It appeared they had been beaten to death.

Officers quickly identified the male victim as Smith, who was well-known among Duluth's homeless people. But as of Thursday night, investigators still had not pinned a name to the middle-aged woman, who carried no identification. She is believed to be American Indian.

Smith was an Indian, too. He was originally from northern Minnesota's Nett Lake Reservation, according to his cousin, Rebecca Halvorson, who said police told her of his death as they swept through Duluth's homeless community Thursday, questioning a lot of street people about where they had been the night before.

Officers checked railroad cars, other transient camps, alleys, doorways and shelter rosters, trying to get leads on the woman's identity and on who might have killed the pair.

"Indications are that the person responsible for this may have known these people," Duluth Police Chief Roger Waller said. "The campsite is in an odd place; it's not a place you'd just happen by." He said the couple may have had a romantic relationship.

Officers asked the city's main homeless shelter, run by Churches United in Ministry (CHUM), as well as three soup kitchens to try to determine if any middle-aged American Indian women who used their services were unaccounted for.

"There are a few women we haven't seen yet today," said Kim Randolph, coordinator of CHUM's shelter and its Drop-In Center, a place for homeless and poor people to warm up, wash clothes and get a noon meal.

The 911 call that summoned authorities was placed by Raymond Manitowabi, who had been sleeping in a nearby tent before waking up and discovering the bodies.

Waller said it's possible Manitowabi drank with the couple earlier. He walked or ran four blocks to the Radisson Hotel to call 911, saying he'd found a man "stiffer than a board" and a woman who might still have a pulse. He said they'd been "beat up."

Autopsies are scheduled for today. Though they appeared to be victims of a violent assault, Waller wouldn't speculate on what weapon was used, if any, and said the cause of their deaths has not been confirmed.

Waller said Manitowabi was not a suspect. A police report released Thursday said that after interviewing him, police brought him to Duluth's detoxification center, to be "lodged . . . on a 72-hour hold."

Waller said Smith was last seen alive about noon Wednesday in downtown Duluth.

Bedless by choice

The Drop-In Center's two big table-lined rooms were crowded Thursday with dozens of street people who had been driven inside by a cold rain. Many were talking about the killings, and many said Smith wouldn't have done anything to provoke the assault.

"He was a nice guy who didn't fight," said Clarice Fiskari, who had known Smith since they were kids. "I saw him a couple months ago in detox, and he asked me to come out and see his camp. Sometimes he went there because he didn't like the crowds in the shelter."

Randolph, the shelter coordinator, said she'd known Smith since she started working at CHUM 16 years ago.

"Don was a gentle man, kind, sweet, with a good sense of humor," she said. She said she'd be surprised if alcohol hadn't played a role in the killings:

"I would guess they were drinking together. Maybe she had a boyfriend who came by and got angry. Or maybe somebody they were drinking with went nuts."

Randolph said homeless people go under the freeway and bridges in that area because it's close to downtown but also hidden, making it less likely that they'll be rousted by police. The area is sandwiched between the freeway and a railroad yard, beyond which is an industrial area of the western Duluth waterfront.

Randolph said that about 40 people sleep outside in Duluth on any given night, even when there is room in shelters, and even during the harsh winters.

"Some aren't able to sleep in the close confines of shelters," said Jean Gornick, executive director of the nonprofit Damiano Center, which has a soup kitchen, clothing exchange and other services. "Some are drunk or using drugs and therefore aren't allowed in shelters. And some have some form of mental illness that makes them shy away from other people."

Randolph said the killings are a reminder that even though many fear street people, it's the street people who often become victims.

Larry Oakes is at loakes@startribune.com.

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County perspective critical to developing options for the chronic homeless

By Commissioner Kevin Goodno
Minnesota Department of Human Services
Minnesota Counties
Published October, 2003

An estimated 5,000 Minnesotans a year, including more than 1,000 children, are chronically homeless. Chronic homelessness is complex to define. Generally speaking, a chronic homeless person is someone who may face a variety of problems – including mental illness and chemical dependency – who has lacked a permanent place to live continuously for a year or at least four times in the past three years. These families and individuals need both support services and affordable housing.

Many of the people who are chronically homeless face a combination of barriers. In addition to chemical dependency or mental health problems, they may face ongoing health conditions or a criminal history that makes it nearly impossible for them to get housing or, more importantly, to keep it. As a group, they may use a disproportionate share of services or simply may not access necessary services except in an emergency.

Reducing and eventually eliminating chronic homelessness is a priority for the Pawlenty administration. Commissioner Tim Marx (Minnesota Housing Finance Agency), Commissioner Joan Fabian (Department of Corrections) and I are working together on a administrative-wide initiative to address this issue.

The Working Group on Supportive Housing for Persons Experiencing Chronic Homelessness was charged by the Legislature to advise us on ways to reduce long-term homelessness, to reduce the inappropriate use of crisis services and to improve outcomes for families and individuals. The group began meeting in July and includes representatives from county boards, housing and redevelopment agencies, nonprofit service providers, philanthropic groups, development and business organizations. The county representatives include Hennepin County Commissioner Gail Dorfman, Ramsey County Commissioner Susan Haigh and Linda Anderson, director of human services for St. Louis County.

Input from the working group will inform the development of a business plan that will assess the needs of this population, determine available resources and currents gaps in support, and propose multilevel strategies to address them. It will work to overcome bureaucratic barriers that typically prevent agencies from joining affordable housing with the supportive services that many of the chronic homeless need to successfully live in the community. The group will also facilitate coordination between funders, service providers and housing developers by proposing an interagency process for the selection and funding of supportive housing projects in the future.

Our goal is to create a better performing, cost-effective system to serve those who need assistance in overcoming housing and other challenges. We are especially concerned with the number of children who are among the most helpless victims of chronic homelessness. A report on the findings of the work group is due to the Legislature in January.

Because of your frontline responsibilities working with chronically homeless people and your key role in administering many of the services, we would like you to share your perspectives and ideas on how to accomplish our goals. We also want to know what gaps you have experienced in serving individuals and families who are chronically homeless and what tools and models you have found to be particularly effective.

More information about chronic homelessness and the task force is available http://www.mhfa.state.mn.us/. This MHFA Web site includes a list of task force members, our agendas, minutes and additional background information. There is also a contact link for providing feedback.

We are confident that our joint efforts will produce an effective plan in this short time frame. We look forward to hearing your ideas and to working with you in the days ahead as we join housing and services to better address the needs of the chronically homeless.

Addressing mental health needs in Southern Minnesota

Faith Kammerdiener
Staff Writer
Published October 15, 2003

ST. PETER – Finding enough funding and finding adequate housing for people suffering from mental illness will be the two top obstacles in implementing community-based mental health services, say human services directors in southern Minnesota counties.

These two concerns surfaced when the Minnesota Department of Human Services Commissioner Kevin Goodno met with human services personnel last week asking what are the barriers counties see in building a solid foundation for the new program the legislature approved last session.

The program promotes treatment for mentally ill individuals in their own communities instead of sending them to Regional Treatment Centers like St. Peter.

The goal is to move those services to the community. Sometime in the future, those programs will no longer be offered at the St. Peter Regional Treatment. However, the security hospital and the sex offender program will see no changes in care and services.

While counties are under pressure to work on setting up the program, Olmstead County Service Director Paul Flussnier said, finding good housing takes a long time to develop. Also county funding is so tight, wondered where the money will come from. Goodno said he recognizes the housing issues and said the state is working on finding solutions along with looking for solutions for chronic homelessness.

However, finding more funding for the program, most likely will have to be found somewhere else. The state most likely will not be able to influx any additional money into the system to help counties in the transitional process.

But despite these barriers, Goodno stressed, counties must build a strong foundation ensuring success of community-based services. "Right now, we have a fragmented mental health system at its infancy," he said. Before this program moves another step further the foundation must be laid for a comprehensive program. The state and counties must identify a solution and then make a plan to make the solution work. Goodno admitted the new program is probably pushing at people's comfort levels a bit.

Other human services directors voiced concerns over closing regional treatment centers before the new program is in place. Goodno said treatment centers and programs won't close until the community-based program can function well on its own. He added the state has no specific dates as to when treatment centers would close and programs would be eliminated.

"It'll take us awhile to get there," Goodno said.

Other concerns brought up dealt with the shortage of good psychiatrists for treating patients. Blue Earth County Human Services Director Robert Meyer even suggested the governor create a program similar to the one he announced last week to attract "super" teachers.

Goodno acknowledged Minnesota has a shortage of quality psychiatrists. It's national and a shortage will probably continue to be a problem.

Working List of DHS Strategies-11/18/03

The following is a working list of the strategies under consideration by DHS staff for submission to the Governor's Working Group on Supportive Housing for the Chronic Homeless. This is a list that is not final. Much work remains to determine feasibility and cost.

Agency-wide proposals

- DHS wraparound service funding proposal.
- Develop and promote best practices among counties for serving the chronic homeless.

GRH/MSA proposals

- Add Rule 36 residents to the MSA shelter needy provision.

- Change the definition of Housing with Services to include proposed supportive housing settings that address chronic homelessness so that they would be eligible to receive GRH funding if serving the target population.

- **MI Proposals**

- Convert the $1,330,000 of housing subsidies currently supplied by mental health client service dollars to support services for homeless people and backfill in the $1,330,00 with additional new Bridges subsidies from MHFA.

- There are currently $460,000 of State dollars included in the PATH federal grants. Those funds could be redirected to Clay, Hennepin, St. Louis and Ramsey Counties to allow for PATH staff in those counties to access MA for persons who are MA-eligible and who receive MA-reimbursable services, such as Assertive Community Treatment (ACT) teams.

- Begin several Safe Haven programs which are places to stay with low demand support services. These should be no more than 5 people per site so that zoning should not be an issue.

CD Proposals

Chemical dependency case management

- When Rule 31 is made final, proposed changes will make, case management costs eligible for payment under the program.

- The Chemical Health Division will re-evaluate its existing commitment in grant funds and look at funding projects that will tie-in with this effort.

Other ideas which need further development:

- Find new resources/grants to support SSI eligibility efforts for DHS clients.

- Ongoing DHS efforts to create a common service menu among the waivers should include exploring ways to clarify the services available to support housing stability and perhaps front desk type operations for the homeless.

- MFIP- Consider requiring Employment Services job counselors for homeless families to coordinate employment plans and activities with other existing service plans/case managers.

- Child Protection and Mental Health- Review three existing programs for ways to focus on chronic homeless children. There are two Targeted Case Management programs (TCM). A third possibility: Family Services Collaboratives - involves schools, counties and other agencies.

- Evaluate outcomes achieved with youth exiting out-of home-placement. Focus on older teens and successful transition supports. Consider role of Alternative Response Teams.

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 4: Interagency Decision Making Process and Criteria for Funding

MHFA FUNDING STRATEGIES PROPOSAL

Priorities

In making awards for capital costs for supportive housing for long-term homeless persons, priority will be given (in addition to existing priorities) to projects that:

1) have project-based assistance committed to the project;
2) leverage other funds, including CDBG, HOME, tax credits;
3) are located in a community that has a cooperatively developed plan that addresses the needs of the long-term homeless including the provision of permanent supportive housing; and
4) provide quality housing at the lowest cost for comparable populations.

In making awards for capital costs for affordable housing, priority will be given (in addition to existing priorities) to mixed-use projects that include some supportive housing units.

Threshold

Services are an essential component of permanent supportive housing. In order to receive either capital or operating cost support, a new supportive housing project must have a services funding plan, which has been reviewed and approved by DHS and the county in which the project is located.

Leveraging

There will be an expectation that state and MHFA resources will leverage other funds as reflected in the priorities. The leveraging expectation will not apply to every supportive housing project, but will apply overall to state and agency resources. The extent to which the leveraging expectations are being met will be tracked. Adjustments may be made to the commitment of funds for permanent supportive housing to reflect progress on achieving leveraging goals.

Agency Resources

MHFA continues to explore what and how much Agency resources can be made available to assist in meeting the goal of ending long-term homelessness. One consideration is how activities currently funded with Agency resources would be impacted and what strategies

can be employed to mitigate the impacts. Use of HOME funds for rental assistance was considered; however, the trade-off in terms of the reduction in funds available for stabilization of affordable rental housing or provision of homeownership opportunities for extremely low-income households does not warrant the redirection of these funds to rental assistance.

Operating Cost Subsidies

Operating cost subsidies may be provided on a temporary basis. Supportive housing managers will be expected to work with the local housing authorities and the tenants to obtain project-based Section 8 or Section 8 tenant-based assistance to cover the operating costs over the long-term. Operating cost subsidies may be provided on a diminishing basis.

The federal government is a critical partner in efforts to end long-term homelessness. In order for Minnesota to be successful in efforts to meet goal, the federal government must assist by increasing the availability of Section 8 vouchers and certificates and ease restrictions on the project-basing of Section 8 assistance when it is being used for supportive housing.

Program Space

Criteria will be developed to help staff assess the need for program and /or common space.

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 5: Plan and Timetable for Funding

MEETING SUMMARY

Welcome, Introductions and Overview

Commissioner Marx welcomed members and introduced the Preliminary Business Plan and Assumptions. Our vision and goal is to produce 4,000 units of supportive housing by 2010. New construction, acquisition, mixed income, rental assistance/operating subsidies, housing support services, and start-up loans are costs and uses to be funded.

Discussion of Preliminary Draft Business Plan to End Long-Term Homelessness

Assistant Commissioner Odman led the discussion on the Preliminary Business Plan. We are assuming 4,000 households need to be served between now and 2010. This represents a 33% increase over the 2001 Wilder survey. This is justified due to the economic downturn, conservative estimates by Wilder, and differences in definitions. One-third of the units to be developed and/or provide rental assistance are for families with children. The 2001 Wilder survey indicated 37% of those homeless were families with children. These assumptions may need to be adjusted based on the 2003 Wilder survey to be released in January. The estimated number of children in each family is two to three.

Housing models: We are proposing single site or sole purpose for 50% of the total units produced. These are mixed income predominately. Forty percent are scattered site with rental assistance only. Twenty-five percent of the 4,000 units that need to be developed are new construction and 75% are acquisition/rehab. If we go to scale over next seven years, we need to rely more on acquisition/rehab for a variety of reasons (i.e. cost, siting).

Rental assistance and operating subsidies: We need a form of rental assistance or operating subsidy for all units (scattered or project based). Some households will come with vouchers, some will have project based Section 8 provided by HUD. A significant portion of rental assistance will be funded by the state and MHFA.

The projected cost of rental assistance is $210,000,000 over the next seven years (the biggest portion of the total cost). Next, construction assumes $170,000 per unit per family and $120,000 for singles. It can be done, but it will be difficult. Not all units will be produced for that amount. Acquisition/rehabilitation projects $90,000 per unit for families and $60,000 for singles representing 1,500 units. Mixed income assumes $140,000 per unit for families and $95,000 for singles (predominately new construction larger scale projects, greater economies of scale). Rental assumes $210,000,000 with housing support services totaling $10,000,000 over

the seven-year period. Start-up loans assume $2,000,000 to fund. We estimated a 5% per year inflationary increase into the numbers. No projections include service supports at this point, except for housing supports.

We based construction/rehabilitation costs on projects funded over the last three years, the significant portion of which closed within last 12 months. This represents firm costs for projects predominately in the metro area where most of the supportive housing has been produced over last several years. They do not represent the average. They are actually less than the average. They do represent units in the lowest percent of costs. We have limited resources and need to get as many units we can for our money.

We challenge the industry to find ways to reduce costs and to extent possible reduce the amount of program space on site using program space available in the community.

Services: Assistant Commissioner Gomez reviewed services in the Preliminary Business Plan. The number represented is only a small portion of what DHS considers services. We are looking at a flexible funding service amount. There are many gaps in existing programs. We need to create flexible funding to make other things work better. We need to connect people to mainstream services. Some chronic homeless are not eligible for anything. Maybe some flexible money could be used in these cases. There are hundreds of millions of dollars in job supports and MA support. We need to get a handle on what we are contributing already and how we can do better. We are trying to make money more flexible and we acknowledge what's being done or could be done.

Corrections: Commissioner Fabian acknowledged that DOC is fairly new to the housing discussion. She introduces two strategies: 1) Institution/Community Work Crew Affordable Homes Program; and 2) transitional policing. We frequently hear that offenders are released and wind up homeless. We recognize more could be done. The intent is to inform people about what work we are doing. With increased communication and coordination we can come up with additional ways to address this issue.

The Institution/Community Work Crew Affordable Homes Program has six goals: 1) vocation skills training for inmates; 2) provide much needed affordable housing; 3) transition inmates back into communities; 4) assist inmates in developing a positive work ethic; 5) enable inmates to earn a wage, a portion of which goes to deduction for victims fund, restitution, child support, savings account, etc.; and 6) help communities reclaim damaged and substandard housing.

Initial Draft Report

Working Group members reviewed the initial Draft Report outline .

Discussion of Follow-Up on Strategies for the Next Meeting

The next meeting is scheduled for Wednesday, January 21. We will work feverously to draft the final report and business plan. We will call on many to help and we appreciate your help.

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SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 5: Plan and Timetable for Funding

Preliminary Business Plan Assumptions 2004 - 2010

I. Number of units to be provided by 2010
   A. 4000
   B. 33% increase over 2001 Wilder Survey
   C. Increase due to economic climate, conservative estimates by Wilder, difference in definitions, and incremental increase

II. Types of households
   A. 1/3 families with children
   B. 2/3 single adults and unaccompanied youth
   C. 2001 Wilder survey: 37% families with children
   D. Size of families: 2-3 children

III. Housing Models
   A. Single Site /Sole Purpose - 50% of total units
      (see development activity below)
   B. Mixed Income/New Development - 10% of total units
   C. Scattered Site - 40% of total units
      (provided through rental assistance only)

IV. Development Activity of Single Site/Sole Purpose
   A. New Construction - 25%
   B. Acquisition/Rehab - 75%
   C. Recent Experience - 50/50

V. Rental Assistance/Operating Subsidy
   A. All households will need rental assistance or operating assistance
   B. 50/50 split on tenant based and project based
   C. Cost: $378 per month for singles and $851 per month for families – based on Fair Market Rents and average tenant contribution in supportive housing developments
   D. Temporary rent assistance provided with state funds until 2010
   E. Assume households will receive either federal project-based or tenant-based assistance by end of 2010

VI. Cost Assumptions
   A. New construction - $170,000/unit families and $120,000/unit singles = $75,000,000
   B. Rehabilitation - $90,000/unit families and $60,000/unit singles = $122,000,000
   C. Mixed-income - $140,000 /unit families and $95,000 /unit singles = $51,000,000
   D. Rental Assistance /Operating Subsidies = $210,000,000
   E. Housing Support Services = $10,000,000
   F. Start-up Loans = $2,000,000

VII. Total Estimated Costs: $470,000,000 over 7 years

VIII. Total costs include an inflation adjustment of 5% increase per year for costs in VI. A-D above

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 5: Plan and Timetable for Funding

PRELIMINARY FINANCING PLAN: SOURCES AND USES

	2004 - 2010*	Total
SOURCES		
G.O. Bonds		
MHFA Sources		
Housing Trust Fund		
PARIF		
Other MHFA Resources		
MHFA Total Sources		
Other State Sources		
DHS Sources**		
Corrections Sources		
Other		
Other Sources		
Federal		
Local Government		
Philanthropic		
Private Tax Credit Equity		
MHFA Tax Credits		
Sub Allocators		
Total Sources		**$470,000,000**
USES		
New Construction		$75,000,000
Acquisition/Rehabilitation		$122,000,000
Mixed Income		$51,000,000
Rental Assistance/Operating Subsidies		$210,000,000
Housing Support Services		$10,000,000
Start-up Loans		$2,000,000
Total Uses		**$470,000,000**
ADDED UNIT CAPACITY		**4,000**

*Work in progress for developing sources and uses for each year. This does not include health and social services for which this population is otherwise eligible to receive.

**This amount does not include funding from MFIP, GA, MA, GAMC, GRH or MI/CD to which the chronically homeless person or family is otherwise eligible.

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FOR SUPPORTIVE HOUSING WORKING GROUP DISCUSSION PURPOSES ONLY:
THIS DOES **NOT** INDICATE THAT FINAL POLICY OR FUNDING DECISIONS HAVE BEEN MADE

SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

DRAFT OUTLINE OF REPORT

This is an initial draft outline of the Commissioners' report and business plan on supportive housing for long-term homelessness. It does not indicate that final policy or funding decisions have been made. It is an opportunity to review the draft outline and to offer suggestions for inclusion in the Commissioners' report to the legislature by February 2004.

Report Structure:

Letter to Governor and Legislature from the Commissioners
Executive Summary
Report
Bibliography and sources
Appendix and supplementary materials from meetings

Report Outline:

I. REVIEW OF CHARGE AND PURPOSE OF REPORT

The 2003 Minnesota Legislature charged the working group to advise the commissioners on a host of issues. The commissioners must report to the Legislature on the activities of the working group and recommend next steps to address the problem of long-term homelessness.

A. Context

1. Place the goal of ending long-term homeless in context of entire homelessness issue. Admit focus on chronic or long-term homelessness is not solving the entire problem of homelessness.
2. Ending long-term homelessness and reforming government systems, not just adding more funding to existing systems.
3. Recognize how poverty impacts homelessness.
4. Acknowledge trade-offs.
5. Highlight federal policies – consistency with Federal Interagency Council to End Chronic Homelessness.
6. Summarize front door to back door strategies – supportive housing most promising approach to end long-term homelessness. (Not abandoning prevention and stabilization).

7. Enunciate policy for the long-term homeless of "housing first" to treat mental illness, treat chemical dependency, reduce recidivism, assist public safety, lead to better outcomes.
8. Recognize prior work upon which this effort is built.

B. Vision and Goal

1. State vision to end homelessness.
2. State goal of ending homelessness by 2009. (Recognize as an aspirational goal based on ability to change systems, obtain funding, and the change in the number of long-term homeless between the 2000 and 2003 Wilder survey).

II. DESCRIPTION OF LONG-TERM HOMELESSNESS

The working group shall determine the key characteristics of individuals and families experiencing long-term homelessness for whom affordable housing with links to support services is needed. ***(Legislative charge to working group #1)***

A. Wilder numbers of persons experiencing chronic/long-term homelessness

1. 2003 Wilder Survey numbers and characteristics (data will not be available until late January/early February 2004).
2. Geographic distribution.
3. Footnote use of HMIS data.

B. Key characteristics of persons experiencing chronic/long-term homelessness

1. Context – Why identify key characteristics?
   a) Not an eligibility criteria, an understanding of population needs in order to develop the plan for housing and services. None of these characteristics are weighted more heavily than others.
   b) What are barriers beyond poverty and funds for housing?
   c) Emphasize length of homelessness over diagnostics.
   d) Focus on populations with greatest barriers.

2. An individual, unaccompanied youth, or family with children
   who has either lacked a permanent place to live
   continuously for a year or more,
   at least four times in the past three years,
   or prior to any incarceration or institutionalization.

and may have
mental illness,
chemical dependency, or
co-occurring mental illness and chemical dependency.

Additional characteristics may include: domestic abuse and neglect, criminal history, cognitive limitations and chronic health conditions (including HIV/AIDS), among others.

C. Cost of chronic homelessness

1. Culhane findings.
2. Wilder Survey information and analysis.
3. Cost savings type research and data. Include information on the costs of homelessness to the individual and society in child protection, schools, emergency rooms, detox, jails, institutions, shelters, etc.
4. National data – Connecticut, New York, Philadelphia.
5. Local data – Portland Village, Anishinabe Waukaigan, Hearth Connection

III. SUPPORTIVE HOUSING MODELS

The working group shall identify a variety of supportive housing models that address the different needs of individuals and families experiencing long-term homelessness. ***(Legislative charge to working group #2)***

A. Supportive Housing

1. The case for supportive housing – cost/benefit analysis.
2. Discussion of models and evidence which supports them.
3. Minnesota's current supportive housing experience and history, number of projects, financing, etc.
4. Indicate the challenges that have prevented a "system" from supporting this information.

B. Make available housing and service options that allow persons who have experienced chronic homelessness to be successfully housed over the long-term.

1. Principles.
   a) Maximize choice of housing and services for families and individuals; ensure flexible housing and service options that respond to need.
   b) Encourage families and individuals to utilize services, but don't mandate services as a condition tenancy in all cases.
   c) Utilize innovative practices that result in cost containment and use evidence-based models for service and housing that have demonstrated positive results.
   d) Prioritize models that connect families and individuals in communities, near public transportation and services.
   e) Provide the necessary housing tenancy supports to find and maintain housing, a critical service need for people who have experienced chronic homelessness.

C. Estimated Need

1. Propose numbers and types of supportive housing units and types of supportive service needs for the identified population.
2. Include estimated per unit cost based on MHFA data:
   Construction, rehabilitation
   Family housing, individual housing
   Scattered site, single site
   SRO with or without bath and kitchen in unit
3. Are there significant cost differences?
4. Create a table of estimated need.

D. Housing Options: Housing First

1. Individuals
   a) Safe haven
   b) Scattered site
   c) Clustered site
   d) Single site – including SRO

2. Families with children
   a) Scattered site
   b) Clustered site
   c) Single site

F. Service Choices: Provide Necessary Services

(Content will be added per discussion from Meeting 2).

IV. CAPITAL, OPERATING AND SERVICES FUNDING GAPS

Determine the existing resources that may fund these models for families and individuals who are experiencing long-term homelessness. Identify the gaps in capital, operating, and service funding that affect the ability to develop supportive housing models. ***(Legislative charge to working group #3 and #4)***

A. Funding Issues: Gaps and Broad Strategies = A Funding "Vision"

1. Recognize that there is little likelihood of major new funding in short-term; but identify potential future funding sources that could make sense over time.
2. This is a more general discussion; specific "business plan strategies" come later.
3. Review of each cost category: sources and uses and major strategies for savings, gap filling, etc. from our existing work plus some others.
4. Set forth some principles.
   a) Maximize federal funds and flexibility.
   b) Service and capital efficiency.
   c) Services follow person.
5. Identify broad strategies.
   a) Maximize access to resources (such as SSI)
   b) Target existing programs
   c) Block granting of service funding for long-term homeless

B. Capital Funding

The bricks and mortar of a supportive housing project (including common or service space), whether new construction, acquisition, or acquisition and rehabilitation.

1. Reduce development costs.
   a) Reduce size of units, reduce service space (appropriately with careful planning).
   b) Consider existing rental housing.
   c) Encourage adaptive reuse of existing structures.
   d) Review loan processing.
   e) Standardize legal documents.
   f) Develop standard design plans.
2. Funding.
   a) Housing Trust Fund
   b) Housing Tax Credits

c) MHFA – Agency resources
d) HUD Supportive Housing program
e) State General Obligation Bonds
f) Philanthropic funds

C. Operating Funding

The costs of maintaining the property (taxes, insurance, utilities, maintenance, reserves, any debt service).

1. Rental subsidy.
   a) Use existing project based Section 8 and public housing.
   b) Housing Trust Fund
   c) MHFA – Agency resources
   d) HUD Supportive Housing program, Shelter Plus Care and Section 8 SRO moderate rehabilitation
   e) Incentive for mixed income development projects to include supportive units.
2. Income.
   a) SSI outreach
      (i) improve existing county SSI outreach work – system change coordinate with local Social Security Administration
      (ii) fund new SSI outreach work for long-term homeless – HOPE
      (iii) improve SSI reinstatement upon release from correctional institutions
   b) GRH
   c) Bridges (requires additional funding)

D. Support Services Funding

The healthcare, case management, life skills, employment and training services and specific housing support services necessary to support stable housing.

(Content will be added).

V. FUNDING STRATEGIES

A. Identify priorities in each area to pursue based on promise of short-term funding; list others either because they cost money or will take time to resolve.

B. Make case for flexible fiscal notes given potential cost savings.

C. Place holder for miscellaneous issues such as siting issues; the need to collaborate with delivery partners and local governments on incentives for localities to site.

D. Planning link to continuum of care planning and the Metro Regional Council to End Homelessness, use continuum of care to maximize HUD capital, operating and service funding.

E. Commit state funding as a "challenge" for federal funding.

VI. INTERAGENCY DECISION MAKING PROCESS

Propose a formal, interagency decision making process and a plan to fund supportive housing proposals based on the agreed upon criteria, with the goal of maximizing access to funding for the capital, operating and service costs of supportive housing proposals either scattered site or project based. ***(Legislative charge to working group #5)***

Describe the decision making process. (List of options below.)

Obtain input and feedback from people who are experiencing long-term homelessness currently or have recently experienced long-term homelessness.

A. Some Operating, Financing, and Project Selection Models

1. Super RFP process
2. Alternative Super RFP process; or
3. Funding Block Grant
6. Funders' Council
7. Integrate ongoing evaluation of strategies for people experiencing long-term homelessness

AND/OR

B. Some Policy, Implementation, or Advisory Group Models

1. Supportive Housing Working Group
2. Agencies' Sub-cabinet
3. Office for Ending Homelessness; or
4. Interagency Task Force on Homelessness

VII. COMMISSIONERS' RECOMMENDATIONS (BUSINESS PLAN)

The plan must include an estimate of the statewide need for supportive housing, an estimate of necessary resources to implement the plan, and alternative timetables for implementation of the plan and propose changes in laws and regulations that impede the effective delivery and coordination of services for the targeted population in affordable housing.

A. Phase I – Three to Five Years.

1. Targeted population.
   a) Priority for key characteristics?
   b) Will long-term homelessness "tenure" be a priority?
   c) Substantial risk of chronic homelessness also a priority?

2. Supportive housing.
   a) (See estimated need section III, C)
   b) Unit goals and capacity.
   c) Cost estimate ranges for each need.

3. Sources of funding by each type of funding need.
   (See funding section IV, A, B, C and D)

   a) General:
      (i) state bonding of $4 million or more for FY 04-05.
      (ii) make some assumptions regarding service and operating based on short-term implementation of various strategies
      (iii) develop an overall cost/uses mix
      (iv) cost estimates for a unit number goal over three years for each cost – capital, operating, services
      (v) develop overall sources mix for each cost based on this unit goal as above (e.g. who pays in what proportion between government, non-profit and charitable organizations, local government)
      (vii) identify the gaps; what we are working on with potential sources being additional MHFA agency resources, foundation resources, federal resources, continued progress on service funding, better fiscal climate will make available funds based on demonstrated cost savings, etc.

c) Resource Analysis
   a. DHS resource analysis
   b. DOC resource analysis
   c. MHFA resource analysis
   d. Other resources

B. Phase II – Long Term

Filling difference between phase I and the end; less detail; need to monitor progress and see results of 2006 Wilder survey.

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Minnesota Department of Corrections
December, 2003

Transition Staff Directory

Location	Name	Title	Phone Number	Email Address
DOC Central Office & MN Correctional Facility - Stillwater	Timothy Lanz	Transition Program Director	651.603.0080 651.779.2738	Timothy.J.Lanz@state.mn.us
DOC Central Office	Hailey Thostenson	Assistant to Tim Lanz	651.642.0285	hthostenson@co.doc.state.mn.us
MCF- Faribault	Chad Christofferson	Transition Coordinator	507.334.0878	CChristof@frb.doc.state.mn.us
MCF - Faribault	Jay Welborn	Transition Coordinator	507.332.4535	JWelborn@frb.doc.state.mn.us
MCF -Lino Lakes	Linda Bergan	Transition Coordinator	651.717.6528	Lbergan@ll.doc.state.mn.us
MCF -Lino Lakes	Joe McCoy	Transition Coordinator	651.717.6632	JMCCoy@ll.doc.state.mn.us
MCF - Moose Lake	Nate Knutson	Transition Coordinator	218.485.5000 ext. 5672	NaKnutso@ml.doc.state.mn.us
MCF - Rush City	Mathew Temte	Transition Coordinator	320.358.0377	Mtemte@rc.doc.state.mn.us
MCF – Shakopee	Sandy Hand	Transition Coordinator	952.496.4921	Hands@shk.doc.state.mn.us

MN Correctional Facility Addresses

Central Office	MCF – Faribault	MCF – Lino Lakes	MCF – Moose Lake	MCF – Rush City	MCF – Shakopee	MCF – Stillwater
1450 Energy Park Dr, Suite 200 St. Paul, MN 55108	1101 Linden Lane Faribault, MN 55021	7525 4th Ave Lino Lakes, MN 55014	1000 Lake Shore Dr Moose Lake, MN 55767	7600 525th St Rush City, MN 55069	1010 West 6th Ave Shakopee, MN 55379	970 Pickett St. Bayport, MN 55003

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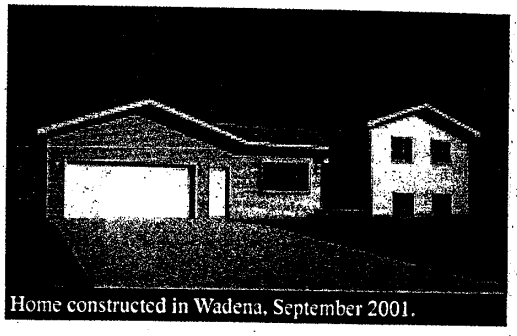
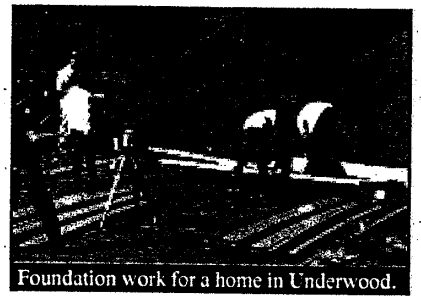
Institution/Community Work Crew Affordable Homes Program (ICWC/AHP)

Background


Home constructed in Wadena, September 2001.

- ✔ The ICWC/AHP began in April 1998 with a $700,000 legislative appropriation to build affordable houses for low-income families. The appropriation is maintained in a revolving fund to provide construction loans to build houses. Loans are repaid as homes are sold.
- ✔ Carefully selected, non-dangerous, minimum-security inmates construct the homes under the supervision of a qualified construction foreman. Offenders are housed in local jails when not on the construction site.
- ✔ ICWC/AHP crew members are paid up to $1.50 per hour for their labor, from which they must pay family support, restitution, and into a fund for victims.
- ✔ Partnerships have been formed with several community action agencies who develop projects, find construction sites, market the homes, and assist buyers in qualifying to purchase the homes.

Benefits


Foundation work for a home in Underwood.

- ✔ ICWC/AHP helps address a housing shortage for low-income families. It helps citizens realize the "American Dream" by providing a much-improved living setting for families who otherwise do not have resources to purchase a single-family home.
- ✔ New homes are targeted to sell to households earning 80 percent or less of the statewide median income adjusted for family size.
- ✔ The program creates a positive way for non-dangerous offenders to repay society for their crimes and learn skills that can help them become productive members of society. They learn the value of work and work ethics.
- ✔ A vocational training program for ICWC/AHP crews has been developed in consultation with Associated General Contractors of Minnesota. This partnership with the construction industry provides crew members with practical industry training and an opportunity for a career in construction upon release.

Homes Completed


Siding installation on a duplex unit in Henning.

- ✔ Crews have completed 130 homes in west central and northwestern Minnesota since the program began. All have been or are in the process of being sold to buyers who meet established income criteria. Construction funds came from the ICWC/AHP revolving fund and the Minnesota Housing Finance Agency.
- ✔ Seven crews will construct approximately 40 new homes during the 2003-2004 season.
- ✔ Twenty-two homes have been renovated under the Minnesota Urban Renewal Program and sold to low-income families.
- ✔ In northwestern Minnesota, nearly 40 homes have been repaired for senior citizens through the Area Agency on Aging Program, and over 20 flood-damaged homes have been repaired for low-income families in partnership with the Regional Development Commission.

For Additional Information

Contact Ron Solheid, ICWC/AHP Program Director, 1450 Energy Park Drive, Suite 200, St. Paul, Minnesota 55108-5219, phone 651/603-0010, email rsolheid@co.doc.state.mn.us, TTY 651/643-3589.

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SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 5: Plan and Timetable for Funding

STAKEHOLDER OBSERVATIONS, IDEAS, INSIGHTS, AND COMMENTS

- Reconsider cost per unit. As population to be served becomes less popular, the quality of unit with amenities needs to be higher (re: NIMBY).

- In plan, have as much documentation of assumptions as possible. This facilitates updating of plan as factors driving assumptions change.

- Concerned about quantifying the need at 4,000. Seems low given the changing Minnesota economy (low wage jobs, fast growing/replacing higher wage). Also, must consider likely increased demand as implications of $1 billion in human services cuts are seen.

- How will focus on ending long-term homelessness change priorities for MHFA? Shifting priorities?

- Concerned that the amount of money of housing supports. May not be enough money.

- The service numbers need to be flushed out. Use existing projects for estimates service costs.

- The inventory estimate of existing supportive housing units (1,500) seems very low. There are at least 1,000 transitional housing currently existing which also fall under the heading of supportive housing.

- What can state and local government do to provide access to property and assistance with siting? Supportive housing that promotes consumer choice and real geographic distribution and ownership.

- Factor in 110% of four to open doors for this population in market rate housing and recognize that traditional voucher programs do not serve this population well. Taking the time to market, build trust, assist in housing search and cooperative supports needs to be built into any voucher-based system.

- Consider modifications with shelter system. Under business plan, it seems that some attention should be given to shelters. How do/should people move from shelters to supportive housing? How does the HMIS fit into the mix?

- The service assumptions should be revisited and assumptions and cost estimates revised.

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SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 6: Draft Report and Business Plan Ending Long-Term Homelessness in Minnesota

MEETING SUMMARY

Welcome, Introductions and Overview
Commissioner Goodno welcomed members and stated that the plan is a work in progress and what we have developed is just the beginning. This report is a valuable tool in assessing the needs. I appreciate all the hard work everyone's been doing up to this point.

2003 Wilder Data
Commissioner Marx announced that the 2003 Wilder survey results have now been released. Greg Owen of Wilder Research Center has confirmed the survey is consistent with our business plan to house and serve 4,000 long-term homeless households over the next seven years. The business plan will be refined as necessary to reflect more of what we learn about the data. The numbers now as it relates to the business plan are annual estimates vs. point in time. The business plan estimated 6,000 long-term homeless individuals. The 2000 Wilder survey showed 5,000 people in 3,000 households. The 2000 survey did not have a good interpretation of long-term homelessness, the 2003 survey does. There appears to be fewer long-term homeless children and more single adults suffering from mental illness. Over time, we will need to serve fewer families and more single adults.

Discussion of the Business Plan
Commissioner Marx led a discussion on the Financing Plan Estimate 2004-2010. W plan on construction of 5,000 units totaling $540 million. Acquisition/rehabilitation will produce a large number of these units in order to minimize the expense of new construction.

Assistant Commissioner Gomez reviewed the cost of the service component. DHS is estimating that about $120 million will be available from human services in terms of expenditures available to this population. The emphasis is that these are estimates and could be more or less and are based on a number of assumptions. Serving the individuals identified in these proposals in terms of services will cost about $150 million based on an assumption service costs will be on average $10,000 per year.

We used the same assumptions in the service plan in terms of the mix of families and individuals. This funding is part of the entitlement that each individual brings with income into the system (MA, group residential housing). We are proposing later on to add some outreach services and engagement efforts, especially in trying to increase income (federal benefits, more benefits). Getting to this level is going to require intensive efforts from all of us and our counties.

We are also proposing DHS to redirect existing funding in several programs to meet the needs for flexible funding of service costs. We would redirect $10 million from these sources. This is in response to many discussions here about the need to have services that are not necessarily tied to one individual at a time. An additional $10 million for mental health services would be available primarily from a redirection of funds.

Commissioner Marx reviewed the sources, $90 million from State GO bonds and MHFA sources are $90 million ($40 million from Housing Trust Fund / $50 million from one time funding of Agency resources). We estimate $60 million in private tax equity.

Commissioner Marx stated that the Commissioners are hopeful that as we start laying the groundwork with the state's $20 million that others start seeing themselves as part of this vision and align ways to make this happen. A lot of collaboration and work over seven-year period is needed. We need to work to increase contributions from those sectors. The important thing underlying this report and business plan is that we don't want to make this existing problem worse by not supporting existing housing. Let's be conscious of that as we move forward. We spent a lot of time focusing on how to address the needs of 4,000 households and this will be a critical component as we march forward to build these 4,000 households.

Comments on the plan include concerns that funding the human service part by reallocating money from transitional and group residential housing is inconsistent with the basic principal that we don't want to advance this plan at the expense of the existing providers serving people that are homeless. Concern was voiced regarding the availability of Section 8 federal rental assistance after 2010.

Assistant Commissioner Gomez clarified changes from transitional and group residential housing. All we are doing is allowing money that is being used for individuals in shelters and transitional housing to be used for the same individual in permanent supportive housing. By increasing flexibility the funds could be used for something far more appropriate. The rational behind that is the additional use of money to serve the same populations.

Commissioner Goodno commented that a good portion of some of the DHS dollars we are putting out there is money not currently being spent. If we sign people up for the programs, they would be eligible for them. This is an example of how better practices can help solve a lot of our problems. As to funding sources in the future, where do you cut it. It comes from somewhere else. Pockets of free money were exhausted last year. We are thinking broadly. Do you cut from local governments, education, parks? Those are the types of things that would be affected. That is the difficulty.

Commissioner Marx stated that we've identified a $185 million gap. Over time this will take a multiplicity of strategies. We are giving ourselves seven years. W will get smarter, there hopefully will be more resources, so let's get the ball rolling. We can't hide the fact this will take more money over time.

Discussion of the Draft Report

Hennepin County Commissioner Dorfman offered a motion that working group members applaud this effort , support the report to be submitted to the Legislature, and recommend moving forward on the plan to end long-term homelessness. All members were in favor.

Next Steps

Commissioner Marx thanked members for their participation. He stated that this has been a tremendous project, there has been a lot of good candid conversation, and we will have another session once we have the complete Wilder data. Many people put a lot of hard work into this effort. We are thankful to all state agency staff and stakeholders. I'd specifically like to single out Cherie Shoquist, Janel Bush, Tonja Orr, and Christine Eilertson. One final thing in regard to our $20 million request before Legislature. Let's get the support.

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SUPPORTIVE HOUSING FOR PERSONS EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

DHS MEETING ON SERVICES FOR PERSONS EXPERIENCING LONG-TERM HOMELESSNESS

In Attendance: Richard Amos, St. Stephens Shelter; Janel Bush, Department of Human Services; Michael Dahl, Minnesota Coalition for the Homeless; Claudia Dengler, Wilder Foundation; Christine Eilertson, Department of Human Services; Duane Elg, Department of Human Services; Commissioner Kevin Goodno, Department of Human Services; Connie Greer, Department of Human Services; Mary Hartmann, New Foundations; Jennifer Ho, Hearth Connection; Terry Schneider, South Metro Human Services; Louis Simon, Salvation Army; Mark Stutrud, Lutheran Social Services; Christine Swenson, Hearth Connection

Kevin Goodno, Commissioner of the Department of Human Services – Facilities can be built, but that alone won't necessarily end chronic homelessness. We cannot end chronic homelessness unless there are services available to help with these issues. We need to identify and work on a better plan as to how we can identify what services are needed in order to meet this goal.

What would you like to see the Working Group do?

- Fully fund the housing part and the services part. It seems that it's easier to get the money to put the building up and then set-up. It's the ongoing supportive services piece that we really need help on.
- We need to have a balance of both the services and operating funds.
- Address concerns that the current plan for services is inadequate.
- Fund services - support services within supportive housing.
- Being informed by this process.
- Reconvene after the report is published so we can do the real work and answer the questions that have been skipped over.
- Focus on scattered site models.
- This population is so important it deserves to have resources designated towards it. The goal would be not to have to take from other populations to achieve that. To really support the full continuum you have to address homelessness and hopefully, we learn some lessons from this process that helps make the other parts of the continuum improve.

- Appreciate the needs of all homeless people including those that are not chronically homeless.

- Define what the service components are and use that as a common foundation among all kinds of different players from this point forward.

- Define what this service package is and what supportive housing is really going to mean.

- Better integration of services with all of the multiple agencies involved.

- Have a set of service outcomes, desired outcomes to end homelessness.

- Just find a way to provide stable financing to the existing unit.

- Take a few of the models that we think have the most promise and where we already have established some really solid providers who we assume have driven out every nickel of excess cost, take a look at those service and costs associated and then see if we wire together stable financing for them.

What are the kinds of services persons experiencing long-term homelessness need and in what kinds of settings? What are the resources and issues currently to address those costs? What are housing support services? Are they more than a front desk?

- Look at what leads to homelessness. CD issues, domestic abuse, mental health, lack of income; depending on what the barriers are whether or not to assign a case manager to connect them to services that they need to stabilize whether they need a case manager to help them maintain their housing stability.

- Develop the community.

- Education, employment, economic stability, children's services, community building and outcomes.

- Distinguish housing differently from case management.

- The universal benefits set.

- Assertive Community Treatment (ACT).

- Rule 79.

- Everything from why you lost your housing, to your chemical use, to your mental health, to vocational needs, and spiritual needs.

- Stuff that falls under case management and assertive community treatment.

- Relationship development and trust building.

- First assessment for an individualized set of needs.

- Supportive housing providers are there for relationship identification and is a link to another service provider that might be a specialist in something else.

- It starts out with outreach and engagement and it moves into case management. It's also information and referral and it's more than that.

- Some are going to need more intensive service than others, some are going to need a $250 month subsidy for two months, and some are going to need it for 6 months. Some may not need it at all.

- How to budget their money and how to remember pay bills, and how to think and plan to grow in the future.

- We want people to be able to decide when they want to move on. They should have the skills so that's possible.

- Assertive Community Treatment (ACT) is close to the service model that we want here. It's just that the doorway to ACT is a serious and persistent mental illness and being a single adult.

- Different kind of case management where you involve the community in helping to solve community problems. One woman had a mental health crisis and needed hospitalization for two and a half weeks. Instead of calling child protection, one of the other women took her kids into the apartment. Another women received treatment by fundraising because Rule 35 said she already had treatment and so she couldn't get it again.

- MA has never been at an adequate reimbursement level.

- If you don't change the financing system, you're not going to end up being able to count costs of savings. We really need to know what service providers are spending on people so that we can figure out ways to improve services and also to figure out what it really costs so we can compare it to some of these outside savings.

- Our job is to figure out what all these resources really cost. If we don't know, we can't talk about the savings.

- If a person is not living in a unit (detox, jail, hospital), the county, state, etc. cannot be billed. We need to think about how to pay for that and stretch it out while someone tracks them and does outreach. Find a way to be able to continue to pay rent so that person has a place to come back too rather than starting the process all over again.

- From a contract perspective, get away from the per diem.

- Pay for the amount of beds whether they are full or not. They are usually full, but sometimes we have a situation where somebody ends up in the hospital. We don't get paid and still have staffing and other expenses associated with operating a facility.

- Figure out funding integration modeling at every level possible so there is a unified way to apply for funding.

SUPPORTIVE HOUSING FOR PERSONS
EXPERIENCING CHRONIC HOMELESSNESS WORKING GROUP

Meeting 6: Draft Report and Business Plan
Ending Long-Term Homelessness in Minnesota

STAKEHOLDER OBSERVATIONS, IDEAS, INSIGHTS, AND COMMENTS

- I would like to know more about redirecting funds. What does this mean in practice? Who gets served? Who will not? Additionally, I am curious if attention is given to how people reach long-term homelessness. I am struck by the statistics from Wilder that say the number of first time homeless remains 60%, but the number of homeless a year or more has grown. This says to me that strategies to prevent long-term homelessness need strengthening.

- One of the key strategies for ending long-term homelessness is housing fist. This approach is not correct for unaccompanied homeless youth. The first approach is family first. Youth have better outcomes when connected to family and community. Providing a new apartment is not our first focus, but only becomes necessary when family reunification or alternative out-of-home placement and services become available.

- The business plan is short on details concerning the source of supportive services funding and operating assistance. The remaining sources of federal government and philanthropic seemed too tapped out. This is stating the obvious, but I believe it weakens the report and business plan by not clearly stating the elephant in our living room. How are housing providers going to cover services and operation costs?

- As to United Way's potential to increase funds, we are already contributing to housing related programs which is currently about $7 million or 8% of our entire pool. Any redirecting of additional funds to help this effort would require that we reduce allocations to other non-housing social service programs. Our housing connections initiative is actively fundraising to get new resources to supportive and service enriched housing projects the work of this group will help us in our efforts.

- The housing that gets created needs to meet the needs of the long-term homeless. Far too often housing (permanent and supportive) is built for a certain population, but because of neighborhood pressure, etc, the population that actually enters the housing looks very different. Accountability is crucial, primarily because the housing will be filled. There is more than enough need among very low-income households. We want to make sure that the people targeted are the people housed.

- Why redirect funds from GRH and transitional housing when they are a part of the continuum of care? People move from shelter to transitional housing to permanent supportive housing.

- The business plan has no heart and does not address social conditions that result in homelessness.

- Homelessness is very much a public health issue. This Working Group needs the Commissioner of Health in order to link housing stabilization to community health, health disparities and the health and well being of people grappling with homelessness.

- The report states clearly that we do not want to jeopardize other segments of the homeless population by shifting resources to the chronic initiative, yet it proposes to shift GRH and transitional housing money away from current populations and into the chronic service area. Doing so would seem to contradict the previously stated purpose.

- Transitional housing does not serve persons in emergency shelter (nine + serves those transitioning out of shelter). Rather, as the Legislature intended in statute, it serves persons in independent, time-limited housing with intensive support services. These are families and individuals who, with assistance, can become independent and no long consume public housing/service funds.

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CHCS

Center for
Health Care Strategies, Inc.

Consumer Action Series

Olmstead and Supportive Housing: A Vision for the Future

By Ann O'Hara and Stephen Day,
Technical Assistance Collaborative, Inc.

Foreword by Alison Croke and
Stephen Somers
Center for Health Care Strategies

Funded through a grant from The Robert Wood Johnson Foundation.

December 2001

Funding for Key Community Services by Funding Source

Program/Funding Source	Care Coordination	In Home Health	Personal Care	Skill Training	Day Services	Vocational Services	Community Support
Medicaid Home and Community-Based Services Waiver (primarily mental retardation/developmental disabilities)	✓	✓	✓	✓	✓		✓
Medicaid Rehabilitation Option (primarily severe mentally ill)	✓	✓		✓	✓	✓ (Not job-specific)	✓
Medicaid Personal Care Option (primarily elders and people with physical disabilities)			✓				
Medicaid Home Health (mandatory Medicaid service)		✓					
Targeted Case Management (all Medicaid enrollees with disabilities)	✓						
PACE (elders)	✓	✓	✓		✓		
Assisted living waivers (elders and people with HIV/AIDS)	✓	✓	✓		✓		
Vocational Rehabilitation (VR) Assertive Community Treatment independent living centers (primarily people with physical disabilities)			✓	✓		✓	✓
VR – employment services (technically for all disabilities – not always accessible to people with mental retardation/ developmental disabilities or severe mental illness in local jurisdictions)				✓		✓	
VR - Adaptive equipment and renovations				✓		✓	
Older Americans Act (elders only)	✓	✓	✓		✓		✓
HUD 202 and McKinney Supportive Housing Programs (elders or people with disabilities who are homeless or at risk of homelessness)	✓						
State and Local General Fund Dollars (all disabilities, but usually categorical)	✓	✓	✓	✓	✓	✓	✓

CFASD Housing Unit

Memo

To: City/County Shelter Advisory Board

From: Don Sabre

CC: David Sanders, Joan Smith, Sarah Maxwell

Date: 04/03/02

Re: CFASD Funding Priorities and Implications

The Children, Family, and Adult Services Department's mission is "To ensure the **safety and stability** for children and adults, who are at risk or have been abused and/or neglected; vulnerable seniors; and individuals with disabilities through the strengthening of communities and the effective and ethical use of resources. " In support of this mission, the attached funding priorities and implications are provided as clarification of our position in assessing the merits of housing and housing services related proposals.

It should be noted that these priorities are not the criteria of the Hennepin County Board, nor any other Department in Hennepin County, and that Board policy and decision-making takes precedence in all matters. However, these priorities have been carefully developed and modeled upon "best practice" as we currently know it. We will use these priorities as a guide for CFASD budget recommendations to assure that all housing and services initiatives support our target populations and the outcomes we value.

Lastly, it is important to consider these funding priorities as a guide and framework as we transition to a more clearly defined process for assessing housing project proposals. Projects that have been in the "pipeline" for some time now are requiring a flexible approach that acknowledges the changes that have occurred over their planning timeframe, as well as changes in the way CFASD is managing resources. It is our hope that these criteria help clarify our thinking and decision-making as we provide input, support, and response to housing and housing service projects.

CFASD FUNDING PRIORITIES AND IMPLICATIONS

HOUSING INITIATIVES

1. **PRINCIPLE: OVERARCHING OBJECTIVE AND TARGET POPULATION.** CFASD clients are: children, youth and adults who have been, or are at high risk of becoming, abused or neglected; vulnerable seniors; persons with disabilities; persons involved in multiple human service systems who are inappropriately using crisis and emergency resources; and adults at high risk of becoming acute or chronic service users. Our mission is to assure safety and stability for our target population.
   FUNDING Implications: To be considered a funding priority, housing services and initiatives must serve our target population and support our mission.

2. **PRINCIPLE: SERVICES.** CFASD recognizes the diversity of human needs, and supports differing approaches to accomplishing our goals. However, for all populations and individuals, our emphasis is upon evidence-based models and measurable client outcomes.
   FUNDING Implications: To be considered a funding priority, housing services and programs must be based upon the most effective, culturally acceptable, and individualized models possible.

3. **PRINCIPLE: CLIENT CHOICE.** CFASD believes clients should have choices regarding their housing and social services. Length of stay should be based upon client choice, not artificial time limits. Participation in social services should be based upon choice, and should not be a condition of housing. This means social services should be "unbundled" from housing; so the client may choose their service provider, and obtain the optimal duration, frequency, and intensity of services. Once selected, the services should follow the client, regardless of the client's housing choice.
   FUNDING Implications: Funding priority will be given to permanent housing; contracts for supportive social services will be client-centered and managed separately, in accordance with our focus on client outcomes. If a service provider is unable to achieve adequate client outcomes, CFASD will exercise its option to contract with another provider.

4. **PRINCIPLE: INTEGRATION.** CFASD believes our clients should have the opportunity to participate fully in their communities. Ideally, clients who receive social services would have access to an appropriate proportion of the affordable housing units in every community. Integration into mixed income housing is even more desirable. CFASD also accepts the philosophy behind the Supreme Court's Olmstead Decision: that elderly and disabled persons should have the maximum possible opportunity to live in settings that are integrated with non-disabled populations.

FUNDING Implications: Housing programs and services that unnecessarily segregate persons with disabilities will not be considered a funding priority. The burden of proof in requesting an *exception* to the integration requirement is demonstrating that segregation is necessary. Cost-efficiency --*alone*-- will not be considered an adequate rationale to give funding priority to segregated housing.

5. **PRINCIPLE: RENTAL SUBSIDIES.** CFASD recognizes that persons with very, very low income (30% of median income) cannot afford housing without a subsidy. While we prefer tenant-based subsidies, we also recognize that project-based assistance is necessary to develop new affordable housing units (which require a deep, permanent operating subsidy to remain affordable). However, subsidized *projects* should be low density, integrated housing, with appropriate, accessible, tenant-based, voluntary social services.
   FUNDING Implications: To be considered a funding priority, project or tenant subsidies must conform with all other CFASD requirements for target population, choice, integration, etc.

6. **PRINCIPLE: CONTRACTING.** CFASD believes that County property taxes should be considered as a last resort, after maximizing all possible sources of federal, state and private funding. It is often possible to obtain non-County funding by modifying the services, staff qualifications or target population. CFASD ALSO believes in competitive contracting. Where we have identified a service/housing need, requesting proposals from a variety of applicants generally results in the best quality and cost. This process also allows CFASD to negotiate revenue maximization issues, and to establish service standards and outcome expectations from the beginning. Where it is necessary or desirable to negotiate directly with a sole source, CFASD reserves the right to establish criteria such as target population, service delivery model, performance targets, etc.
   FUNDING Implications: Housing program/service providers must expect to negotiate contract parameters for any funding managed by CFASD, and should not make commitments to other funders before assuring that CFASD criteria will be met.

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Dakota County Strategies to Combat Homelessness

Dakota County uses several models of supportive housing to house persons and families experiencing homelessness. The constant with all of these models are services that are delivered based on the individual needs of each client. Supportive services include case management, assistance applying to mainstream resources such as MFIP, MA and SSI, independent living skills including budgeting and housekeeping, chemical dependency support and mental health support such as medication monitoring. As there is a continuum of housing models there is a continuum of services. Some services are delivered daily, some weekly based on the person's needs.

1. *Scattered site apartments with private landlords.*
   Dakota County has used a variety of subsidies to lease market rate apartments in the community. Dakota County Social Services provides and/or contracts case management services and refers eligible persons to Medical Assistance reimbursable services such as the CADI Waiver, Personal Care Attendant and Home Health Care:
   - Mainstream Vouchers – 50 vouchers administered by the Scott Carver Dakota CAP Agency. Priority is given to persons receiving Dakota County Social Services. (HUD program administered by the Scott Carver Dakota CAP Agency.)
   - Shelter + Care – approximately 18 vouchers. Dakota County provides the services match through case management. (HUD program administered by the CDA.)
   - Bridges – 30 vouchers for persons with serious mental illness. (MHFA program administered by the CDA.)
   - Housing Trust Fund – funding for 21 subsidies. (MHFA administered by the South St. Paul HRA)
   - Group Residential Housing Demonstration Project -25 subsidies for persons with mental illness. Guild, Inc. and Mental Health Resources provide support services. (State program administered by Dakota County Social Services.)

2. *Small single-site developments.*
   The Scott Carver Dakota CAP Agency owns three apartment buildings (2 six-unit buildings and an eight unit building) in South St. Paul with a total of 20 units. Dakota County contracts with the CAP Agency for use of these apartment units. The apartments are designated for persons who are homeless and have mental health or adult protection issues. On-site services are provided as needed through Medical Assistance reimbursed services such as in-home nursing care, personal care attendant or home health aide. All tenants have Dakota County case managers.

   The Scott Carver Dakota CAP Agency has used several funding streams to buy apartment buildings including HUD McKinney/Vento, HOME, MHFA, the HOPE Fund and bridge loans from the Corporation for Supportive Housing.

3. *Clustered apartments in private landlords' buildings.*
   Project Restore – Mental Health Resources received HUD McKinney/Vento funds for 10 units of housing and supportive services. Mental Health Resources is working

with a local landlord to lease 10 apartments within a complex. The units are targeted to homeless persons with serious mental health problems.

4. *Medium single-site developments (under development).*
   - Apple Valley – 16 units of a 36-unit apartment building will be designated as permanent supportive housing for persons with mental illness. Community Housing Development Corporation is the developer. Mental Health Resources will provide on-site services. The apartment building will be part of the Legacy Development on Galaxie Ave. and 153rd Street.
   - Burnsville – Approximately 25 units of permanent supportive housing for young adults ages 18 – 25 with a focus on employment/vocational services. This housing will be built at the Burnsville Transit site on Highway 13 allowing the tenants easy access to transportation to schools and jobs.
   - Hastings – A collaborative project with the Hastings Veterans Home. This project will provide permanent supportive housing for vets and persons with chronic mental illness and/or chemical dependency. 24-hour front desk coverage and intensive services will be provided on-site. This project will be built on the grounds of the Hastings Veterans Home.

Funding for new construction / development will come from several sources including Dakota County Low Income Tax Credits, MHFA Low Income Tax Credits, MHFA, HUD McKinney/Vento, CDBG, HOPE Fund. Service funding will be more difficult with the restrictions on the CADI waiver. Other Medical Assistance reimbursable services such as PCA, Home Health Care and ARMHS may work for some developments.

Barriers to permanent supportive housing –

- The long term funding of services in permanent supportive housing is difficult. The restrictions on the CADI Waiver have impacted Assisted Living and Assisted Living Plus the programs that were best suited to adequately fund services in permanent supportive housing.
- Communities are reluctant to site new permanent supportive housing due to neighborhood opposition. Incentives would help communities accept permanent supportive housing particularly for the more chronically ill. The Dakota County Board has made TIF contingent on the inclusion of permanent supportive housing in one development.
- Due to the higher vacancy rate more subsidies would help get homeless persons into housing quickly. Subsidies are also necessary to provide enough funds to cover operating costs in new development. The current federal legislation could reduce the number of Section 8 subsidies.
- Until recently it has been difficult to attract developers for new permanent supportive housing.
- All of the described strategies take a long time to implement.

Dakota County Supportive Housing Unit
Scattered-site apartments with private landlords

Dakota County established the Supportive Housing Unit (SHU) in 1996 to centralize access for persons and families experiencing housing crises. SHU is a collaborative effort between the Employment and Economic Assistance and Social Services Department at Dakota County. SHU is housed in the Employment and Economic Assistance Department and managed by Social Services this arrangement maximizes the use of mainstream financial resources and access to social service programs. While there are numerous entry points in the system for homeless and near homeless families and individuals, SHU is recognized as a primary focal point in directing and accepting referrals for people with housing needs.

SHU provides on-going case management for families with children and youth (age 18 – 21) for up to two years to reduce the risk of homelessness and to assist the families in establishing stable housing. Individuals and families can self-refer, or are referred by other agencies and concerned parties to the Supportive Housing Unit. SHU addresses acute housing needs supporting at-risk youth and families in times of crisis through landlord dispute resolution, emergency housing payments and eviction prevention in order to resolve and prevent escalation of housing problems to homelessness. SHU case managers work closely with employment counselors to ensure that parents are meeting the MFIP employment standards and assist disabled parents in applying for Social Security. SHU clients receive assistance locating transitional shelter, obtaining financial assistance and becoming proficient in home maintenance, money management and related skills for the benefit of gaining permanent and stable housing. Services provided include:

- Information and referral;
- Prevention services
- Consultation to agencies and individual requests
- Strength-based assessments and case planning with families
- Intensive case management and advocacy with homeless families
- Access to shelter services
- Referral to mainstream programs for cash assistance, mental health or chemical health services

During 2002, SHU had 3,789 intake contacts and served 174 households plus 120 crisis cases.

Surveys of families served by SHU indicate that 80% are still in stable housing six months after their SHU case was closed. Part of this success is due to the SHU case managers following the family or individual from shelter to housing and working on the necessary skills to successfully live in the community and maintain their housing. For maximum effectiveness SHU tries to maintain a ratio of 20 families per case manager.

Funding for SHU comes from various sources –

Salary/fringe/travel for 8.6 SHU FTEs:	**$571,776**: 50% of this is Federally reimbursed; in addition, the non-Federal share of 1.6 FTEs is paid through the FHPAP (Family Homeless Prevention and Assistance Program) grant ($54,031).
Net County Cost SHU Salary/etc.	**$232,322** (E&EA)
County Homeless Budget	**$247,000** (funds emergency shelter stays at Dakota Woodlands, motels, rent, damage deposits, furnishings, and miscellaneous housing stuff. (Social Services)
SHU Total County Costs	**$479,322**
FHPAP Grant	**$109,233** as noted under salaries, $54,031 is designated for salaries, leaving $50,000 for direct client services, $10,403 for administration costs.
HUD Grant	**$395,767** Subsidies for 35 families $300,689, operations $23,935, supportive services $52,297 and $18,846 for administration costs.
HOME Money	**$50,000**
SHU Grand Total All Sources	**$1,319,745**

With the state cuts in funding to counties Dakota County may have problems sustaining the staffing levels in SHU. To maintain the level of services county staff have explored the possibility of using Targeted Case Management funds.

Hennepin County Recommendations on How to Fund Supportive Housing Services

Develop "Umbrella MA-Targeted Case Management" payment for contracted vendors tailored specifically to the populations eligible for supportive housing: **"SH-TCM"**. Eligible population would be deep-end families or individuals in need of housing *combined with* services. SH-TCM would parallel, not replace, existing TCM options. SH-TCM would pay for case management services delivered to eligible supportive housing residents in a less categorical, more holistic manner than is possible with other county-administered revenue sources. Like existing TCM options:

- DHS defines eligible population. Example: adult or child at risk of abuse or neglect and/or with disabilities requiring housing with case management services to reduce risk or manage chronic disabilities
- DHS defines minimum professional qualifications for service delivery. Example: BA or above in social work or related human services (same as other TCM options)
- Counties set rate, authorize services for eligible individuals, & reassess that eligible residents continue to need case management services
- Eligible clients must be on MA and meet other established eligibility criteria for SH-TCM
- Contracted vendor must have contract with county social services agency & MA billing number
- Rate would be set based on current cost experience such as Portland Village, Perspectives, Emma's Place, Glenwood, Anishinabe, for congregate models; home visitor models for scattered site supportive housing
- Non-federal share = 52.5% funded by county property tax

Fiscal Impact

- None on state budget
- Counties responsible for non-federal share
- Dual case management by county social workers and contracted TCM vendor in certain circumstances (example: Child Protection must remain open until risk is reduce and court dismisses case). This would be offset by savings in other deep-end services and recidivism in such areas as foster care, emergency shelter, detox, chemical dependency treatment, psychiatric hospitalizations, corrections costs, homelessness.

Limitations:

- Would pay for case management only; ARMHS and CADI could be incorporated into individual contracts as appropriate
- Not covered:
  - Direct services such as community activities, therapeutic services, child care
  - 24-hour front desk services
  - Room & board
  - Flex funds

Implementation Requirements

- DHS agreement and support
- Legislation amending or authorizing new form of TCM
- Amend state Medicaid plan
- Housing must be affordable for persons at <30% SMI to serve county clients

Advantages:

- Counties can opt in or out
- Uses a federal funding stream (MA-TCM)
- Virtually all low-income residents of supportive housing are on MA or should be (even homeless youth).
- Support services are tied to individual, not to building -- therefore buildings can be integrated/mixed like assisted living for elderly where not everyone receives services
- Appropriate for congregate housing or scattered site because services wrap around individual in accord with individual needs
- Housing is not contingent on receiving services -- unlike an institution, you don't have to be in the "program" to keep your housing as long as you abide by your lease

Disadvantages:

- Will not cover all costs of supportive housing. Other funding sources would be needed for 24-hour front desk coverage, community activities, therapeutic services, flex funds
- Contracted provider needs MA billing capacity
- Case managers must have BAs, cannot be paraprofessionals

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Comments on Ending Long-term Homelessness in Minnesota

Catholic Charities of the Archdiocese of St. Paul and Minneapolis is pleased to endorse the report and business plan on ending long-term homelessness in Minnesota. We commend Commissioners Tim Marx, Kevin Goodno and Joan Fabian for their leadership in addressing a long neglected issue.

In our view, the business plan provides a plausible framework for creating 4,000 supportive housing units to end long-term homelessness by 2010. As a provider of approximately 500 shelter spaces and 500 supportive housing units in the metro area, Catholic Charities looks forward to collaborating with other community partners to work towards the fulfillment of the plan.

While the plan serves as a solid foundation, there are a number of challenges to its fruition. Securing long-term subsidies and service funding from federal, state, local government and private resources is the most daunting. Redirecting funds in a way that doesn't negatively impact existing programs that serve homeless families and individuals is another area of concern. As the plan states, "it is important not to lose focus on the needs of the broader homeless population and those at risk of homelessness." Any redirection of funds will require careful study and ongoing vigilance.

To address these challenges, and others, we recommend the creation of an implementation group, which would include members from the working group and/or stakeholders group. From our perspective, the establishment of an implementation group would provide the necessary oversight to execute the plan, conduct ongoing evaluation, make necessary changes and maximize opportunities.

Submitted by:
Tracy Berglund
Administrator-Exodus Division

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GAIL A. DORFMAN
COMMISSIONER

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BOARD OF HENNEPIN COUNTY COMMISSIONERS
A-2400 GOVERNMENT CENTER
MINNEAPOLIS, MINNESOTA 55487-0240

March 5, 2004

Commissioner Tim Marx
Minnesota Housing Finance Agency
400 Sibley Street, Suite 300
St. Paul, MN 55101

Commissioner Kevin Goodno
Minnesota Department of Human Services
444 Lafayette Avenue
St. Paul, MN 55101

Commissioner Joan Fabian
Minnesota Department of Corrections
1450 Energy Park Drive
St. Paul, MN 55108

Dear Commissioners:

It has been an honor to serve on the Supportive Housing Working Group. I thank you for your leadership and endorse this plan to end long-term homelessness in Minnesota by 2010.

I am pleased that the report recognizes that the plan, "... must be implemented so that the broader homeless situation is not made worse." This must be a guiding principal as we take steps to obtain the funding necessary for capital, operations, and the critical social services that make supportive housing successful. To that end, I strongly urge that we do not redirect dollars from successful homeless prevention and transitional housing programs. Rather, we must work to identify new funding sources and create more funding flexibility, such as expanding the use of Medicaid waivers. I agree with the report's assertion that, "... more cost-effective service and delivery mechanisms must go hand-in-hand with increases in resources."

Lastly, I believe that outreach is one of the most critical components of moving people from homelessness to housing. Building trusting relationships with those most marginalized in our society often takes years. We must make outreach a priority.

Thank you for the time, effort and resources you have dedicated to ending long-term homelessness in Minnesota. Working together, we can make this goal a reality.

Sincerely,

Gail Dorfman
Hennepin County Commissioner

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hearth connection

March 5, 2004

Commissioner Tim Marx
Minnesota Housing Finance Agency
400 Sibley Street Suite 300
St. Paul, MN 55101-1998

Commissioner Joan Fabian
Minnesota Department of Corrections
1450 Energy Park Drive Suite 200
St. Paul, Minnesota 55108-5219

Commissioner Kevin Goodno
Minnesota Department of Human Services
444 Lafayette Road North
St. Paul, MN 55155-3815

Dear Commissioners:

Thank you for your tremendous leadership shaping a plan to end long-term homelessness in Minnesota by 2010. Although there is certainly much work to be done, the plan points us in the right direction. I am writing to formally convey Hearth Connection's enthusiastic endorsement of the plan and to offer these comments for the public record.

The plan's key strategy is to provide 4,000 units of various kinds of supportive housing to families and individuals experiencing long-term homelessness. Hearth Connection agrees that supportive housing must be the centerpiece of the plan. Supportive housing is the national model for people who have experienced long-term homelessness. When people are in stable, supportive housing, they use far fewer crisis and institutional services that are costly to taxpayers.

We also agree that we cannot make the broader homeless situation worse. We are lucky to have a strong advocacy community and excellent measurement tools in the Wilder survey and shelter counts to hold ourselves accountable to this commitment.

We applaud the financial component of the plan. The projected need of $540 million in capital, operating, service and income supports seems grounded in good

assumptions about the cost of development and rental assistance, and the intensity of support people will need as they transition from the streets and shelters to homes of their own.

Hearth Connection has keen interest in three of the strategies discussed in the plan because of our experience to date with the Supportive Housing and Managed Care Pilot:

1. The plan states that service funding will come from maximizing mainstream programs in supportive housing and changing current programs to expand use of human services money. As we make these changes, we must recognize that human services financing is very different from housing finance. Housing dollars are attached to units. Human services dollars are properly attached to individuals, giving people choice in where they live while maintaining continuity in their supports. We must find a way to fund services in supportive housing, but we cannot expect human services financing to mirror housing finance. Creating a systematic way to marry housing and human services will likely be our greatest challenge implementing the plan.

2. The plan includes expanding eligibility for Social Security and other mainstream programs, especially for single adults who have barriers to getting disability determinations. The limits the federal government has imposed on SSI for people with chemical dependency keep many single adults from getting adequate income support and Medical Assistance, thereby putting the full financial burden on the state and counties. Changes in the federal law are needed to accomplish this strategy.

3. Another major strategy is to document and capture cost savings associated with reduced crisis and institutional services, predominantly in health care, and to reinvest them in permanent supportive housing. We are working with DHS on the evaluation of the Supportive Housing and Managed Care Pilot. Once the cost offsets are better understood, we may be in a better position to make the up-front investments needed to yield savings over the long term.

I made a number of specific suggestions last Friday to improve the draft plan, which I thank you for incorporating into the final report. I want to specifically thank you for recognizing that the problem of homelessness is entwined in the problem of racial disparity. A solution to long-term homelessness must seek to eliminate racial disparity in every way possible. Who is at the table? Who is envisioned as a part of the solution? What does that solution look like? How is the execution of the plan accountable to stakeholders from communities of color, whether neighborhoods, provider groups or consumers?

As our experience together on the pilot has continuously reinforced, this is difficult work. There will most certainly be many challenges ahead. We must generate public and political will to fund and site 4,000 units of supportive housing. We must continue to build bridges and break down silos – between MHFA and DHS, between the state and counties, between the public and the private sector – involving consumers and communities of color every step of the way. To that end, we strongly recommend that some form of public-private group continue to take this work forward.

The plan offers the first step of many. The vision of a *system* that creates and sustains supportive housing still needs to be brought into clearer view, but it will be a pleasure taking the next steps with you. Thank you to you and your staff for your commitment to do the difficult work ahead to end long-term homelessness in Minnesota. Thank you for the honor of serving on the working group with such an esteemed group of supportive housing experts. We share the confidence the Governor has expressed that this is an achievable goal, and that this can be done.

Sincerely yours,

Jennifer L. Ho
Executive Director

copy: Hearth Connection Board of Directors
Working Group on Supportive Housing for Persons Experiencing Chronic Homelessness

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Date: March 5, 2004

To: Kevin Goodno, Commissioner
Department of Human Services

Joan Fabian, Commissioner
Department of Corrections

Tim Marx, Commissioner
Housing Finance Agency

From: Rachel Kincade, Executive Director
Life House

Re: Comments on the "Ending Long-Term Homelessness in Minnesota Draft Report"

Dear Commissioners Goodno, Fabian, and Marx,

Thank you for the opportunity to participate in the Working Group on Long-Term Homelessness. Having dedicated the past thirteen years to working with homeless youth in Duluth, I have seen the need for systemic change, increased and targeted resources, and community support to address the needs of people experiencing chronic homelessness throughout our State.

I would like to address my comments to Page 28, Footnote 12, where it states that "Supportive Housing or transitional living programs are almost always not the answer for 12-16 year old unaccompanied youth experiencing long-term homelessness. Youth need families and family centered housing support. Alternative placements should be provided by child protection services". The specific population of youth that I would like to address is the 16 and 17 year olds that fit the definition of chronic homelessness in the Draft Report.

In addition to their mental and/or chemical health issues, their age adds a unique barrier to their ability to access housing and services. Changes to the current system and mainstream resources are needed in order to provide viable housing and services to minors experiencing chronic homelessness.

Child Protection Laws lumps ages 0-18 together with the same licensing requirements, which then determines funding and services available to them. Sixteen and seventeen year olds with multiple issues, such as mental illness or chemical dependency, are not successful in traditional out-of –home placements. By the time many of these young people reach the age of 16 they have been in multiple failed placements.

Supportive housing and transitional living programs do provide effective models for this age group. Youth experiencing chronic homelessness need a safe environment with structure, supervision, and support so that they can begin to address their mental and

chemical health issues and learn the life skills necessary to break the cycle of homelessness.

Child Protection Laws should be flexible and creative enough to add more transitional programming to meet the needs of these older adolescents. In addition, a criteria needs to developed for this specific population to avoid categorizing all adolescents in this group and to open up traditional mainstream adult resources to serve this population.

Funding streams such as Group Residential Housing (GRH), Assertive Community Treatment (ACT), and Adult Rehab Mental Services (ARMS) only provide services for those that are 18 and older. Adult Mental Health and Children Mental Health Departments should come together to address the needs of this population, who are not quite adults but are not young children, to create and support transitional services for these specific young people.

A young person requesting assistance last week provides a perfect example of the unique barriers facing chronically homeless unaccompanied minors. "J", 17 years old, has experienced multiple episodes of homelessness in the past couple of years, both with his family and on his own. He has severe mental and chemical health issues. He had run out of friend's couches and due to the cold weather had been sleeping in the skywalk system, hotel couches, and unlocked apartment entryways. Desperate, he went to Social Services with a weapon and cried out "I need help, can anyone help me". The police came, took away his knife and let him go. He came to Life House exasperated. The County could not shelter him at the youth crisis shelter because of his mental health issues and the concern for the younger children sheltered there. He could not be hospitalized. At age 17, he is too young for adult shelters (including mental health crisis shelter), a motel voucher, and could not be housed at the Board & Lodge. One month away from being 18, "J" has no options available but the streets.

This population of homeless youth are literally "falling through the cracks" in our system of care. I would like to see the plan to end chronic homelessness include specific solutions for addressing 16 and 17 year olds experiencing chronic homelessness.

Sincerely,

Rachel Kincade, Director
Life House

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CORPORATION *for* SUPPORTIVE HOUSING

Ending Long-Term Homelessness in Minnesota

The Corporation for Supportive Housing (CSH) enthusiastically endorses the draft Business Plan to End Long-term Homelessness released by the State's Working Group on Long-term Homelessness. Every member of the Governor's Working Group on Long-term Homelessness, especially its chairs Commissioner Tim Marx, Commissioner Kevin Goodno, and Commissioner Joan Fabian, deserves much credit for having the courage to set out such an ambitious goal and the common sense to draft a practical plan to achieve it.

While there is much work to do, the business plan provides a solid framework for achieving the goal, and the Corporation for Supportive Housing looks forward to working closely with MHFA, DHS, DOC and all of our partners to make the plan a reality. From this perspective, outlined below are CSH's initial comments on the plan, including our thoughts on key challenges as we move forward and key actions items that we believe can ensure this plan gets off to a solid start in 2004.

Guiding Principles of the Plan

The business plan outlines a number of guiding principles that will be invaluable as the state begins implementing this ambitious but doable plan, including these statements from the report:

> ***"This plan is structured, and must be implemented, so that the broader homeless situation is not made worse."*** CSH strongly agrees with this principle and believes that while we work to end long-term homelessness, we must not undermine existing programs that serve homeless families and individuals.
>
> ***"Long-term homelessness and strategies to address it are multidisciplinary; multi-jurisdictional, and multi-sector."*** CSH firmly believes that successfully addressing long-term homelessness requires a serious commitment and effort on all sides and must recognize the vital links between affordable housing, human services, corrections, and a range of other issues.
>
> ***"The system change necessary to accomplish the goal of ending long-term homelessness will have a positive impact on the entire housing and service systems serving homeless individuals and families."*** CSH strongly supports the Working Group's assertion that systems change – changing the funding, decision-making, and delivery systems – is essential to creating a comprehensive, coordinated response to long-term homelessness.
>
> ***"More cost effective services and delivery mechanisms must go hand-in-hand with increases in resources."*** CSH is reassured that the Working Group recognizes not only the need to innovate

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and create more effective delivery systems, but also that ending long-term homelessness in Minnesota will require additional resources.

"Maximize choice of housing and services for families and individuals; ensure flexible housing and service options that respond to the need." CSH endorses the concept of maximizing client choice, including client-based and site-based services for people experiencing long-term homelessness. Additionally, CSH supports a pluralistic view of supportive housing that includes scattered site, single site, and clustered housing options.

Strategies for Implementation

The central strategy of the Business Plan involves the creation of 4,000 units of supportive housing by 2010. The creation of these units requires significant investment in the capital development, operating costs, and supportive services that make for successful supportive housing. The plan estimates that $540 million in capital, operating, service and income supports will be necessary to finance 4,000 supportive housing units. The report outlines a number of key strategies for identifying and securing these resources:

- **Capital investments** will come from a combination of state allocated General Obligation Bonds, state appropriated resources including the Housing Trust Fund, and private equity from the Low Income Housing Tax Credit program.

- **Operating subsidies** will come from a combination of federal resources (primarily the Section 8 Housing Choice Voucher program and the Shelter Plus Care program) and state funded programs, including the Bridges program.

- **Service Funding** will come from a variety of Department of Human Services programs, including waivered services of Medicaid, the PATH program, flexible dollars at DHS, and other state, federal, county, and private resources.

Collectively, these strategies and potential sources of funding provide a promising starting point for identifying and securing the resources necessary to meet the plan's goal of 4,000 units of supportive housing by 2010.

The Challenges Ahead

As the State moves forward to implement the plan, identify funding gaps and make the plan a reality, a number of key challenges will need to be addressed. Included among them:

Creating and Institutionalizing Systems Change – In order to effectively and comprehensively coordinate housing and human service systems - intentional, long term efforts must be made to break down the "silos", both programmatically and jurisdictionally, that impede the effective, efficient delivery of supportive housing. State leaders, government staff, private sector practitioners, and stakeholders must work together to create systemic change.

Accessing "Mainstream" Resources – The plan leans heavily on accessing mainstream resources including Medicaid and the Housing Choice Voucher (Section 8) program to finance much of the service and operating dollars needed. These programs have significant resources and provide great promise, but numerous

regulatory and statutory barriers must be dismantled in order to maximize use of these resources. The state and its partners must work closely with its federal partners to maximize access to mainstream programs.

Attracting Investment – As the plan indicates, success will depend on innovation, but also on new resources. Securing the additional state, federal, county, and private resources necessary to make this plan a success will be difficult, during good and bad economic times. The state and its partners must actively engage policy makers and funders to attract significant new resources.

Building the Capacity to Deliver – Ultimately, creating the plan and identifying the resources necessary will only be successful if we have strong, capable housing developers and service providers that are dedicated to housing the "hardest to serve" and understand the barriers and challenges of people experiencing long-term homelessness. The state and its partners must actively work (through trainings and other venues) to cultivate and expand the capacity of providers and developers to create and operate successful supportive housing, and embrace service delivery models that work for the population.

Improving Discharge Planning Practices – Ending long-term homelessness will require significant improvements in our collective efforts to appropriately place people leaving public institutions, including jails, community mental heath centers, treatment programs, etc. Greater coordination among the corrections, mental heath, chemical dependency and housing systems, coupled with additional resources, is the only way to ensure that we do not expand the ranks of those that experience long-term homelessness.

<u>Short-term Next Steps</u>

Implementation of this plan over the next six years will necessarily involve significant changes in public policy and additional resources from all levels of government. Fortunately, there are a number of concrete steps that can be taken in the short-term to get this initiative off to a solid start. CSH recommends the following for this year.

- Create an Implementation Group for the plan - made up of stakeholders, including: people experiencing homelessness, service providers, developers, counties, MHFA, DHS, and others - and involve it in the execution of the plan, including making recommendations for mid-course corrections and measuring outcomes and potential savings in our health care, corrections, and other systems.

- Support passage of the $20 million bond bill for supportive housing. This bill will create 260-550 units of supportive housing and will provide a springboard for future investments.

- Work with DHS and the State legislature on minor modifications to existing DHS funding streams to expand access for people experiencing long-term homelessness, while holding harmless other homeless programs.

- Support authorizing legislation and appropriations for the Ending Long-term Homelessness Services Initiative (ELHSI). This new federal initiative would provide $70 million in service funding for supportive housing in FY05.

- Work closely with the Department of Housing and Urban Development to increase the availability and flexibility of federal rent subsidies programs (e.g. Section 8 and Shelter Plus Care)

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TO: Supportive Housing for Persons Experiencing Long-term Homelessness Working Group

FROM: Kristin J. Robbins, *American Experiment Quarterly*

DATE: March 4, 2004

SUBJECT: Additional Comments

I would like to express my great thanks to Commissioners Marx, Goodno and Fabian and their staffs for the excellent work they have done in developing strategies, negotiating and writing the Report and Business Plan. I know this difficult task was just the first stage of an enormous undertaking, but given the leadership and skills you have all exhibited, I have every confidence we will be able to make significant progress toward ending long-term homelessness in Minnesota.

I have decided to add my name to the Report and Business Plan because I believe the goal of ending long-term homelessness is important and achievable. I do have some concerns, however, and I hope these additional comments will be helpful as we move forward with the implementation.

I recently read Indianapolis' strategic plan for ending long-term homelessness ("Blueprint to End Homelessness, Final Draft, April 18, 2002; hereafter "Blueprint"), which I commend to you. While this document had many points in common with ours, it included a few innovations that may be worth considering as we proceed. Ideas borrowed from the Indianapolis plan have been duly noted below.

1. Systems Change

My greatest concern about the Report and Business Plan is that there are no explicit drivers to affect systems change. Despite the good intentions and high level of commitment by all involved, there are no built-in mechanisms which will help ensure that this effort does not get bogged down by the cumbersome nature of the state and county bureaucracies involved. One of the big concerns raised throughout the course of our meetings was the difficulty of streamlining – or even cataloguing – the maze of categorical funding sources and requirements for various services and populations. Rather than empowering a single entity which can be evaluated, the Report and Business Plan permit responsibility to be diffused. This lack of accountability will likely limit or delay progress toward the goal.

a) The "lead entity" for implementation should be outside of state government.

The Indianapolis Housing Task Force and the various stakeholders involved decided that it would be best if the effort to end homelessness in Indianapolis was led by a non-profit

agency. The rationale for this decision was to "ensure the realization of the Blueprint's ambitious goals transcends electoral cycles" (Blueprint, pg. 33).

I believe this idea merits consideration. Rather than creating a staff position to coordinate the implementation of the plan for the Departments of Human Services, Housing Finance, and Corrections, empowering a "lead entity" outside of the state government, but accountable to it, could increase the efficiency and effectiveness of the implementation. It is much easier to hold one non-profit organization accountable for results than it would three large state departments.

Given that ours is a statewide effort, it might be advisable to contract or subcontract with one "lead entity" for each major population center involved (e.g, one for the Twin Cities, one for Moorhead, one for Duluth, etc.). Each "lead entity" would be responsible for implementing the Business Plan in their area and would be able to tailor their outreach, case management and other strategies to meet the specific needs in their communities.

b) Establish an entity to coordinate case management services.

The lead entity to could hire a "care management organization" to coordinate support services either for those meeting our definition of "persons experiencing long-term homelessness" or for those persons served in the 4,000 units identified in the business plan (Blueprint, pg. 20).

Hiring one entity to coordinate case management services would again be a driver for systems change. The population they served would be well-defined and it would (again) be easier to hold one group accountable for results. It would also be more efficient to focus case management services specifically on the targeted population, rather than to have services for this group blended with services for others who are not long-term homeless.

c) Strengthen our information and referral network to provide real-time information on vacancies at area shelters and transitional housing units.

Indianapolis uses a computerized data collection system, known as ClientTrack, to track case management and client follow-up for providers of services to homeless and near-homeless people (Blueprint, pg. 21). This system, or something like it, could also be used in conjunction with our 211 system (formerly First Call for Help) to help clients and service providers know where shelter beds are available in real time. A similar system, known as the Day One Project, currently provides such information for battered women's shelters in the Twin Cities.

Perhaps we could also create a unified database on the availability of housing that is affordable to very-low income people and integrate that information into either the ClientTrack-type system and/or the 211 system (Blueprint, pg. 21).

In addition, we need to prioritize the continued development of the state's Homeless Management Information System (HMIS). Accurate data on the actual number of persons experiencing homelessness, use of services and effectiveness is critical to our ability to target resources and successfully implement and evaluate the Business Plan.

d) *Allow for-profit companies to compete for the opportunity to provide the above-mentioned services.*

Although I realize this will be controversial, I believe for-profit companies should be able to compete to be the "lead entity," run the case management and/or develop and run the necessary information systems. There is an unspoken notion that individuals or companies should not be able to "make money on the plight of the poor." That is certainly true where exploitation is involved, such as charging exorbitant interest rates, but it is not true when legitimate businesses can effectively provide services that enable low-income people achieve self-sufficiency. If a for-profit company can deliver better services at less cost to the state (which may or may not be true – we'd have to evaluate the proposals), why should they not be allowed to compete?

Allowing for-profit, non-profit, and state/county agencies to compete to offer services would be the most significant driver we could introduce to effect real systems change. This has been done successfully in other service areas, such as providing employment training, and should at least be on the table.

2. Engaging the Philanthropic Community

Although the Report and Business Plan mention the need to bring the philanthropic community into the implementation process, no mechanism for doing so is discussed. Rather, the document seems to rely too heavily on re-directing existing state resources or finding unspecified federal dollars.

Drawing again on the Indianapolis example, I'd like to suggest the formation of a "Funders' Collaborative," which would work with the "lead entity" to bring together public and private donors for the sole purpose of developing a strategy to meet the funding requirements outlined in the Business Plan (Blueprint, pg. 35). This group would take the lead on putting the various funding streams together to successfully develop and/or rehab the housing units and would also issue RFPs to bring together the various partners needed for providing services. Such a focused, united group would help inspire confidence in the philanthropic community that the goals are achievable. It would also ensure that one group, rather than various agencies and partners, was accountable for the funding piece.

3. Partnerships with small, faith-based organizations:

Although I realize that the large (more institutional, in my mind) faith-based organizations such as Catholic Charities and Lutheran Social Services, have been at the table since the beginning, I think we would be remiss if we did not highlight the need to

partner with smaller, community-based faith organizations. These smaller groups, such as Urban Homeworks, tend to have a keen understanding of the housing/service needs in a given neighborhood, as well as what resources/infrastructure in the community could be harnessed to meet those needs. They also tend to have on-going relationships with people in need of services, and a basic level of trust and continuing contact is essential to helping people achieve stability. Partnering with these groups could be a key component of the expanded outreach efforts, as well as efforts to keep the near-homeless from joining the ranks of the homeless.

A related example from Indianapolis was the creation of "homelessness prevention programs" in targeted neighborhoods. These programs, which could be located at churches, food pantries, community centers, CDC's, schools, etc., would identify those most likely to become homeless and work to prevent that outcome through referrals, housing subsidies, assistance with employment services, childcare, transportation, etc. (Blueprint, pg. 17).

I hope these comments are helpful as we work to refine the Report and Business Plan. It has been a great pleasure to serve with you in this endeavor!

HousingMinnesota
Homes For All By 2012

Minnesota HOUSING Partnership

TO: The Working Group on Supportive Housing to End Long-Term Homelessness
FROM: Rachel Callanan and Chip Halbach, Minnesota Housing Partnership/ HousingMinnesota
RE: Comments on "Ending Long-Term Homelessness in Minnesota"
DATE: March 5, 2004

Minnesota Housing Partnership/HousingMinnesota commends the Pawlenty administration, the state agency staff involved in this effort, and the working group members who devoted hours of their time to take a bold step toward addressing one of the most pressing housing issues faced by our state and nation. The months of work that have gone into shaping and drafting the report, "Ending Long-Term Homelessness in Minnesota," was a tremendous undertaking and the beginning of a visionary effort that will positively impact the way Minnesota approaches long-term homelessness.

With this large of an undertaking in such a short period of time, a tremendous amount of work was accomplished toward setting up a plan to end long-term homelessness. While many pieces of the plan are solidly in place, there are understandably many pieces that will take time to put into place while maintaining our state's proven commitment to address homelessness. A key to the success of this proposal will be to maintain and solicit the commitment of stakeholders in the implementation of the plan. We recommend that a permanent committee of stakeholders reflecting the range of housing, homeless, and service providers, as well as members of the philanthropic community, and local, state, and federal government, be formed to facilitate and oversee the implementation of the plan.

This effort continues Minnesota's status as a national leader in providing for the range of housing needs across the housing and homeless continuum. However, the efforts to end long-term homelessness should not undercut key housing strategies that must be pursued more broadly in our state to create a healthy continuum of housing. Resources shifted dramatically from one segment of the continuum will create a ripple throughout that will set us back in progress made over the years. We recommend that the plan should be clear about how any redirection of funds will reduce or defer our state's efforts on other housing initiatives or serving other populations.

In regards to the report and the implementation of the plan, **we recommend that the plan expand upon four strategic goals that must be pursued to successfully end long-term homelessness.** The current report contains many elements of these strategic goals, but could use improvement on others.

Goal #1
Expand the supply of supportive housing to meet the projected need of permanent supportive housing for 4,000 households through the year 2010.

This goal is the most thoroughly addressed in the plan. The specific objectives in the plan to meet this goal include raising and reallocating the funding to meet the need for unit

production/rehab, operating costs, and service provision. The report also identifies the need to reform programs and institutional roles, such as increasing the federal funding commitment, in order for the units to continue in service past 2010. We are concerned that one third of the funding is specified as coming generally from federal, state, and local governments, and philanthropic/nonprofit resources. Understandably, every source of funding cannot be explicitly named or projected for the next six years. We recommend that the plan should include a strategy to ensure that the resources come to fruition over the next several years, and should identify a contingency plan in case they do not.

Goal #2
Ensure that the number of people experiencing long-term homelessness does not increase above the 4,000 household projection.

This goal is featured several times in the report, but there is not a specific set of recommendations to prevent long-term homelessness. Steps that could be taken to meet this goal include:

- The state should vigorously advocate to Congress and the White House for, at minimum, no reduction in numbers of people served by rent vouchers or public housing.
- Take steps to preserve current federally assisted housing so as not to lose units.
- All housing serving extremely low income households must be maintained or replaced. This means that housing serving extremely low-income people needs to be shielded from increases in operating costs (particularly property taxes).
- The recently released BBC study commissioned by MHFA, found that there will be a need for an increase of 33,000 units affordable to extremely low income persons by 2010. The number of affordable housing units or rent assistance must be expanded to meet the housing needs of those with extremely low incomes.
- Next to poverty, the leading indicator of the likelihood of adult homelessness is experiencing homelessness as a child or youth, efforts to prevent and address homelessness among children/youth must be expanded.
- Income supports that help extremely low income people remain in their housing (like Emergency Assistance) and homeless prevention efforts must be fully funded. Two policies implemented this year were a particular setback for income supports—the $50 housing penalty and the $125 SSI penalty levied on MFIP participants will both undermine this plan and should be repealed.
- Budget reductions and policy changes that were made for the 04-05 biennium to programs and services that extremely low-income households and people experiencing homelessness rely on should be closely reexamined for their impact on this population. Cuts to healthcare, emergency services and transitional housing, emergency assistance, domestic violence programs, youth shelters and services, and other programs, will likely exacerbate the challenges of serving these populations.

Goal #3

Ensure that all homeless individuals are treated humanely, now and through 2010.

The plan for increasing supportive housing realistically shows that the 4000 household goal would be met in increments, and only by 2010 would 4000 households be served. That means for most of the planning period many people who should be in supportive housing will

be homeless. The plan should better reflect this reality and call for basic support for these individuals. This would mean:

- Shelters and transitional housing must be funded and shelter space must be added so that people are not turned away due to inadequate space.
- The quality of shelters should be enhanced to ensure that people relying on shelter space meet their basic needs for safety, food, personal hygiene, and health care.

Goal #4

Provide a structure for efficiently meeting the long term homeless goal and tracking progress toward that goal.

There are many actors contributing to the success of the long-term homelessness plan. The plan would be enhanced, and the work to address long term homelessness would proceed more efficiently, if the plan clearly articulated the roles and the interaction among roles. This would include setting out specific roles, functions, and mechanisms for interaction for the following:

- The long-term homeless director
- MHFA, Dept. Corrections, and DHS
- Continuum of Care participants and the Interagency Taskforce on Homelessness (ITH)
- Shelter and Transitional Housing providers/HMIS participants
- Owner/developers of supportive housing, including nonprofit and for-profit owners, and Housing and Redevelopment Authorities/Public Housing Authorities
- Service providers
- Technical assistance providers and predevelopment cost providers
- Owners of rental housing,
- Funders—both current and potential
- The housing advocacy community in general, communities of color, the mental health community, veterans and others that likely have a high interest in the success of the plan

Conclusion

Minnesota Housing Partnership and HousingMinnesota join in this historic effort to end long-term homelessness. We look forward to working with all the stakeholders to furthering this goal. Although we have recommendations about some elements of the plan and its implementation, we value the work that has been done and will work with the state agencies to enhance and fully implement the plan to end long-term homelessness.

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TO:	**Working Group on Long-Term Homelessness**
FROM:	**Tarryl Clark and Pam Johnson, Minnesota Community Action Association**
RE:	**Comments on "Ending Long-Term Homelessness in Minnesota**
DATE:	**March 8, 2004**

The Minnesota Community Action Association is very supportive of Governor Pawlenty's goals to end long-term homelessness by 2010 and to "fill the cracks" so that new individuals and households do not enter long-term homelessness. Community Action Agencies work statewide in all eighty-seven counties to assist families and individuals to move out of poverty while further strengthening our communities. The creation and support of decent, safe, and affordable housing is one of major MCAA's initiatives which require the support of local, state and federal government proposals such as the one proposed by Governor Pawlenty on January 7. We are particularly pleased that the first steps taken to move the Governor's initiative forward have included intentional interviews with, and input from, low-income people who are currently experiencing homelessness. Low-income citizens play critical leadership roles in the work of Community Action Agencies in Minnesota, filling one-third of our policy-making bodies and informing our program development efforts.

We view this first draft as a strong *first step* towards the construction of a Plan to achieve the Governor's goals. We also strongly believe, however, that the following areas of concern must be addressed in order to ensure success. You will notice that many of our comments are identical to those submitted by MCH, who successfully captured much of what we wished to say and who are supportive of our repetition.

We are in agreement with the MN Coalition for the Homeless perspective that the DRAFT Plan articulates the following critical principles:

1. **Increased and concerted efforts of local, state, and federal government**
2. **Maximization and increased access to use mainstream programs and services**
3. **Preventing long-term homelessness**
4. **Doing no harm to the rest of the housing/homelessness continuum**

The following comments provide detailed thoughts regarding each of these principles.

1. Increased and concerted efforts of *both* the state and federal government

a. State

The Plan proposes to increase state housing resources, which we concur is critical to achieving the Governor's goals. It is also critical that additional resources be identified, or current resources modified, for the provision of services to supportive housing participants.

- "The plan anticipates additional capital appropriations of $25 million in 2006 and $30 million in 2008" (p 48).
- "Appropriation increases of $2 million each year for the Housing Trust Fund in 2005, 2007, and 2009" (p 48).

While this is a positive first step, we feel that the final Plan must identify additional operating and service resources to assist households experiencing long-term homelessness. Acknowledging that many of the former sources available to provide this support were significantly reduced during the 2003 Legislative unallotment actions and budget-balancing cuts made to human services, we feel that it is important to identify where these new resources will be found.

We have two additional concerns regarding the use of state bonds. First, while most of the shelters and transitional housing are currently provided by non-profit agencies, these organizations are not eligible for this funding. It is important that the public entities awarded this funding seek creative avenues to work with non-profits in order to make this work. Secondly, in order to ensure that the funds are ultimately used to develop the targeted projects intended by this Plan, we recommend the development and use of a tracking system.

Federal

The DRAFT Plan recognizes that "without additional rental assistance for persons experiencing long-term homelessness, the national and state goal of ending long-term homelessness cannot be accomplished" (p 37). However, uncertain assumptions are made about the dollar contribution provided through federal programs.

Again we agree with MN Coalition for the Homeless that the Plan should: 1) clearly articulate the number of households that will be assisted through state supports alone and 2) outline clear policy objectives that will be targeted at the federal government, including a timeline for when the supports are needed for full success.

- Section 8: The Plan notes that only one quarter of applicants actually receive housing vouchers. The Plan relies on an increase of Section 8 housing vouchers, while at the same time, the Bush Administration's current budget cuts 250,000 existing vouchers. Large increases, instead of decreases, in the housing voucher program need to be made to achieve the Plan's rental assistance goals. We believe that the Pawlenty Administration can be persuasive in bringing about a positive outcome on this issue. The Plan should also provide back-up strategies, however, if the Administration's cuts to Section 8 are ultimately made.
- The Plan should endorse increases to Rural and Indian Housing. The Administration is proposing cuts to these programs.
- The Plan should endorse an increase to the Section 811 program.

2. Maximization and increased access to use mainstream programs and services

The Plan states that a bulk of the resources to accomplish the Governor's objectives can be drawn from mainstream programs and services (p 6) yet we know that additional resources will be required to ensure this outcome. We respect the strategies identified within the Plan to better coordinate these state and federal resources.

In addition to the eight programs listed in the Plan, we recommend the three following action steps: 1) re-examine the need for more CADI waivers; 2) encourage counties to look at how their social welfare funds can be used in alternate ways to support this housing initiative; and 3) ensure that, whenever the DHS and other state agencies are conducting research on an issue (such as "health needs"), they pursue the question of how to better meet the needs of homeless people in a more effective and efficient manner. We look forward to working with the DHS, MHFA and the DOC to assist mainstream programs in their improved utilization of these funds.

The HHS report articulates, as does the state Plan, several obstacles to utilizing mainstream programs, including: 1) the creation of a seamless service delivery system; 2) a person experiencing homelessness may meet eligibility standards in one categorical program but not another; and that 3) there may be numerous structures and rules that present challenges and few incentives for public or private providers to search for solutions. In order to be successful, the state Plan should provide options for overcoming these barriers. Also, it is important to note that in some cases, such as in the case of the Community Development Block Grant, local entities are empowered to make funding determinations and allocations and not the state.

MCAA, like MCH, is also concerned that several of the service options discussed are not unlimited entitlements, and thus will not be as readily available as the Plan describes:

- For Medical Assistance, any additional federal resources would necessitate a one-for-one increase in state resources.

- By definition, block grants are not unlimited entitlements. Therefore, prioritization means merely shifting from one needy population to another.
- The SSI application process requires clients to work their way through a complex and often overwhelming system. Maneuvering through the SSI application process becomes difficult, if not impossible, for homeless people with mental disabilities. While waiting for SSI, most people can only access General Assistance (GA) or MFIP. GA, in particular, is so low that it is almost impossible to avoid long-term homelessness without subsidized housing. Additionally, it is important to assist this population with accessing rehabilitation services when needed.

  It is also important to note that households were further destabilized following 2003 State Legislative changes that cut $125 per month from MFIP households receiving SSI support, and which included $50 of monthly housing subsidy as income for MFIP households in subsidized housing.

  An additional significant concern is the elimination of Emergency Assistance as a separate program and its consolidation with other programs in a TANF block grant to counties. Now, in much of Minnesota, a family facing homelessness is no longer able to receive assistance sufficient to resolve a housing crisis. We believe that an unintended consequence of consolidation is that there will be more long-term homeless families in our state. Restoration of funds in both of these areas is needed to meet the Governor's goals.

3. Preventing long-term homelessness

Data from the 2003 Wilder Survey shows that approximately the same percentage of households were experiencing homelessness for the first time (59%) when compared to 2000 (60%); however, an increasing percentage are homeless for a year or more/more than a year. In 2003, 44% of households reported they were homeless a year or more; in 2000, 37% reported they were homeless more than a year. This illustrates that, while more housing and service options are required for households experiencing longer terms of homelessness, Minnesota will not end long-term homelessness if it does not prevent it to begin with.

Hundreds of households fall into long-term homelessness because of limited prevention services and supports that would re-route the temporarily- and episodically-homeless back into mainstream housing and services. As described above, cuts to human services made during the 2003 Legislative Session have weakened or removed safety net systems that formerly prevented homelessness. The Minnesota Economic Opportunity Grant (MEOG), the core funding for Minnesota's Community Action Agencies, received a 53% cut in addition to an unallotment of funds earlier in the 2003 Session. Community Action Agencies are often the primary homeless response system in many counties, and now are equipped with fewer resources to do so. The final Plan must describe the role that members of the broader housing/homelessness continuum plays in preventing long-term homelessness.

4. Doing no harm to the rest of the housing/homelessness continuum

We again agree with MCH's perspectives in this area. We concur that "the broader homeless situation should be improved, not worsened, as a result of proceeding to implement these recommendations" (p 42). Therefore, we oppose shifting resources to serve other low-income populations in order to address long-term homelessness. The current Plan does not clearly articulate when such shifting occurs and who loses:

- Under "DHS Sources and Uses/Costs," it is unclear where all the $75 million (plus inflation) not covered by existing state and federal programs will be drawn from (pp 49-51). We believe that it is important that the Plan includes an outline of the service provision component, and funding sources.
- *"Incentives":* The current Plan mentions two reforms relating to rental assistance: larger tenant contributions towards rent as an incentive to access Section 8 and giving priority to requests for rental assistance funds that will serve households at the lowest monthly cost.
    - Commissioner Marx testified before the Senate Economic Development Finance Committee that this would likely come in the form of requiring additional $25/month from each household receiving rental assistance. While this alone presents a major concern, in light of recent increased demands placed on low-income households (i.e. $50 housing penalty, $125 SSI penalty, increased medical

co-payments, and increased child care co-payments for parents), it seems completely unworkable for many households experiencing long-term homelessness and will result in new long-term homelessness for others. Additionally, there are already large waiting lists for Section 8 statewide.

- Adequate funding for the rest of the continuum to address homelessness cannot simply be monitored while the state focuses on long-term homelessness.
    - Additional bonding resources will be needed over the next seven years to maintain/improve the *existing* affordable housing/homelessness program continuum.
    - Cuts made in 2003 funding on the state and local levels are counterproductive to the Governor's initiative:
        i. $1 billion in cuts to Department of Human Services funding;
        ii. Emergency Assistance was eliminated as a separate program and consolidated with other programs in a TANF block grant to counties. Families who need emergency housing or utility assistance will now compete with a range of interests from county administrative costs, to education & training, child care assistance, and services for pregnant teens. Many counties are not able to make sufficient funds available to prevent homelessness under the new block grant;
        iii. A 53% reduction in funding for the Minnesota Economic Opportunity Grant (MEOG) –as mentioned previously—which is the core funding for Community Action Agencies. This was in addition to unallotment of funds earlier in the Session. These agencies are often the "last stop" for individuals and families in crisis;
        iv. A 29% reduction in service funding through DHS—OEO. Transitional housing cuts will result in more households experiencing longer periods of homelessness. Shelter cuts will hurt the outreach strategies already identified by the Working Group as necessary for success;
        v. MHFA's resources were reduced by 33%, including cuts to the Housing Trust Fund the Bridges Program;
        vi. A wide range of programs serving youth were combined into a Community Services Act block grant to counties, with a 25% cut in overall funding; and,
        vii. Crime Victim Services were reduced by 65%; per diem funding for battered women's programs was cut by 22%.

In conclusion, we submit these comments with the goal to supplement the Plan in order for it to ultimately e*nd* long-term homelessness in Minnesota by 2010. Most prominently, we applaud the commitment the Plan makes to create new housing, while underlining the need for similar secure funding for adequate services for project success. We are thankful for the efforts of those who have joined together with the Governor in a bold step to do what many of us have envisioned for years, but have lacked the resources to do. We believe that Minnesota has constructed a strong, locally-driven continuum-of-care network that is already in place to support this important initiative. It is critical that resources not be taken from one element of this network to bolster another, creating unintended new homelessness. Instead, the Plan must build upon the foundation already in place. We would like to request a seat with the on-going permanent advisory group, which will oversee the implementation of this Plan. We will continue to work hard in all 87 counties to assist Minnesotans to find housing, stabilize their lives, and contribute to the growth of their communities. MCAA will provide additional information, testimony, and support as is needed. We look forward to continuing to work together with you and others in these goals to end long-term homelessness and to "fill the cracks" so that new homelessness is not created.

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Minnesota Coalition for the Homeless

Working to ensure that everyone has a safe, decent, affordable place to call home

TO: Working Group on Long-Term Homelessness
FROM: Michael Dahl, Minnesota Coalition for the Homeless
RE: Comments on "Ending Long-Term Homelessness in Minnesota
DATE: 3 March 2004

On 7 January 2004 Governor Pawlenty stated that he wanted to: 1) end long-term homelessness by 2010 and 2) "fill the cracks" so new individuals and households do not enter long-term homelessness. The Minnesota Coalition for the Homeless' (MCH) mission is to end homelessness (temporary, episodic, and long-term) and, thus, ardently agrees with the Governor's objectives.

While the DRAFT Plan, "Ending Long-Term Homelessness in Minnesota," begins to construct a plan that will achieve these goals, MCH respectfully submits the following comments we feel are necessary to address to ensure its success.

The DRAFT Plan articulates, either explicitly or in concept, the following principles we feel are vital:

1. **Increased and concerted efforts of local, state, and federal government**
2. **Maximization and increased access to use mainstream programs and services**
3. **Preventing long-term homelessness**
4. **Doing no harm to the rest of the housing/homelessness continuum**

The following are detailed comments regarding each of the principles.

Increased and concerted efforts of *both* the state and federal government

State

MCH appreciates the recognition that increased resources will be required for state programs to achieve the Governor's goals:

- "The plan anticipates additional capital appropriations of $25 million in 2006 and $30 million in 2008" (p 48).
- "Appropriation increases of $2 million each year for the Housing Trust Fund in 2005, 2007, and 2009" (p 48).

While this is a great first step, we feel that the final Plan must identify additional operating and service resources to assist households experiencing long-term homelessness. Equally important is that existing resources to assist those experiencing homelessness not be used to fill these gaps.

Federal

The DRAFT Plan recognizes that "without additional rental assistance for persons experiencing long-term homelessness, the national and state goal of ending long-term homelessness cannot be accomplished" (p 37). However, uncertain assumptions are made about the dollar contribution provided through federal programs.

The Plan should: 1) clearly articulate the number of households that will be assisted through state supports alonen and 2) outline clear policy objectives that will be targeted at the federal government, including a timeline for when the supports are needed for full success.

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- The Plan should endorse increases to Rural and Indian Housing. The Administration is proposing cuts to these programs.
- The Plan should endorse an increase to the Section 811 program.
- Section 8: The DRAFT Plan notes that only 1 in 4 who apply get a housing voucher. Large increases in the housing voucher program must take place to achieve the Plan's rental assistance goals. The Administration's current budget cuts 250,000 existing Section 8 vouchers.

Maximization and increased access to use mainstream programs and services

MCH agrees that a bulk of the resources to accomplish the Governor's objectives should come from mainstream programs and services (p 6). We appreciate the strategies identified within the Plan to better coordinate these state and federal resources.

MCH believes the Plan will be strengthened by describing how the programs identified in "Ending Chronic Homelessness: Strategies for Action," (HHS, March 2003) can be better utilized/coordinated to achieve the Governor's objectives. Specifically, the report lists the following 8 mainstream assistance programs as being relevant to the treatment and service needs of people experiencing long-term homelessness: Medicaid, TANF, Social Services Block Grant, Community Services Block Grant, Community Health Centers, Ryan White Programs, Substance Abuse Prevention & Treatment Block Grant, and Community Mental Health Services Block Grant.

The HHS report articulates, as does the state Plan, several obstacles to utilizing mainstream programs, including: 1) the creation of a seamless service delivery system; 2) a person experiencing homelessness may meet eligibility standards in one categorical program but not another; and, 3) there may be numerous structures and rules that present challenges and few incentives for public or private providers to search for solutions. In order to be successful, the state Plan should provide options for overcoming these barriers.

Lastly, MCH is concerned that several of the service options discussed are not unlimited entitlements, and thus will not be as readily available as the Plan makes it seem:

- For Medical Assistance, any additional federal resources would necessitate an one-for-one increase in state resources.
- By definition, block grants are not unlimited entitlements—merely shifting from one needy population to another gets us nowhere.
- The SSI application process requires a client to answer numerous forms, deal with long waits, face over-worked and under-trained personnel, and follow a complex and often incomprehensible system. Many people experiencing homelessness who have mental disabilities are fearful, suspicious or paranoid; many cannot tolerate crowded rooms or noise; most are especially susceptible to stress; and many have significant cognitive limitations. Add to this the further obstacles presented by being homeless - no phone, no address, and no consistent medical care – and maneuvering through the SSI application process becomes difficult, if not impossible, for homeless people with mental disabilities. Without SSI benefits, indigent people with significant mental disabilities have little access to healthcare and seldom enough income for housing. Without consistent treatment and medication, without any form of stability or support, they deteriorate on the street.

Preventing long-term homelessness

Data from the 2003 Wilder Survey show that approximately the same percentage of households were experiencing homelessness for the first time (59%) when compared to 2000 (60%); however, an increasing percentage are homeless for a year or more/more than a year. In 2003, 44% of households reported they were homeless a year or more; in 2000, 37% reported they were homeless more than a year. This illustrates that while more housing and service options are required for households experiencing longer terms of homelessness, Minnesota will not end

long-term homelessness if it does not prevent it to begin with. Hundreds of households unnecessarily fall into long-term homelessness because of limited prevention services and the types of supports that would re-route the temporarily- and episodically-homeless back into mainstream housing and services. ***The DRAFT Plan fails to describe the role the broader housing/homelessness continuum plays in keeping households from becoming long-term homeless.***

Doing no harm to the rest of the housing/homelessness continuum

MCH agrees that "The broader homeless situation should be improved, not worsened, as a result of proceeding to implement these recommendations" (p 42). Therefore, MCH opposes shifting resources to serve other low-income populations to address long-term homelessness. The current plan does not clearly articulate when such shifting occurs and who loses:

- Under "DHS Sources and Uses/Costs," it is unclear where all the $75 million not covered by existing state and federal programs comes from (pp 49-51).
    - Members of the Working Group to End Long Term Homelessness have already articulated concerns regarding the use of existing Transitional Housing and Group Residential Housing resources. Specifically regarding Transitional Housing, greater flexibility in the length of time which a limited number of households can be served is welcomed *if additional resources are provided to do so.* If such resources are not made available, an expanding backlog will result—in practice, a reduction of transitional housing units. With hundreds of eligible households currently unable to access transitional housing due to the lack of capacity, MCH finds this option unacceptable.
    - Where does the $30 million in estimated costs of providing income supplements come from (p 51)?
    - MCH is concerned that the estimates do not include an inflation factor (p 51).
- *Incentives?* The current plan mentions two reforms relating to rental assistance: 1) larger tenant contributions towards rent as an incentive to access Section 8 and 2) giving priority to requests for rental assistance funds that will serve households at the lowest monthly cost.
    - Point #1 is not acceptable. In testimony to the Senate Economic Development Finance Committee, Commissioner Marx testified that this would likely come in the form of requiring $25 extra per month from each household receiving rental assistance. While this alone is a major concern, in light of recent increased demands placed on low-income households (i.e. $50 housing penalty, $125 SSI penalty), it also seems wholly unworkable for many households experiencing long-term homelessness and will result in more households becoming long-term homeless. Additionally, there are already huge waiting lists to get on to Section 8 across Minnesota.
    - Point #2 is unclear.
- Adequate funding for the rest of the continuum to address homelessness cannot simply be "monitored" while the state focuses on long-term homelessness.
    - Additional bonding resources will be needed over the next seven years to maintain/improve the existing affordable housing/homelessness program continuum.
    - Cuts made in 2003 funding on the state and local levels are counterproductive to the Governor's initiative:
        i. $1 billion in cuts to Department of Human Services funding;
        ii. Emergency Assistance was eliminated as a separate program and consolidated with other programs in a TANF block grant to counties. Families who need emergency housing or utility assistance will compete with a range of things from county administrative costs, to education & training, child care assistance, and services for pregnant teens;
        iii. A 29% reduction in service funding through DHS—OEO. Transitional housing cuts will result in more households experiencing longer periods of homelessness. Shelter cuts will hurt the outreach strategies already identified by the Working Group as necessary for success;
        iv. MHFA's resources were reduced by 33%, including cuts to the Housing Trust Fund the Bridges Program;

v. A wide range of programs serving youth were combined into a Community Services Act block grant to counties, with a 25% cut in overall funding; and,
vi. Crime Victim Services were reduced by 65%; per diem funding for battered women's programs was cut by 22%.

Additional Comments:

- (page 2) Research indicates 3.5 million people will experience homelessness in the U.S. each year.
- (page 2) The Plan is to be a "multi-disciplinary" approach; please include crime victims' services.
- (page 6) Minnesota does not need to wait until the next Wilder Research Center report on homelessness (2006) to assess the Plan's impact on emergency shelter/transitional housing need. The Office for Economic Opportunity—DHS conducts quarterly shelter surveys.
- (page 9) Without new money, there will be no new savings. Due to the tremendous backlog in households requiring assistance, we will simply be able to assist more households experiencing homelessness.
- (page 10) The Plan makes no specific mention of the needs of unaccompanied youth.
- (page 14) "The gap between wages and housing costs plays *an increasing* role in homelessness" understates the main cause of homelessness. Data from the 2003 Wilder Survey confirm this.
- (page 15) Include domestic abuse in the causes of "crisis" or "temporary" homelessness.
- (page 15) It should be noted that the Culhane study was done in New York City, where at the time there was a constitutional requirement to serve everyone—including people experiencing long-term homelessness. In Minnesota, no such requirement exists and services often "triage," helping those who have the greatest likelihood of "success."
- (page 19) It is inaccurate to state that regional Continuum of Care planning is "especially" poised to address long-term homelessness. The Continuum of Care process is especially poised to address an approach that looks at the full continuum, but lacks sufficient funds to do so.
- (page 32) In the first paragraph, for what length of time does the "$800" refer to?
- (page 37) Preferences for serving persons experiencing long-term homelessness create unnecessary competition between populations experiencing homelessness. Our starting point should be adequate funding to address the full need.
- (page 41) Please make clear if usage of the term "supportive housing" is inclusive of permanent and transitional supportive housing.
- (page 42) MCH questions whether sufficient free space will be created within the existing emergency shelter and transitional housing capacity as a result of the Plan's permanent supportive housing production goals.

CommonBond
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March 4, 2004

Cherie Shoquist
Minnesota Housing Finance Agency
400 Sibley Street, Suite 300
Saint Paul, MN 55101-1998

RE: Comments on "Ending long-Term Homelessness in Minnesota"
Draft Report

Dear Ms. Shoquist:

We thank you for the opportunity to respond to the Draft Business Plan relating to ending long-term homelessness. We commend the working group for its work on this important issue. However, we believe the recommendations in the Plan raise serious questions about whether the goal can be achieved and if so, at what cost to the remaining parts of the housing continuum and human service delivery system.

Our concerns are in three main areas:

1. Recognition of Housing Continuum

   CommonBond acknowledges that homelessness is a serious issue, but long-term homelessness is only one piece of the housing crisis. People are homeless because affordable housing is in very short supply. There is a continuum of affordable housing needs that requires a comprehensive approach to financing, both for the housing and the necessary support services. The Plan only deals with a small segment of the homeless population and does not address the preventative actions needed to assist the "near homelessness" or persons at imminent risk of homelessness. Many of these individuals are one paycheck away from homelessness. Affordable housing and support services need to be linked to serve all lower-income people better.

2. A Reality Check on the Availability of Section 8 Vouchers

   The Plan is premised on the availability of new Section 8 vouchers. This federal program has been significantly cut back in previous years and lacks the support of the Bush Administration. As a result, many low-income people are on waiting lists for years. Relying on the availability of this program is unrealistic unless the Governor intends on taking a strong advocacy position to increase federal funding for this program. The Plan does not reflect this level of commitment.

The Plan establishes an "incentive payment" ($25 a month) to be paid by individuals receiving temporary state housing subsidies as a way to encourage them to transfer to the Section 8 program. However, if Section 8 is not increased, it penalizes the individual for lack of federal funding of this program. This incentive payment acts more as a financial penalty.

3. Funding for Support Services - Another Reality Check

The Plan lacks clarity and sufficient detail on funding of the support services. It proposes that the initiative can be funded through reallocations of existing human service dollars or expanded coverage through the entitlement programs. These programs experienced a $1 billion dollar reduction in the last state legislative session. It does not seem realistic that this service expansion for the long term homeless could be achieved without new funds or without negatively impacting other clientele and disability groups.

The Plan calls for funding $75 million of the support services needed through current level funding available in eight mainstream type programs, such as Medicaid, TANF, and social service block grant programs. The Plan is not clear where these dollars come from. With regard to Medicaid, we agree that some homeless persons may be eligible for this health care program through their participation in the federal SSI program and this should be aggressively explored. This should result in more individuals accessing Medical Assistance (MA) and thus more dollars being spent for basic health services. However, any expansion of the Medicaid "waivered service" for the homeless population will displace other populations. For example, in the last legislative session, the Legislature "capped" the CADI and TBI Medicaid waiver funding that primarily serves a disabled population. Counties already have waiting lists for these programs. Expanding the use of this funding to cover homeless persons who have severe mental illness without adding new funding will displace other persons with disabilities.

Other block grants (social services / children's) referenced in the report are not entitlement programs and have limited appropriations. In fact, funding for many of these programs was reduced in the last legislative session. It does not appear to be realistic to fund the homelessness services without adversely impacting other needy populations.

The Plan calls for funding the other support services by shifting resources away from programs such as Emergency and Transitional Housing, Group Residential Housing and PATH, that serves other needy populations. It is shortsighted to recommend that additional clientele (long-term homeless) can be served through dollars that are already being used. Funding reductions made to these programs in the last legislative session have already impacted the existing clientele. No data is presented on the impact of these reallocations to those clients being served.

CommonBond has a long history of providing supportive affordable housing through its Advantage Centers. We have demonstrated the importance of bringing supportive services directly to the residents of affordable housing communities, thus preventing many of these residents from becoming homeless. Governor Pawlenty's goal of ending homelessness can only be achieved by supporting all lower-income people in the housing continuum. CommonBond agrees with the Plan's statement "The broader homeless situation should be improved, not worsened, as a result of proceeding to implement these recommendations."

Sincerely,

Joseph A.L. Errigo, Jr.
President & CEO

Nellie Johnson
Vice President of Advantage Services

cc: Commissioner Kevin Goodno
Commissioner Tim Marx
Commissioner Joan Fabian

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MINNESOTA SUPPORTIVE
HOUSING CONSORTIUM

March 5, 2004

Commissioner Tim Marx
Commissioner Kevin Goodno
Commissioner Joan Fabian

c/o Cherie Shoquist – Minnesota Housing Finance Agency

The State Business Plan to End Long-Term Homelessness

Response from the Minnesota Supportive Housing Consortium

The Minnesota Supportive Housing Consortium, a membership organization of over 45 housing and social service agencies in Minnesota, endorse the creation of a state plan to address the housing and social needs of Minnesotan's experiencing long-term homelessness. Following the release of the Report and Business Plan of the Working Group on Long-Term Homelessness on February 27, 2004, the Consortium distributed the plan and took comments from its membership.

The Consortium applauds the Commissioners, State Working Group and Interagency Working Group for developing a sound framework for increasing the development of supportive housing, while recognizing many of the challenges facing our state and country to reach the goal of ending long-term homelessness. The following is a summary of comments received and our collective thoughts on the opportunities and challenges ahead as Minnesota strives to end homelessness for this segment of the larger homeless population.

Principles:

Several of the guiding principles set forth in the plan are invaluable to realizing the implementation of this plan. From the Consortium's perspective, the principles that most notably govern successful implementation of the plan are:

- Structuring the plan so that the broader homeless situation is not made worse.
- Addressing the system change necessary to accomplish the goal of ending long-term homelessness.
- Increasing access to and maximizing the use of mainstream programs and services.
- Investing in homeless prevention as well as housing and services for those currently experiencing long-term homelessness.

Implementation Strategies:

The plan estimates that $540 million in capital, operating, service and income supports will be necessary to finance 4,000 supportive housing units. The report outlines a number of key strategies for identifying and securing these resources. The Consortium believes these strategies are a useful starting point for identifying and securing the resources necessary to fully implement the plan.

Recognition of the Challenges Facing Minnesota:

The State's Working Group deserves credit for developing an ambitious plan to end long-term homelessness in Minnesota. The plan identifies more than $360 million in potential sources of funding to meet the goal. As the State moves forward to implement the plan, a framework for engaging stakeholders and a number of challenges will need to be addressed. These include;

- State leaders, government staff, private sector practitioners, and stakeholders must work together to create systemic change to break down the "silos", both programmatically and jurisdictionally, that impede the effective, efficient delivery of housing and services.
- The state and its partners must work closely with the federal government to maximize options in mainstream programs, and assure that federal resources for homeless programs, Housing Choice vouchers, and Medicare remain constant (at a minimum).
- The state must appropriate additional resources for on-going operating and social services costs to fully realize the plan.

Specific Comments on the Plan from Consortium members:

- "Forceful state advocacy at the federal level, especially for homeless programs and housing choice vouchers is critical."
- "Concerned that reliance on GRH funding in the plan, does not recognize the limitations this funding source places on individuals and their ability to become more self-sufficient."
- "The plan does not address prevention of long-term homelessness."
- "The proposed redirection of Transitional Housing funds into rental subsidies is short-sighted. Transitional Housing is an important link between shelter and permanent housing."
- The plan fails to recognize the proposed cut of 250,000 existing Section 8 vouchers in the Bush Administration's budget." "What's the contingency plan?"
- "I don't like defining supportive housing as 'housing first.' I think it refers to a model that doesn't allow sobriety and other requirements. I would like the report to specifically say that different models including housing first and sober housing are important."

- "The biggest concern is the revenue side. No new funds (except bonding), makes this a shell game. The plan to divert the revenue they've identified will have serious impacts somewhere else that will effect this population."
- "Question the inclusion of the $16.2 million in 2002 bonding dollars and the 1,600 supportive housing units in the 'pipeline.' To what extent do these developments target the long-term homeless?"
- "The service funding component of the plan indicates a considerable gap in funding sources and for redirecting some existing resources. While this may work for start-up, additional resources will have to be secured to ensure the plan's long term success."

Critical Next Steps:

- Create an Implementation Group for the plan and charge it with addressing the questions raised by stakeholders to the plan, implementation of the plan, making recommendations for mid-course corrections, and measuring progress.

- Support passage of the $20 million bond bill for supportive housing. This bill will create 260-550 units of supportive housing and will provide a springboard for future investments.

- Work with DHS and the State legislature on modifications to existing DHS funding streams to improve access for supportive housing programs while holding harmless other homeless programs.

- Raise the profile of ending homelessness in the public and address the siting and neighborhood resistance to supportive housing forcefully.

- Utilize the Governor's relationship with the current federal administration to assure that the federal resources pledged to end long-term homelessness nationally, are fully realized and support the Minnesota plan.

Thank you for the opportunity to respond to the Report and Business Plan in advance of it's submission to the legislature. Please consider the Minnesota Supportive Housing Consortium as an agency that joins in the plan's goal of ending long-term homelessness in Minnesota by 2010. A special thank you to the dedicated state staff that commitment so much time and energy in the process and plan.

Sincerely,

Jonathan Farmer
Executive Director
Minnesota Supportive Housing Consortium

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DEPARTMENT OF PLANNING
& ECONOMIC DEVELOPMENT
Martha G. Fuller, Director

CITY OF SAINT PAUL
Randy C. Kelly, Mayor

25 West Fourth Street
Saint Paul, MN 55102

Telephone: 651-266-6565
Facsimile: 651-228-3261

March 8, 2004

Kevin Goodno, Commissioner
Department of Human Services

Joan Fabian, Commissioner
Department of Corrections

[redacted]
Minnesota Housing Finance Agency
400 Sibley Street, Suite 300
Saint Paul, Minnesota 55101-1998

Re: **Ending Long-Term Homelessness in Minnesota**
Report and Business Plan

Dear Commissioners:

The City of Saint Paul wishes to commend the Governor and you for your leadership and the hard work of the entire Working Group in preparing the report and business plan to end long-term homelessness in Minnesota. Saint Paul endorses the plan and commits to work with all the parties to develop appropriate new supportive housing facilities within the city. Saint Paul requests that this endorsement be made part of and submitted with the report to the Governor and the State Legislature.

We believe the strategies of the business plan complement the housing development activities Saint Paul now has underway. Since 1999, Ramsey County and the City of Saint Paul have been implementing a five-year housing and homeless services plan to assist the homeless and develop emergency shelter facilities and transitional or permanent supportive housing. Also, Saint Paul just successfully completed the first two years of a four-year initiative to produce 5000 new housing units within the city (Housing 5000). Therefore, the strategy to develop new supportive housing for the homeless that is the cornerstone of the Working Group's plan to end homelessness, is also a key element in both of these current Saint Paul housing initiatives.

During the multi-year period of the plan, we strongly believe success will only be achieved if bold steps are taken and the following elements are part of the initiative:

- Engage the entire community in the production of the necessary housing and support services
- Strengthen and expand the capacity of the housing development community and maximize private sector leverage including for-profit privately-owned and operated supportive housing facilities
- Focus the delivery of support services to the physical developments
- Reduce red tape between and among all the capital and support services funding partners and maximize the effectiveness of the partnership
- Increase the financial commitment from traditional funding partners, and identify new, non-traditional funding partners

We commit to continue to work to produce new supportive housing. In fact, during the past two years, seven projects with 147 supportive housing units have been completed or are under construction. Two other projects with 18 units will start construction early this year. Additionally, a more than 400 unit apartment complex is undergoing substantial redevelopment by a for-profit developer that includes a provision for support services for the residents. Saint Paul will continue to look for opportunities to develop additional supportive housing facilities that meet all of our complementary objectives.

Along with our strong support for the report and plan, we offer the following comments for your consideration:

1. The "housing first" strategy is the right first priority for this homeless initiative. However, it should be seen as part of a continuum of housing types available for our low income residents. The continuum includes: emergency/transitional housing facilities, permanent supportive housing, very low income public or other independent affordable housing, general occupancy rental housing (with or without Section 8 assistance) and home ownership (with or without home buyer counseling and assistance). The availability of this continuum of housing types within the market place ensures there is a continued progression of low income residents, including the currently homeless population, through the continuum, with units available when they are needed. Therefore, a successful homelessness initiative depends largely on the availability of units throughout the continuum of housing types. This comprehensive approach to addressing the current homeless population may also give us the best opportunity to evaluate the savings and benefits of reduced human support services costs when the homeless are permanently housed.

We agree with the order of priority of funding for proposals outlined in the plan that serve long-term homeless households and that have committed project-based rental assistance and other funding in place. Additionally, proposals should demonstrate as explicitly as possible how they will deliver long-term results, and how the previously homeless households will move along the continuum of housing types.

2. Experience has shown that the total development costs for supportive housing projects are considerably higher than other developments. Though we need to ensure quality housing is constructed, capital development costs must be reduced when and wherever possible. As part of this effort, the State should solicit additional Section 8 vouchers for the plan, not only to assist households afford rental charges, but also as a means to increase revenue sources to pay for capital costs.

   We applaud efforts to increase the flexibility of support services funding, and for rental assistance and capital funding as well. However, we caution against measures that merely redirect rental assistance and capital funding toward service delivery without increasing the total pool of funds available for all components.

3. We completely agree a key challenge to the initiative is obtaining necessary support services funding and directing services to the residents of specific housing developments. This challenge cannot be left unresolved.

4. Another key challenge is identifying the necessary capacity by developers and facility operators to produce and manage the proposed 4,000 supportive housing units. We believe the plan needs to more fully address this challenge.

   We agree that a variety of models of supportive housing should be considered, including models that deliver support services on-site as well as off-site. Also, we strongly suggest that the plan look to housing models that are owned by private, for-profit developers that include of provision for support services. In fact, we believe it is essential that the plan maximize privately-owned development and it not result in primarily developments that are exempt from property taxes.

5. The plan does not address where the new units should be located within the State. We understand it is important that new developments occur with ready access to public transportation and necessary support services while offering a wide locational choice for residents. Job training is an essential part of the support services that must be available to the homeless population. Future employment for the unemployed homeless must be a crucial objective. Hence, it is important that the new supportive housing is near support services and employment opportunities for low income workers.

Saint Paul will be part of the solution to end long-term homelessness. Our commitment to this is reflected in the number of best practice models included in the report that are in Saint Paul. The plan's commitment to flexible housing and service options must also be a commitment to geographic options. We strongly urge that within the Twin Cities metropolitan area, the availability of support services (including job training and employment opportunities) and the location of new developments must be uniformly and fairly targeted throughout the region.

6. Related to the above point, local municipalities and neighborhood residents will play a direct role in siting the proposed new supportive housing projects. Land use, zoning, design and other site issues will need to be carefully addressed. Oftentimes, these issues will be key challenges for the siting and long term success of specific developments.

   In this regard, on a statewide basis, we believe it is important to review applicable regulatory requirements that restrict the development of low income housing, and opportunities should be considered to uniformly waive or remove very restrictive statewide measures.

Along our endorsement of the report and plan and our commitment to continue to assist in the production of supportive housing facilities, Saint Paul supports inter-agency cooperation and is very willing to serve on an ongoing advisory body. Also, we believe Saint Paul has implemented a number of core concepts as part of our Housing 5000 business plan that have proven to be very successful and can be applied to this homeless initiative. We offer the opportunity to share these concepts with the Working Group staff, the future advisory body, or the expected new executive director.

Again, we commend you for your leadership on this important issue and the hard work of the Working Group. With you, we eagerly await the review, endorsement and funding of the plan by the Governor and the Minnesota Legislature.

Sincerely,

Martha Fuller
Director

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Brain Injury Association of Minnesota

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Date: March 5, 2004

To: Commissioners Goodno, Fabian and Marx
c/o Cherie Shoquist

First let me congratulation the work group on the draft "Ending Long-term Homelessness in Minnesota-Working Group Status Report and Business Plan". It is encouraging to see multiple State agencies partner on such an immense challenge with creativity and collaboration. This report is extremely thorough and easily understood. However The Brain Injury Association of Minnesota has several recommendations.

First, the omission of brain injury or traumatic brain injury (TBI) is a glaring one. Traumatic brain injury is the leading cause of death and disability for children and young adults. The Wilder Report states 29% of the adults surveyed "reported receiving a blow to the head hard enough to knock them out or make them see stars, followed by problems with headache, concentration or memory, understanding, excessive worry, sleeping, or getting along with people. (An indication of a possible traumatic brain injury)" According to Minnesota statute most if not all of these people do have brain injury; other research suggests that the percentage is probably much higher. Additionally Wilder backed this up with 30% reporting that they often feel confused or have trouble remembering things, or have problems making decisions, to the point it interferes with dialing activities, all symptoms of brain injury. National data shows that the prevalence rate of people who have a disability resulting from traumatic brain injury is similar to the prevalence of people with mental illness in the general populations and there is no indicators that would lead us to think the prevalence within the long term homeless population would not be similar likewise. Best practices also demonstrate that for people with brain injury with co morbid mental illness and/or chemical dependency issues that if the brain injury related issues are not dealt with success in the other two areas is severely limited.

The report also includes data from Families with Children that indicates 95% involved domestic violence; again national data indicates that domestic violence is a leading cause of brain injury and results in brain injury in the majority of cases.

There is also a correlation between the extreme racial disparities in the Wilder report and the racial disparities found within people with brain injury.

The long term results of traumatic brain injury are a significant factor leading to long-term homelessness and this report failed to address it.

Recommendation 1. Include brain injury or traumatic brain injury (TBI) where ever the report mentions mental health, mental illness and/or chemical dependency.

The inclusion of special outreach efforts to address eligibility for Medical Assistance and other "mainstream" funding/support service are great opportunities. For many people with brain injury the lack of awareness of their disability keeps them from accessing needed services. We know that people with TBI can be some of the most expensive and challenging individuals if the appropriate support services are not in place. They will surface in the corrections, medical and homeless systems as crisis cases. It is also critical that the outreach effort in addition to case management and service coordination is conducted by individuals with expertise and experience in working with people with traumatic brain injury as well as mental illness and chemical dependency.

Recommendation 2. DHS include the private sector when initiating or requesting proposals (RFP) for the special outreach effort. Perhaps the model available for relocations service coordination for people in institutions could be expanded to include the long term homeless population.

In 2003 DHS capped the number of individuals who could access Medical Assistance Waivers including the TBI and CADI Waivers, two tools that could potentially support many of the individuals with brain injury who are homeless. Caps were placed on these waivers due to the sharp increase in usage, yet we know that these waivers are more cost effective than the institutions they reside in or the crisis services used if left on the streets.

Recommendation 3. The cap on the number of TBI and /CADI waivers must be removed if we are going to be successful moving the 1,000 plus individuals with TBI from the long-term homeless population to living in the community with appropriate supports. It is important we not reduce access to these waivers to individuals currently living in institutions and in the community.

The report refers consistently to utilizing existing funding sources, but does not address how this could impact individuals who currently utilize services currently being funded by these sources.

Recommendation 4: Funding moved from existing services that will impact on current clients should be analyzed and documented to reduce the impact on available resources for current clients.

Currently the Department of Corrections does not have a system in place to address the support needs of offenders with TBI similar to the system established for persons with mental illness.

Recommendation 5: The Department of Corrections initiates a system of identification of offenders with a disability resulting from TBI and provides access to transition planning specific to brain injury for those individuals.

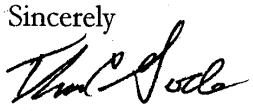
Recommendation 6: The new position Director of Long-Term Homelessness must have a thorough back ground in disability issues and services.

We are delighted that this report takes a holistic approach recognizing that support services, case management, etc are critical to success and play an important role in addition to the accessibility of affordable housing. The Section Housing with Support Services Nationwide does a wonderful job of pointing out the value of this approach and the consequences of not addressing the individual holistically.

The Brain Injury Association of Minnesota welcomes the opportunity to join any future stakeholder or working group that will be addressing the long term homeless issue.

Please include these comments when submitting the report.

Sincerely



Thomas C. Gode
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MEMO

TO: Claudia Dengler, Pat Teiken (and interested others)

FROM: Craig Helmstetter

RE: Report and Business Plan of the Working Group on Long-Term Homelessness

DATE: March 2, 2004

Thank you for the invitation to comment on the draft "Ending Long-Term Homelessness in Minnesota" report. I was impressed with the report's depth and scope. For me, the area of the report that needs additional attention and emphasis is its discussion of research and evaluation. Evaluation does receive a bullet point in the introduction and a paragraph in the implementation section (page 45), but needs more attention if the plan is to be successful.

Why is evaluation important to this plan? (1) Evaluation equals accountability for the many partners that will be providing housing and services under the plan; (2) rigorous evaluation will tell us whether the investment in supportive housing pays off; and, (3) if evaluation becomes an afterthought (rather than incorporated at the outset) client-level outcomes may only be measured inconsistently by the various providers, or even not measured at all.

Perhaps the most effective way to establish evaluation as an important part of the plan would be to give it an explicit line item in the "Financing Plan Estimate" budget tables (pages 8 & 43). If the workgroup wanted to go further, the report could include a brief outline of an evaluation plan in an appendix: The outline could be as simple as (1) a baseline study of existing supportive housing services (the state does not have an inventory of existing supportive housing services), (2) annual or bi-annual status reports including client demographics and outcomes (as well as progress on unit production goals), and (3) a final report. This would undoubtedly be useful to the state's new Director of the initiative to end long-term homelessness.

Additionally, the state's Homeless Management Information System could be a key component of the evaluation plan (I hope it does not sound too self-serving since I am the projector director for HMIS).[1] The system currently is positioned to collect data from the state's HUD McKinney-Vento funded housing and service providers, as well as those funded through the DHS's Office of Economic Opportunity and MHFA's Family Homeless Prevention and Assistance Program.

If the workgroup so chose it could require all permanent supportive housing programs to collect common intake information, and even track a common set of outcomes, via HMIS. Additionally, since most of the state's emergency shelters, transitional housing programs, and domestic violence shelters will be on the

[1] Although Wilder serves as system administrator for HMIS, the data could be analyzed by a third party, given proper safeguards on data privacy.

system, HMIS will make it easier to see whether clients leaving supportive housing return to temporary housing programs.

HMIS receives passing mention on page 45, but the footnote does not seem to reflect positively on HMIS, stating it "may possibly" track success and "may take several years" to become effective. As a point of clarification, although it will take approximately 2 years to get enough agencies on the system to say something about the state's homeless services as a whole, HMIS is immediately useful for an agency once they start using the system. If HMIS is supported by this plan – as it is nationally by the National Alliance to End Homelessness's and many others[2] – it will become an important mechanism for assisting and guiding the state's efforts to end long-term homelessness.

Enough about evaluation and HMIS. Here are a couple other issues:

- Page 10, last sentence of 1st paragraph under section 8 ("Even if..."). I would delete the sentence – it sounds too much like we are expecting to fail.

- Pages 21-24 summarize evaluations of supportive housing programs in Minnesota. Two studies that could be added are:
    - Wilder's evaluation of Minnesota's Supportive Housing Demonstration Program, which used GRH funding and ran from 1996 to 1998. Although it is very relevant to the plan, I do not think the demonstration report was ever released publicly, so we would need an OK from Mari Moen at CSH before releasing it to the workgroup.
    - Wilder's evaluation of its now discontinued Section 8 Participant Support Program, which ran from 2001-2003. This model of "portable" supportive housing is very relevant to the initiative, which includes Section 8 among its funding sources. (The evaluation model, based on participant self-reliance, is also worth noting.) I think Claudia Dengler could OK the inclusion of this report.

- The discussion of Housing Options and Service Choices starting on page 27 would benefit from the continuum of supportive housing typology put together by Wilder's internal working group on affordable housing (specifically the subcommittee on supportive housing that Greg Owen, Rod Johnson, and others participate in).

- Page 29, paragraph under the heading, "Clustered or scattered site." The paragraph seems overly negative about scattered site development, when sometimes it might be the way to go (see the Section 8 Participant Support Program, noted above). How about adding something like: "In some cases scattered site development may help to improve individuals' ability to function in a community by removing them from an environment dominated by others with various dysfunctions. Additionally, the long-term outcomes for children are likely to be better if such housing is sited in lower-poverty neighborhoods."

- As Paul Mattessich observed, the report generally seems to take a kitchen sink approach rather than focusing or prioritizing on any particular part of the plan. If possible, a sharper focus may be helpful to the group.

- As Greg Owen has mentioned, a comprehensive evaluation of the state's transitional housing programs is in order. Such a study would complement the long-term homeless initiative: It may be the case that for some people in this category transitional housing is more effective than permanent supportive housing—currently we don't know.

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[2] HMIS is cited as one of 10 "essential tools" to ending homelessness, see: www.endhomelessness.org/pub/tenyear/

Restart, Inc.
Services • Support • Independence

Cherie Shoquist
Minnesota Housing Finance Agency
400 Sibley Street, Suite 300
St. Paul, MN 55101-1998

March 4, 2004

Dear Cherie,

Please consider this letter a formal comment on the draft of the report for the Working Group on Long-Term Homelessness.

As supportive housing providers and advocates for persons with brain injury since 1986, and as stakeholders attending the meetings of the Working Group on Long-Term Homelessness, we at Restart, Inc. would like to bring some information about brain injury and chronic homelessness to your attention:

- Over **94,000** Minnesotans have a brain injury. Everyday, 55 more go to the ER with a head injury.
- Brain injury results in long term consequences: physical and cognitive impairments, memory loss, compromised social and emotional coping skills. Because it is not visible it is often undiagnosed, misdiagnosed and misunderstood. Persons with brain injury are especially vulnerable because their disability cannot be seen.
- People with brain injuries face many barriers, including access to safe, decent and affordable housing, safe transportation, employment, self-advocacy, medical treatment, psychological and emotional counseling, and support services.
- Many persons with brain injury can progress to a higher level of independence and safety if they receive highly specialized supportive services. However, if housing is provided without support services, individuals will inevitably fail to maintain their safety and placement, and return to the cycle of homelessness once again.
- **29% of homeless persons report having a brain injury. 30% reported that they experience cognitive deficits.** These statistics can be found on page 5 of the 2003 Wilder Survey summary report on Homeless in Minnesota.
- Persons with brain injury who are homeless cost the taxpayer a great deal of money for ER services, treatment for mental health and/or Chemical Dependency issues (which may actually be misdiagnosed consequences of brain injury), and Psych-ward placement. Many are also in prison.

Restart, Inc.
Services • Support • Independence

- The impairments and challenges caused by brain injury resemble no other disability.

It is a proven fact that a person with a brain injury who receives services for cognitive rehabilitation, social skills, independent living skills, and vocational rehabilitation can move on to greater independence, ultimately **costing the taxpayer much less over time.** Having received services, many reintegrate into the community as working, contributing participants and live independently, drastically decreasing their need for social services.

We ask the Working Group on Long-Term Homelessness to list the percentage of homeless persons with brain injuries and cognitive deficits as a separate category with the other statistics found on page 5 of the report draft.

Sincerely yours,

James A. Jasper,
Executive Director

Patricia H. Pettit,
Organizational Development

March 64, 2004

Kevin Goodno, Commissioner
Minnesota Department of Human Services

Joan Fabian, Commissioner
Minnesota Department of Corrections

Tim Marx, Commissioner
Minnesota Housing Finance Agency

Members of the Statewide Working Group on Long-Term Homelessness

Dear Commissioners and Members of the Working Group:

Thank you for your hard work and for the opportunity to comment on the *Report and Business Plan of the Working Group on Long-Term Homelessness*. Each of you has put forth a tremendous amount of time and effort toward developing the recommendations included in this report.

Governor Pawlenty's goal of ending chronic homelessness in Minnesota by 2010 is an important undertaking and could be a significant component of how Minnesota provides homeless individuals opportunities to lead more stable, productive lives. Given the constraints of the current fiscal climate in which we are trying to do more with less, we applaud the Working Group's creative approach to considering how existing programs and services can be provided to more individuals who so desperately need supportive housing.

Need for Broader Representation

We greatly appreciate the opportunity to participate in this effort as a member of the stakeholder group. However, while the Working Group included a broad representation of homeless service providers, affordable housing developers and other community representatives, there was an absence of representation from the disability community – either from service providers or representatives from the Disability Services Division of the Department of Human Services. The most recent Wilder Survey on Homeless in Minnesota revealed:

- 47 percent of homeless adults reported a significant mental health problem

- 41 percent reported having a physical, mental or other health condition that limited the kind or amount of work they could do
- 14 percent reported having a condition that makes it hard to engage in activities of daily living

Given these figures, we hope that, as this effort moves forward, you more formally incorporate into the process representation from the disability services side of the equation – either at the state agency level and/or community service providers.

Reliance on Limited Services and Programs

We are concerned with the Business Plan's reliance on Medicaid and Medicaid waivered services at a time when the Legislature has enacted changes limiting increases in enrollment and reducing spending for many of these programs. Even though outreach efforts to individuals experiencing long-term homelessness does not necessarily mean there will be a significant woodwork effect, ~~the floodgates to Medicaid services will fly open,~~ it is important to be mindful of Medicaid's financial limitations. This is even more important when considering Minnesota's current commitment to transitioning working-age individuals with disabilities from nursing homes to more appropriate housing, many of whom will also need similar supportive housing services to live more independently in the community.

The same is true insofar as the Business Plan relies on greater use of Section 8 vouchers for more individuals to secure affordable housing. Again, Minnesota is working to meet its current commitments to nursing home relocation efforts that~~which~~, in many instances, also require greater use of Section 8 vouchers for many individuals seeking affordable housing. At the same time, the President's proposed FY05 budget falls $1.6 billion short in funding all housing vouchers currently in use. By 2009, the proposed funding cuts would reach 40 percent – a loss of 800,000 vouchers.

More to the point, we hope the final Business Plan will include more specificity around how Governor Pawlenty, state agencies, Minnesota's congressional delegation and other state representatives will work with the Federal government ensure it fulfills its important role in all of this.

Similar Need for Supportive Housing Beyond the Long-Term Homeless Population

Most individuals with physical disabilities needing the very same types of permanent supportive housing such as what is provided in this plan won't qualify for these services. Currently, there are approximately 3,000 working-age individuals with disabilities languishing in nursing homes, many of whom want to live more independently in the community but are unable to do so because they cannot secure affordable, accessible housing with support services.

We recognize that there is a *considerable* difference between a homeless individual as defined for the Working Group's purposes and one who lives in a nursing home with a stable source of room and board ~~a roof over their head and three meals a day~~. Yet, for many individuals with disabilities, the nursing home is really nothing more than a shelter when they cannot find more

appropriate, affordable housing in the community. What's more, it is many times more costly to place individuals in nursing homes than to connect them with community-based services that often lead to better health outcomes, greater independence and even employment opportunities for many.

In its 1999 *Olmstead* decision, the U.S. Supreme Court mandated that states provide the necessary relocation services to help individuals move from nursing homes to less-restrictive community settings. Our state and local agencies and policymakers are making strides toward implementing the *Olmstead* decision. But it will likely take a similar, concerted statewide effort and set of solutions on the scale of the Supportive Housing Taskforce to truly address the needs of the non-elderly disabled who have been existing in their own type of "shelters" for too many years. Other states have convened similar statewide taskforce efforts focused on implementing the *Olmstead* decision. Hopefully, Minnesota will make it the next priority for a statewide affordable housing effort. Minnesota is one of only eight ~~[is this right?]~~ states that has not drafted a coordinated statewide *Olmstead* implementation plan. Perhaps appointing a Minnesota *Olmstead* Director similar to the Long-Term Homeless Director recommended in the Long-Term Homeless Report would be a good place to start.

Again, we applaud your hard work and dedication to such important issues. We understand the need to first address long-term homeless issues and offer our support and assistance to ending long-term homelessness any way we can. We also encourage you to next consider a similar effort to address how Minnesota will formalize and coordinate its efforts to help non-elderly disabled individuals currently living in nursing homes secure more appropriate supportive housing in the community.

Sincerely,

Heather Peterson

cc: Eric Stevens, CEO, Courage Center
John Tschida, Vice President Public Affairs and Research, Courage Center

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March 5, 2004

Commissioner Tim Marx
Minnesota Housing Finance Agency
400 Sibley St, Suite 300
St. Paul, MN 55101

Commissioner Kevin Goodno
Minnesota Department of Human Services
444 Lafayette Avenue
St. Paul, MN 55101

Commissioner Joan Fabian
Minnesota Department of Corrections
1450 Energy Park Drive
St Paul, MN 55108

Dear Commissioner Marx, Commissioner Goodno, and Commissioner Fabian:

Metro-wide Engagement on Shelter and Housing (MESH), as a non voting stakeholder member, endorses the State's Supportive Housing Working Group's Draft Report and Business Plan on Ending Long-term Homelessness in Minnesota. You deserve much credit for bringing the Minnesota Housing Finance Agency, the Department of Human Services and the Department of Corrections and all of the Working Group members together to begin to address this important issue and setting forth a Plan to end long term homelessness in Minnesota by 2010.

While there is much work to do and many challenges ahead, the Business Plan provides a framework for achieving this goal, and MESH looks forward to working closely with all of the partners to make the Plan a reality, especially in the seven county metropolitan area.

The Plan highlights key principles that MESH feels are vital to the success of the stated goals. Outlined below are MESH's initial comments and recommendations on the Plan.

As the vision and goals [of ending long term homelessness] are pursued, it is important to not lose focus on the needs of the broader homeless population and those who are at risk of homelessness.

MESH truly appreciates and strongly agrees with the report's recognition that in pursuing the goal of ending long-term homelessness, the state should not increase homelessness among other populations. The Plan must not redirect funds for homeless prevention or for those experiencing a short-term housing crisis in favor of those experiencing long term homelessness. While movement into housing would be beneficial for those experiencing

long-term homelessness, if resources for those in a short-term crisis are no longer available, they may then become the "new" long-term homeless.

The system change necessary to accomplish the goal of ending long-term homelessness will have a positive impact on the entire housing and service systems serving homeless individuals and families

MESH strongly agrees with the report's assertion that systems change is necessary to accomplishing the goal of ending long-term homelessness. The Plan details that 75% of the 4000 units will need to be sited in the metropolitan area. In order to that goal in the in the metro area, the counties in the metro area will need to work together to address systems change. The Plan should specifically encourage metro counties to participate in the "regional committee to end long term homelessness" proposed by the report, "*Addressing Homelessness: A needs assessment and plan for the seven county metro area*" and endorsed by the Hennepin and Ramsey County Boards of Commissioners to affect systems change in the metropolitan area.

As part of this systems change, counties in the metro area need to coordinate county policies affecting those experiencing long term homelessness, address barriers to siting supportive housing, coordinate the six metro continuum of care processes, and create a regional funders council to integrate funding streams for creation of units that would house those experiencing long term homelessness.

Finally, the Plan and subsequent discussions need to focus on systems change to ensure that children aging out of the foster care system do not become part of the "long term" homeless population. According to the 2003 Wilder survey, 71% of the homeless youth interviewed had experienced placement in a foster home, group home or corrections facility with over half of those youth indicating that they had lived in a foster care home. Clearly there is a correlation between foster care placement and homelessness among youth, indicating a systems failure for those youth who have been in the foster care system and now are homeless.

More cost-effective services and delivery mechanisms must go hand-in-hand with increases in resources.

MESH is pleased to see that the report acknowledges the need for innovative services and delivery systems as well as the need for increased resources in order to accomplish the goal of ending long-term homelessness.

If the Plan is to succeed by relying on mainstream resources such as Section 8, the State must work closely with federal agencies to ensure that there is an increase in Section 8 resources over the long term. Moreover, there are many regulatory barriers at the state and federal levels that need to be addressed in order for the reliance on mainstream resources to prove successful for ending long-term homelessness in the state.

In addition to federal programs, the Plan should also look at state resources like the use of the MSA Shelter Needy Grant. This income supplement is available to those transitioning back into the community from a residential setting such as a regional treatment center or hospital. Recipients must be receiving SSI to qualify and housing costs must be greater than 40% of their monthly income. The Shelter Needy grant provides $139/month to help pay rent. Greater use of this program among eligible

homeless SSI recipients would complement use of GRH funds for rental subsidies by reducing the amount of GRH necessary to fill the affordability gap.

Finally, although the Plan focuses on existing resources, it does acknowledge the need for increased resources. The State and its partners should work diligently to identify new resources for capital, operating and services funding to ensure that the State is successful in ending long term homelessness by 2010.

Rigorous evaluation and search for best practices should be integrated into the implementation process.

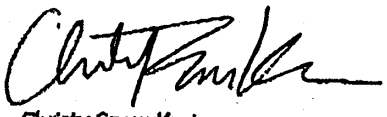
MESH strongly agrees that as the Plan to end long-term homelessness by 2010 is implemented, there must be systems in place to evaluate and monitor the Plan's progress. To that end, the State should contribute non-service funding toward implementing the statewide Homeless Management Information System, which will provide much needed data on who is accessing homeless services, help to identify gaps in services, and help evaluate the effectiveness of those services. However, in order to get the most comprehensive data available, HMIS needs to incorporate non-traditional homeless service providers, like food shelves, free clothing stores, and churches that provide meals because people experiencing homelessness may be accessing only those services and not shelter, transitional or permanent supportive housing programs.

MESH is pleased to see that the report calls for ongoing stakeholder participation. MESH recommends an ongoing implementation group to monitor the Plan's success. This group should, as the report indicates, include people who have experienced homelessness and people of color as they are disproportionately represented in the sheltering system.

Finally, as the evaluation process demonstrates increased institutional and systems savings, the Plan should reflect a way to recapture these savings to invest in continued implementation.

Although there are many challenges ahead in making the Plan become a reality, MESH appreciates your belief that we can in fact end homelessness in Minnesota. We look forward to working with you in partnership to achieve this goal. Please feel free to contact me at (612) 278-1165 if you have questions.

Sincerely,



Christy Snow-Kaster
Executive Director
Metro-Wide Engagement on Shelter and Housing

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4 March 2004

Kevin Goodno, Commissioner, Health and Human Services
Joan Fabian, Commissioner, Department of Corrections
Tim Marx, Commissioner, Minnesota Housing Finance Agency
C/O Minnesota Housing Finance Agency
400 Sibley Street Suite 300
St. Paul, Minnesota 55101

Dear Commissioners Goodno, Fabian, and Marx:

We submit this letter in response to the recently released publication "Ending Long Term Homelessness in Minnesota: Report and Business Plan of the Working Group on Long Term Homelessness."

The Office for Social Justice assists Archbishop Harry Flynn in research and analysis on issues relating to questions of economic justice. In addition, we work closely with Catholics in parishes throughout the Archdiocese who are dedicated to eliminating poverty.

Housing is among the deepest concerns of the Archbishop and of the people of this Archdiocese. The Catholic community is one of the largest providers of emergency, and transitional supportive and permanent housing. Catholics in this community work hard to provide immediate relief to those suffering the consequences of homelessness and to advocate for public policies that provide safe, decent, affordable housing for all.

We wish to sign onto the Working Group's report, and offer these comments with the hope that they will aid the Working Group in its efforts.

Several elements of the Working Group's report are very helpful in terms of helping elected officials understand the scope and nature of the problem and effective solutions that have worked in other settings.

Minnesota needs to have a substantive conversation about how to address this public problem, and the report does a great deal to start that conversation. Relying on the Wilder Foundation's study on homelessness and on interviews with those who struggle with long-term homelessness set the report on an excellent foundation and provide Minnesotans with important fodder for conversation.

Moreover, documenting the savings that supportive housing would generate for state spending on crisis and other services demonstrates that addressing long-term homelessness is not only the morally right thing to do but the economically sound thing to do. We believe this will hold much sway with fiscally minded legislators.

Having said these things, we believe that there needs to be a more careful analysis and explication of how the State might meet the costs associated with eliminating long-term homelessness. Specifically:

- The business plan refers to the need for increased resources on a number of occasions, but in many instances, fails to identify potential revenue streams.

Our concern is that one option would include diverting money from other parts of a larger continuum of care in housing.

For example, the business plan suggests that DHS transitional housing dollars would be reallocated to help pay for this initiative. We are concerned that any diversion of resources from current housing programs could have a detrimental effect on existing efforts that prevent long-term homelessness.

We would hope that the business plan would emphasize the need to maintain existing housing programs and identify new sources of revenue to address the problem of long-term homelessness.

- We are also concerned about funding for the social services that would be necessary in addressing long-term homelessness. In general, the business plan is unclear as to where the actual funding dollars for social services would come from.

  The business plan recommends drawing from existing funding for Medical Assistance and SSI as one concrete way of paying for these services. However, the report does not take into account spending caps placed on these programs in recent years. Clearly, these are limited revenue streams.

  In the absence of greater specificity in the business plan, we are concerned that there may be a tendency to turn to existing funding for social services as a potential source of revenue in efforts to combat long-term homelessness.

  In light of last year's budget cuts, we are very concerned about any effort to further deplete social service spending. Again, we hope the business plan states clearly the need to hold existing social service funding harmless in the search for revenues to pay for supportive housing services.

- The business plan highlights the role of the federal government in addressing long-term homelessness, and makes specific comments about using more Section 8 funding to help those facing long-term homelessness.

  Unfortunately, the Bush administration has proposed significant cuts in Section 8 funding. The business plan does not acknowledge the very real possibility that there will be fewer federal resources to pay for our efforts to eliminate long-term homelessness.

Ultimately, we would hope the final business plan addresses some of these concerns in the following ways:

- We hope that the business plan strongly encourages legislators to refrain from drawing from existing resources to pay for this effort, especially in instances where such actions would divert money away from programs that keep families out of long-term homelessness.

- We hope that the business plan strongly encourages legislators to use all the tools available to them in their efforts to eliminate long-term homelessness, including those tools that could generate additional revenue.

- We hope that the business plan strongly encourages Governor Pawlenty and members of his administration to play a vigorous role in advocating for increased federal resources for housing, including resources to address long-term homelessness.

  The State cannot pay for this effort on its own. We need partners in Washington. There are members of our Congressional delegation who are currently opposed to increased funding for housing, and who support cuts in this area.

- Property tax reclassification is essential. With the demise of the 4-D classification for rental properties, these supportive housing developments would have to pay property taxes out of their operating funds rather than concentrate on the provision of supportive services.

We appreciate the opportunity to provide comments on the business plan. If you wish to discuss these comments further, please do not hesitate to contact us. Thank you for the tremendous amount of effort you have put into raising this important question. We look forward to moving forward in the effort to eliminate homelessness in Minnesota.

Sincerely,

Kathleen Tomlin, Director
Office for Social Justice

Matt Gladue, Public Policy Manager
Office for Social Justice

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Comments on "The Plan to End Long Term Homelessness in Minnesota"

Submitted by: Sue Watlov Phillips, President National Coalition For The Homeless

I want to thank the Governor, State Agency Staff, the Working Group, Stakeholders, People experiencing homelessness, and others who spent thousands of hours over the last several months in developing this draft plan to end long term homelessness.

I also appreciate the use of the phrase long term homelessness instead of chronic homelessness to describe this population. The definition includes youth, individuals, and families and does not require a disability status, this a significant improvement over the narrow definition used by the Federal Government.

The mission of the National Coalition For The Homeless is to end homelessness in the United States. We believe we must deal with the immediate needs of people at risk or experiencing homelessness while addressing the systemic causes of homelessness.

The principles articulated in the draft plan are vital to accomplishing the goals of this plan.

1. Increased and concerted efforts of local, state, and federal government.
2. Maximization and increased access to use of mainstream programs and services.
3. Preventing long term homelessness.
4. Doing no harm to the rest of the housing/homeless continuum.

The following are my comments on the plan:

Increased and concerted efforts of local, state, and federal government.

I appreciate the recognition that additional resources will be necessary to accomplish this goal.

State: Capital appropriations of $20 Million in 2004, $25 Million in 2006, $30 million in 2008. Housing Trust Fund appropriations of $2 Million each year in 2005, 2007, 2009. To prioritize tax credits for housing for this population.

Concerns and suggestions:

1. It is imperative that the present priority to use tax credits to preserve Federally subsidized housing is continued. This is a key component to preventing long term homelessness.

2.While the plan calls for DHS to develop a $10 million flexible fund and maximize and increase access to use of mainstream programs and services, there is no provision for additional resources to do so. On the contrary, the draft plan indicates that fully utilized

funds may be re-directed from transitional housing, group residential housing, and Medicaid programs under Federal waivers. This violates principle 4 to do no harm to the rest of the housing/homeless continuum.

3. The plan does not address the cuts in funding last year, which are some of the causes of long term homelessness. The following need to be addressed in the plan.
a. Restoration of $1 Billion in cuts to DHS
b. Restoration of cuts to emergency shelters and transitional housing
c. MFIP: time limits, elimination of the $50 housing penalty and the $125 penalty for people on SSI
d. Elimination of co-payments for medications and medical care.
e. Restoration of cuts to MHFA and increase funding for permanent housing.
f. Require counties to utilize Emergency Assistance to prevent homelessness and to provide shelter.
g. Restoration of cuts to Crime Victim Services.
h. Restoration of cuts made to the Community Services Block Grant and require that communities utilize funds to assist homeless youth.

4. The report fails to identify more equitable use of our housing tax resources and use our successful tax policies to increase funding targeted for people experiencing homelessness.

Federal: The success of the plan is very dependent upon Federal resources being available.

Concerns and suggestions:

1. The report fails to recognize the present Administration's plan to cut 250,000 existing Section 8 vouchers.

2. The report should endorse the Bringing America Home Act, it would provide significant increases in Federal resources to end homelessness for everyone- Housing, Health Care, Income, and the protection of people's Civil Rights. (More information available at bringingamericahome.org)

3. The report should endorse increases to Rural and Indian Housing. The Administration is proposing cuts to these programs.

4. The report should endorse an increase to the Section 811 program with a 30% set aside for long term homelessness.

5. The report should endorse the National Housing Trust Fund and increase resources in HHS in both targeted programs for people experiencing homelessness and increasing Block grants and giving a priority to people experiencing homelessness.

Maximization and increased access to use of mainstream programs and services

Overall, the plan has identified some excellent resources that could be utilized.

Concerns and suggestions:
Additional resources should be made available and services are not reduced for other populations.

Preventing long term homelessness.

Concerns and suggestions:

The plan appears to have no plan to prevent long term homelessness.

The plan needs to be coordinated with the work of the existing housing/homeless continuum to prevent long term homelessness.

Doing no harm to the rest of the housing/homeless continuum.

Concerns and Suggestions:

1.While the plan calls for DHS to develop a $10 million flexible fund and maximize and increase access to use of mainstream programs and services, there is no provision for additional resources to do so. On the contrary, the draft plan indicates that fully utilized funds may be re-directed from transitional housing, group residential housing, and Medicaid programs under Federal waivers. This violates this principle to do no harm to the rest of the housing/homeless continuum.

2. The plan does not address the cuts in funding last year, which are some of the causes of long term homelessness. The following need to be addressed in the plan.

a. Restoration of $1 Billion in cuts to DHS
b. Restoration of cuts to emergency shelters and transitional housing
c. MFIP: time limits, elimination of the $50 housing penalty and the $125 penalty for people on SSI
d. Elimination of co-payments for medications and medical care.
e. Restoration of cuts to MHFA and increase funding for permanent housing.
f. Require counties to utilize Emergency Assistance to prevent homelessness and to provide shelter.
g. Restoration of cuts to Crime Victim Services.
h. Restoration of cuts made to the Community Services Block Grant and to require that communities utilize funds to assist homeless youth.

3. Adequate and increased funding for the rest of the continuum is critical to the success of this plan.

I again want to thank everyone for their time and energy in putting this plan together. I believe it is a good first step.

I recommend that an implementation committee be developed to address the comments, concerns and suggestions and to continue to refine the plan so it can be successful.

Sincerely,

Sue Watlov Phillips
President, National Coalition For The Homeless
Executive Director, Elim Transitional Housing

Minnesota Assoc. of Runaway Youth Services

Committee on Public Policy and Advocacy

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phone (612) 252-2735 fax (612) 252-2736 * richard.wayman@freeportwest.org
Pursuing public policy reform to increase opportunities and resources for homeless and runaway youth.

March 4, 2004

Commissioner Tim Marx
Minnesota Housing Finance Agency
400 Sibley St, Suite 300
St. Paul, MN 55101

Commissioner Kevin Goodno
Minnesota Department of Human Services
444 Lafayette Avenue
St. Paul, MN 55101

Commissioner Joan Fabian
Minnesota Department of Corrections
1450 Energy Park Drive
St Paul, MN 55108

Dear Commissioner Marx, Commissioner Goodno, and Commissioner Fabian:

I write on behalf of a state-wide coalition of agencies serving homeless and runaway youth to provide comments to the Report on Ending Long-Term Homelessness in Minnesota. I appreciate the opportunity to review the draft report and to make comments to the Working Group. I have attended most of the Working Group's meetings and appreciate the effort and planning that went into the Report's production.

The Governor should be honored for his commitment to end long-term homelessness. Providing a vision for community members is a hallmark of leadership. The Report is an excellent first step in quantifying the number of units needed to end homelessness in Minnesota and articulating the level of resources required to build or establish those units. Identifying the need and providing solutions offers a foundation from which to garner additional community support.

Furthermore, the Plan's endorsement of the following principles should be bolstered in any policy decisions made by the Governor or Legislature:

- Increased and concerted efforts of local, state, and federal government;
- Maximization and increased access to use of mainstream programs and services;
- Preventing long-term homelessness; and
- Doing no harm to the rest of the housing/homelessness continuum.

However, the Report fails to address the needs of unaccompanied homeless youth, and nationally recognized policies and best practices that may prevent or end homelessness for this population. Minnesota agencies providing outreach, intervention, shelter, housing, and life skills to homeless youth have a national reputation as leaders in the field of at-risk youth work. I offer the following

observations in the hope that they may result in recognition of homeless youth in this population and modifications to the Report before it is sent to the Legislature:

- Recognition of Unaccompanied Homeless Youth: The Report should specifically recognize in Section 4 (page 3) that unaccompanied homeless youth experience long periods of homelessness or sequential episodes of homelessness in a given year. Sixteen percent (16%) of minors in the Wilder Survey of October 2003 were homeless for more than a year, which is approximately 1,600 youth. However, the Wilder Survey does not capture information on the repeating occurrence of homelessness that a youth may encounter each year. Youth, like adults, may cycle in and out of homelessness each year. Sufficient data does not exist on the number of youth experiencing this type of long-term homelessness.

- Recognition of Systemic Barriers: The Report, while quantifying the number and individual characteristics of persons experiencing long-term homelessness, fails to discuss the complexity of the social conditions which lead an individual or family into homelessness. Contrary to some stereotypes, many homeless individuals and families do not choose to be homeless, and experience systemic barriers (lack of affordable housing, lack of jobs paying living wages, and racism) to achieving housing stability in their lives. Section 4 should be amended to talk about this population in the context of the systemic or societal barriers that exist in ending homelessness.

- Key Strategies for Ending Youth Homelessness: Youth providers don't agree with the Report's findings in Section 5 (page 4) that a "key strategy to address long-term homelessness is a 'housing first' strategy which places a priority on providing persons experiencing homelessness a permanent place to live." This implies that our first priority is an apartment with supportive services. However, independent, supportive housing may not be the key strategy to address unaccompanied homeless youth. Particularly, youth-serving agencies center attention on building trusting relationships with youth, family reunification, independent living skills, and provision for basic needs before looking for transitional or permanent housing. If the Report fails to recognize this key point, the recommendations will do little to further support of homeless youth.

- After-care Planning and Services for Youth Leaving County Child Protection or Juvenile Delinquency Placements: I find it odd that the Report is silent on "after-care planning" or "transitional services" to youth exiting out-of-home placements. According to the Wilder Research Center's survey of unaccompanied homeless youth in October of 2003, 51% of all homeless youth reported having had a history in foster care. Additionally, 34% of all homeless youth reported having a history with out-of-home placements with the Department of Corrections. We know that one of the simplest ways to prevent long-term homelessness in at-risk youth is to provide proper transitional services and after-care services for youth exiting out-of-home placement. It is puzzling that such a recognizable solution is not presented in the Report. It seems that both the Department of Human Services and the Department of Corrections would wish to provide better outcomes for the children they service through foster care, child protection, chemical health treatment, mental health treatment or juvenile delinquency rehabilitation than homelessness and shelter placements.

- Early Prevention and Intervention: Likewise, it is troubling that "preventative, intervention services" are not listed as a potential practice or policy change in order to end long-term homelessness for youth. Most youth-serving agencies in Minnesota report great difficulty in accessing child protection and foster care alternative placements for teenagers experiencing abuse and neglect. The "child welfare" system in Minnesota does not provide a lot of options for older adolescents, and counties complain that they lack state and federal funding to adequately intervene in the lives of abused or neglected

teenagers. The Report should note that early intervention and prevention services (like family group conferencing, alternative response services, family conflict mediation and counseling, and mental health counseling) may prevent many teenagers from ending up in shelters or on the streets.

- Barriers for Youth to Mainstream Services: Often youth are not eligible for "mainstream services." Few public assistance programs provide for unaccompanied youth. In particular minors can get GA and MA. Food stamps are only available for three months. However, once youth turn 18 years most become ineligible for GA. Additionally, few youth qualify for disability income (SSI) because of lack of diagnosis or lack of severity in disability status. There is not a golden pot of money that youth can obtain to better support themselves in apartments. Additionally, many Section 8 programs and public housing options are not available to unaccompanied homeless youth under the age of 18. Therefore, the Report may overstate an emphasis on "mainstream resources" as a way to end long-term homelessness for youth.

- Permanent and Transitional Supportive Housing: The report needs to recognize the variety of youth-housing models. Community groups and agencies should be able to successfully apply for funding when proposing either scattered site, transitional, site-based transitional, foyer models, and permanent, supportive units. The Report is not clear on whether "supportive housing" includes Permanent and Transitional Housing models. Youth providers offer an array of housing options including permanent supportive housing and transitional supportive housing.

- Lack of Identified Supportive Service Funding: Youth housing providers find few alternative funding streams to support operation or supportive service costs. The Report needs to be realistic about the "elephant in the room" – the lack of specificity around supportive service funding to make the proposed units successful homes for persons (youth) experiencing homelessness. There continues to be work needed by the Governor, Legislature, and Communities to identify financial resources to support outreach, intervention, and case management services.

Often, if youth programs are not specifically mentioned, the recommendations and outcomes become centered on single adults and families only. We hope the Report will be modified to acknowledge this group and include the recommendations offered.

Finally, the Minnesota Association of Runaway Youth Services is supportive of a continued Implementation Advisory Group to the state departments. Implementation of the business plan requires continued dialogue, planning, and coordination. The creation of a Long-term Homeless Director position is necessary to bring focus to future work, policy and practice modifications, and capacity planning.

I appreciate your advocacy and belief that we can end homelessness in Minnesota! Please keep up your strong leadership and feel free to call me at (612) 252-2735 (work) or (612) 730-7574 (cell) if you have any questions regarding these comments. I hope that my comments will be accepted as formal comments to be submitted along with report.

Sincerely,

Richard A. Wayman

Richard Wayman, J.D.
Chair, Committee on Public Policy and Advocacy

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