



THE KNOXVILLE AND KNOX COUNTY TEN-YEAR PLAN TO END CHRONIC HOMELESSNESS

OCTOBER 2005

PREPARED BY

THE TEN-YEAR PLAN TO END CHRONIC
HOMELESSNESS TASK FORCE

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***The Ten-Year Plan
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Ten-Year Plan to End Chronic Homelessness

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Mayor Mike Ragsdale

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The participation in work groups was invaluable. Executives and staff from mental health centers, psychiatric facilities, social services, law enforcement, and homeless services made significant contributions. Neighborhood associations, libraries, transportation organizations, and businesses were represented and contributed to a comprehensive perspective on chronic homelessness. While it is risky to list names—realizing that some will be omitted—Appendix D illustrates the extent of participation using sign-in rosters from different workgroups.

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A listing of many others who assisted with this project can be found in Appendix D.

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Executive Summary

Introduction

Homelessness is an issue of national importance—an issue with economic, social, philosophical, and spiritual implications. Homelessness is a concern that unpleasantly reminds us that, in the wealthiest nation in the history of the world, many peoples’ most basic needs are not being met. While most Americans are able to return home each night to a place protected from the elements, there are a significant number of people in our country who have no such place.

Homelessness is also a question of significant local impact. While many homeless individuals and families go largely unseen by the general population, there are others who are very visible, sleeping on streets and suffering from sickness and mental illness. They often make us uncomfortable with our seeming inability to solve this problem. Nationally, the issue is abstract: statistics and sound bytes on the nightly news. Locally, the issue is real, embodied in people we see and meet every day.

On a nationwide level, the Federal Interagency Council on Homelessness (ICH) has brought together federal agencies and other resources to coordinate the national effort to combat homelessness. The ICH has issued a challenge to communities across the country to do something different—to address the problem of homelessness at its core: the chronically homeless. Knoxville and Knox County responded to this challenge by developing a plan to end chronic homelessness. This plan recognizes the need to do things differently, and to coordinate local,



state, and federal resources to address the most difficult part of homelessness in a way that is both more cost effective and that yields a more successful humanitarian result.

On any given night in Knoxville and Knox County, approximately 900 people sleep in emergency shelters, on the street, in cars, in transitional housing, or doubled up with friends. The homeless population is not a static one and over the course of one month approximately 1,900 different individuals in Knoxville and Knox County will experience homelessness. Projecting these numbers over the course of a year suggests that as many as 8,000 to 9,000 different individuals may experience homelessness at some time.

Homelessness was not recognized as a profound social problem until the 1980's. During that period several economic and social changes con-

verged. These included a decrease in the availability of affordable housing, a lack of growth in real earnings, the closing of institutions that had served the mentally ill and substance abusers, and an increased number of discharges from correctional institutions. These factors joined to create a dramatic increase in the number of individuals facing homelessness. Since then, homelessness has become a critical problem that demands community attention. Despite available services that provide emergency care, the number of persons experiencing homelessness has steadily increased. Knoxville and Knox County have witnessed an increase from 800 homeless persons during any given month in 1986, to approximately 1,900 homeless persons per month in 2004. Many of these individuals have multiple problems—chronic mental illness, substance abuse, and domestic violence. Many lack the skills and resources for self-sufficiency.

A small segment of this population is chronically homeless—people who have been homeless for over one year. While the chronic homeless represent only 10% of the homeless population, they consume over 50% of the resources including emergency medical services, psychiatric treatment, detox facilities, shelters, law enforcement, and correctional facilities. Given the complexity and magnitude of this problem it is essential that Knoxville and Knox County seek new ways of preventing and ending chronic homelessness.

The Ten-Year Plan

The East Tennessee Coalition for the Homeless in conjunction with Knoxville Mayor Bill Haslam and Knox County Mayor Mike Ragsdale identified the need to examine homelessness in the area and to establish a plan to

address the needs of the homeless population. The Mayors selected a group of civic and community leaders to serve on a task force to develop a ten-year plan to end chronic homelessness in Knoxville and Knox County. The task force was charged to:

1. Review the extent of chronic homelessness and existing services in Knoxville and Knox County.
2. Solicit input that represents stakeholders and the larger community,
3. Define the problems that need to be addressed to reduce and prevent chronic homelessness,
4. Review “best practices” in other communities,
5. Identify current and needed efforts, strategies, and models that will effectively address homelessness in Knoxville and Knox County,
6. Develop a ten-year plan to end chronic homelessness with action steps and timelines.

The ten-year plan to end chronic homelessness in Knoxville and Knox County is part of a national movement to end long-term or chronic homelessness. The plan offers a long-range comprehensive approach to help homeless persons gain stability in permanent housing. The emphasis on chronic homelessness reflects a new initiative on the national level. Under the leadership of the Interagency Council on Homelessness and its Executive Director, Philip F. Mangano, localities across the country have developed plans to end chronic homelessness. By adapting the national model and practices to local needs the number of individuals who are in danger of becoming chronically homeless should decrease. The Knoxville and Knox County ten-year plan will support state, regional, and federal efforts. Implementing the actions recommended in this plan will cost money, but that cost is consider-

ably lower than the cost of addressing homelessness through public emergency systems. Likewise, doing nothing will incur a far greater cost in the loss of human potential. While the ten-year plan focuses on chronic homelessness, it will also reduce the incidence and length of homelessness among youth, families, and individuals who are homeless or are at risk of becoming homeless.



Why Focus on Chronic Homelessness?

The ten-year plan focuses on chronically homeless people—those who have been homeless more than one year, or have experienced mul-

multiple episodes of homelessness and have a disability. While they represent 10 to 15% of the homeless population, they are the most visible and often suffer from long-term unemployment, untreated mental illness, and substance abuse. When a small segment of a population places exceedingly high stress on the service systems, it negatively impacts the ability of those systems to serve others who face incidental homelessness or who are simply at risk of homelessness.

Who is Chronically Homeless?

As defined by the United States Department of Housing and Urban Development, a chronically homeless person is an unaccompanied individual with a disabling condition who has been living in a place not meant for human habitation of in an emergency shelter for at least one year or who has had at least four episode of homelessness in the last three years.

Ownership

While recognizing homelessness as a community-wide problem, the Task Force determined at the outset that ownership of this plan would be key to its success. Specifically, lines of authority and accountability should be very clearly defined in order to see to it that this plan would be fully implemented.

After reviewing a number of options, the Task Force determined that this plan must be implemented through what it calls The Mayoral Model. A director should be appointed, with this individual serving in a position directly accountable to one or both Mayors. An advisory board representing key interests throughout the community would be appointed to advise and assist the director in implementing this plan. Board members would be composed of representatives from city and county governments, emergency

shelters, social service providers, the East Tennessee Coalition for the Homeless, medical and mental health services, law enforcement, the business community, neighborhoods, and faith-based organizations.

The Ten-Year Plan: Strategies

In appointing the committee to develop a ten-year plan to end chronic homelessness, Mayor Bill Haslam stated, “It starts with saying that we’re not going to keep doing it like we’ve done it before.” Ending chronic homelessness requires participation by all stakeholders: local government, public and private social service providers, mental health and correctional facilities, and representatives from a cross section of the community. The plan, while challenging the community to be more proactive in addressing chronic homelessness, also promotes higher levels of accountability and responsibility among the homeless. The following are strategies that offer a different approach to the problem of chronic homelessness.

1. Move People into Housing First

The most critical issue facing homeless people—the lack of permanent housing—must be the first and most important issue to be addressed. The concept of housing first is considered both a philosophy and structure for the ten-year plan. The concept itself is straightforward: if a chronically homeless person is able to quickly obtain stable, appropriate, permanent housing, then the issues of mental illness, chemical addictions, education and employment become eminently more manageable. The housing first approach combines affordable, permanent housing with the support services necessary to increase self sufficiency to remain in permanent housing.

2. Stop Discharging to the Streets

Institutions such as mental health hospitals and jails usually lack referral services with access to permanent supportive housing. The result is that far too many individuals are discharged directly to emergency shelters or the streets. Studies on homelessness in Knoxville have found that between 30% and 50% of the homeless individuals surveyed said that they have been discharged from a hospital directly into homelessness. Similarly other studies have found that among all persons discharged from state psychiatric institutions, over 30% will be homeless within six months. This pattern is also evidenced in the foster care system as young people are discharged at age 18 and experience a high risk of becoming homeless.

3. Increase Coordination and Effectiveness of Service

Homelessness is an extremely complex problem. While there are no simple solutions, the nature of homelessness underscores the need for different agencies and sectors of the community to work together in seeking solutions. The existing service delivery system has been criticized as being ineffective, fragmented, and too frequently duplicating services. The task force reviewed the current system through meetings with providers, agency executives, and homeless persons. This examination resulted in a conclusion that service coordination and effectiveness of services can be increased. Specific areas of attention include 1) coordinated case management, 2) outreach and engagement 3) single point of entry into the service system, and 4) designated agency function—coordination and specialization of the major shelters and services.

4. Increase Economic Opportunities

Lack of employment, income, and economic opportunity are often identified as major causes

of homelessness. Although many homeless individuals report being employed or having occasional work, many of the jobs they hold are of such a nature and skill level that they do not provide adequate wages and benefits for self-sufficiency. As part of the effort to solve chronic homelessness, it is crucial to maximize income and achieve economic stability.

5. Implement New Data Collection Methods

Through the implementation of a Homeless Management Information System (HMIS), more reliable, comprehensive information about homelessness in our community can be found. With better information regarding the problem as well as the effectiveness of implemented solutions, this plan will have a much better chance of achieving successful results. The HMIS is a centralized internet-based system that provides a database of homeless information. Shelters, housing providers, service agencies, and others who work with the homeless can share client information, within the strictest bounds of individual privacy and confidentiality. The HMIS offers a number of benefits for addressing chronic homelessness. It provides for the collection of accurate and timely data on numbers of homeless persons in the community, patterns of homelessness, and other demographic characteristics. The system will provide a resource for better coordination of case management. Additionally, HMIS will provide information on effective service delivery, as well as provide data to guide agency and community planning for improved and targeted services delivery.

6. Develop Permanent Solutions

The current service system for homelessness has an emergency orientation. Services respond on an emergency or crisis basis rather than being directed at permanent solutions. Few homeless people are placed and supported in long-term housing. Many are using the emergency shelters

as long-term housing. These shelters, designed to provide temporary housing, have been overwhelmed by persons who are chronically homeless. Currently Knoxville addresses public intoxication among the chronically homeless population mainly through law enforcement. These and other issues represent a shortsighted, costly approach to dealing with the chronically homeless. The task force has identified a number of key elements, along with housing first, that will more permanently and cost-effectively address chronic homelessness. These include the establishment of a detoxification facility, broad implementation of the HMIS system to include all areas of housing and service that affect the homeless, and establishment of an assertive outreach team to go out to the homeless where they are with services and case management designed to bring them into the system that will ultimately result in them being housed.

7. Strengthen Partnerships with Faith-Based Organizations

Faith-based organizations have played a central role in providing help and support for the homeless as far back as history has been recorded. The calling to serve the least among us is the core reason many people strive to end homelessness, whether that calling is based on reading of scripture or on other systems of values. This plan recognizes the importance of partnerships with faith-based organizations, and the Task Force considers these organizations to be one of the critical components in the plan to develop permanent solutions to homelessness. Central to all the recommendations is coordination throughout the community to focus efforts efficiently and effectively, to avoid working at cross purposes, and to provide each homeless individual with the clear message that help is available and that this community will work as one to improve that individual's situation.

8. Recognize Homelessness as a Community Challenge

Ending chronic homelessness is a challenge for the entire community. While there are no simple solutions, ending homelessness will require cooperative effort by government agencies, private and public services, businesses, faith-based organizations, and neighborhoods. This plan calls for a coordinated effort to inform and communicate with the broader community about homelessness. Through a better understanding of the issues and of the opportunities to contribute to substantive change, the entire community can be brought to bear on the solutions in this plan.

9. Prevent Homelessness

The Federal Interagency Council on Homelessness speaks of prevention as “closing the front door” to homelessness. Homelessness prevention is any action that prevents an individual or family from losing their housing. Prevention of homelessness is almost always less costly in financial and human terms than finding and establishing housing for someone after they have become homeless. Providing services and assistance that contribute to housing stability, such as assistance with rent or utility bills, can be preventative. Additionally, case management and preventive protocols for individuals being discharged from hospitals, state institutions,



and foster care should be implemented to break the cycle of homelessness before it starts. Regardless of the level of prevention—identifying persons at risk, early intervention, or breaking the cycle of chronic homelessness—it is critical to utilize strategies that have been demonstrated to be effective.

Conclusion

Homelessness is a major challenge for Knoxville and Knox County. While there are no simple solutions, the complexity of homelessness underscores the need for all sectors—social and health services, government, business providers and consumers, neighborhoods, and churches—to work together toward solutions. The city and county mayors' appointment of a task force to develop a Ten-Year Plan to End Chronic Homelessness is an important step in system transformation and development. Likewise, the development of the HMIS is a promising resource.

Chronic homelessness points to the shortage of affordable supportive housing, as well as the occurrence of mental illness, substance abuse, and the lack of employment and other skills necessary for self-sufficiency. The Ten-Year Plan to End Chronic Homelessness recognizes the need for a comprehensive, coordinated, and continuous effort. Without an ongoing commitment at the federal, state, and local levels to solving the problems, there will be little success.

This plan offers a framework for ending the institution of homelessness. By increasing the availability of permanent housing, providing coordinated case management, and linking homeless persons to community resources, Knoxville

and Knox County can reduce chronic homelessness and perhaps more importantly, prevent others from becoming chronically homeless.

The Ten-Year Plan to End Chronic Homelessness is the beginning of a long-term process. It recognizes the need for adjustments and changes, as well as new innovations to support the community effort to end chronic homelessness. Already during the time that this plan was being developed and written, major events took place that will inevitably affect homelessness in this community. The state of Tennessee made significant cuts and changes to TennCare. While the intent of those changes was certainly not to cause or exacerbate homelessness, unintended consequences will undoubtedly have negative effects on those at risk of becoming homeless. About a month before this plan was released, Hurricane Katrina ravaged New Orleans and the Gulf Coast, rendering hundreds of thousands of people homeless, displacing them to communities across the country, including Knoxville. While significantly adding to the problem of homelessness, the devastation also served to raise public awareness about the plight of the homeless. It is intended that this plan be a living document, that changes be made to it in response to the success or failure of individual strategies and in response to events that will change the dynamics in yet unforeseen ways.

The process that developed this plan—individuals and organizations identifying problems, pointing out barriers, and suggesting solutions—represents an important move toward coordination and systematic change. By continuing to work together and implementing a plan, the community can end chronic homelessness and reduce all homelessness within ten years.

Ten-Year Plan

Introduction

Homelessness is an issue of national importance—an issue with economic, social, philosophical, and spiritual implications. Homelessness is a concern that unpleasantly reminds us that, in the wealthiest nation in the history of the world, many peoples’ most basic needs are not being met. While most Americans are able to return home each night to a place protected from the elements, there are a significant number of people in our country who have no such place.

Homelessness is also a question of significant local impact. While many homeless individuals and families go largely unseen by the general population, there are others who are very visible, sleeping on streets and suffering from sickness and mental illness. They often make us uncomfortable with our seeming inability to solve this problem. Nationally, the issue is abstract: statistics and sound bytes on the nightly news. Locally, the issue is real, embodied in people we see and meet every day.

On a nationwide level, the Federal Interagency Council on Homelessness (ICH) has brought together federal agencies and other resources to coordinate the national effort to combat homelessness. The ICH has issued a challenge to communities across the country to do something different—to address the problem of homelessness at its core: the chronically homeless. Knoxville and Knox County responded to this challenge by developing a plan to end chronic homelessness. This plan recognizes the need to do things differently, and to coordinate local,

state, and federal resources to address the most difficult part of homelessness in a way that is both more cost effective and that yields a more successful humanitarian result. In the Knoxville and Knox County area as many as 9,000 different individuals may experience homelessness during one year.

On any given night in Knoxville and Knox County, approximately 900 people sleep in emergency shelters, on the street, in cars, in transitional housing, or doubled up with friends. The homeless population is not a static one and over the course of one month approximately 1,900 different individuals in Knoxville and Knox County will experience homelessness.¹ Projecting these numbers over the course of a year suggests that as many as 8,000 to 9,000 different individuals may experience homelessness at some time.

On any given night in the Knoxville and Knox County area, approximately 900 people sleep in emergency shelters, on the street, in cars, in transitional housing, or doubled up with friends. As many as 9,000 different individuals may experience homelessness during one year.

Homelessness was not recognized as a profound social problem until the 1980's. During that period several economic and social changes converged. These included a decrease in the availability of affordable housing, a lack of growth in real earnings, the closing of institutions that had served the mentally ill and substance abusers, and an increased number of discharges from correctional institutions. These factors joined to create a dramatic increase in the number of individuals facing homelessness. Since then, homelessness has become a critical problem that demands community attention. Despite available services that provide emergency care, the number of persons experiencing homelessness has steadily increased. Knoxville and Knox County have witnessed an increase from 800 homeless persons during any given month in 1986, to approximately 1,900 homeless persons per month in 2004. While the homeless population has doubled, the general population for the area has experienced a smaller increase of approximately 20%.² Many of these individuals have multiple problems—chronic mental illness, substance abuse, and domestic violence. Many lack the skills and resources for self-sufficiency. A small segment of this population is chronically homeless—people who have been homeless for over one year.³ While the chronic homeless represent only 10% of the homeless population, they consume over 50% of the resources including emergency medical services, psychiatric treatment, detox facilities, shelters, law enforcement, and correctional facilities.⁴ Given the complexity and magnitude of this problem it is essential that Knoxville and Knox County

¹ Knoxville Coalition for the Homeless.

² According to the U.S. Census Bureau, the Knoxville, Tennessee metropolitan statistical area (MSA) grew from 546,488 in 1980 to 585,960 in 1990 and to 687,249 in 2000. Current projections suggest an MSA of approximately 700,000. The 2000 census listed the poverty rate as 12.6% for Knox County.

³ The United States Department of Housing and Urban Development (HUD) defines chronic homelessness as the state of being an unaccompanied individual with a disabling condition who has been living in a place not meant for human habitation or in an emergency shelter for at least one year or had at least four episodes of homelessness in the past 3 years.

⁴ Ibid.

seek new ways of preventing and ending chronic homelessness.

The Ten-Year Plan

The East Tennessee Coalition for the Homeless⁵ in conjunction with Knoxville Mayor Bill Haslam and Knox County Mayor Mike Ragsdale identified the need to examine homelessness in the area and to establish a plan to address the needs of the homeless population. The Mayors selected a group of civic and community leaders to serve on a task force to develop a ten-year plan to end chronic homelessness in Knoxville and Knox County. The task force was charged to:

1. Review the extent of chronic homelessness and existing services in Knoxville and Knox County;
2. Solicit input that represents stakeholders and the larger community;
3. Define the problems that need to be addressed to reduce and prevent chronic homelessness;
4. Review “best practices” in other communities;
5. Identify current and needed efforts, strategies, and models that will effectively address homelessness in Knoxville and Knox County;
6. Develop a ten-year plan to end chronic homelessness with action steps and timelines.

The ten-year plan to end chronic homeless-

ness in Knoxville and Knox County is part of a national movement to end long-term or chronic homelessness. The plan offers a long-range comprehensive approach to help homeless persons gain stability in permanent housing. The emphasis on chronic homelessness reflects a new initiative on the national level. Under the leadership of the ICH and its Executive Director, Philip F. Mangano, localities across the country have developed plans to end chronic

In 2005, Mayors Bill Haslam and Mike Ragsdale convened a task force to develop a ten-year plan to end chronic homelessness.

homelessness. By adapting the national model and practices to local needs, the number of individuals who are in danger of becoming chronically homeless should decrease. The Knoxville and Knox County ten-year plan will support state, regional, and federal efforts. Implementing the actions recommended in this plan will cost money, but that cost is considerably lower than the cost of addressing homelessness through public emergency systems. Likewise, doing nothing will incur a far greater cost in the loss of human potential. While the ten-year plan focuses on chronic homelessness, it will also reduce the incidence and length of homelessness



⁵ Previously called the Knoxville Coalition for the Homeless.

among youth, families, and individuals who are homeless or are at risk of becoming homeless.

Why Focus on Chronic Homelessness?

The ten-year plan focuses on chronically homeless people—those who have been homeless more than one year, or have experienced multiple episodes of homelessness and have a disability. While they represent 10 to 15 % of the homeless population, they are the most visible and often suffer from long-term unemployment, untreated mental illness, and substance abuse. When a small segment of a population places exceedingly high stress on the service systems, it negatively impacts the ability of those systems to serve others who face incidental homelessness or who are simply at risk of homelessness.

Homelessness places enormous stress on services, impacting the ability of providers to serve others who are homeless or at risk.

A major study conducted by the University of Pennsylvania found that a mentally ill homeless person utilizes over \$40,000 in publicly funded services annually. In comparison, the average cost of supportive services to enable mentally ill persons to maintain housing is slightly over \$16,000. According to this study, reductions in incarceration, hospitalization, and shelter use would effectively pay for 95% of the cost of

housing.⁶

There is increasing evidence to suggest that housing the homeless is cost-saving.

Various housing models use service teams to maintain people in housing by providing them with appropriate support services. For example, in a study of 204 people from San Francisco, served by such teams, it was found that emergency room use decreased 56%, with concordant cost reduction, inpatient hospitalization decreased similarly, and use of inpatient mental health facilities was practically eliminated.⁷ In addition, the study found:

- a 37% reduction in hospital inpatient days;
- a virtual elimination of residential mental health care outside of a hospital;
- an 89% decline in residential alcohol and drug treatment; and
- a 44% reduction in days sentenced to incarceration.

In addition to the financial cost, homelessness leads to a tremendous cost to humanity.

Homelessness is disruptive and has devastating and lasting repercussions on individuals and families. Homelessness often impacts the victim's health, causes additional barriers to employment and educational achievement, and fragments families. It is a particularly high risk factor for children as evidenced by elevated rates of emotional and behavioral problems during childhood as well as during the adult years.⁸

⁶ Culhane, D.P., Metraux, S., & Hadley, T. (2001). *The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals*. New York: Corporation for Supportive Housing.

⁷ Proscio, Tony. (2000). *Supportive housing and its impact on the public health crisis of homelessness*. New York: Corporation for Supportive Housing.

⁸ Better Homes Fund (1999). *Homeless children: America's new outcasts*. Newton Centre, MA: Better Homes Fund.

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***Knoxville and Knox County
can make progress toward
reducing and preventing
chronic homelessness.***

The positive side of the homelessness story is that something can be done. Knox County Mayor Mike Ragsdale recently stated, “One challenge our community faces as we move forward is both confronting and finding a solution to end chronic homelessness. We must continue to raise awareness that these individuals are in need of our help, and we owe it to them, ourselves, and our community to assist in mending their hurt. The Ten-Year Plan to End Chronic Homelessness is a progressive step in this direction.” The experience of other communities, research, and new technologies indicate that Knoxville and Knox County can make substantial progress toward reducing and preventing chronic homelessness. Ending chronic homelessness in the region will not only provide humanitarian benefits, but will also have a positive economic impact. Addressing this segment of the population will free up resources and reduce the demand for emergency rooms, jails, police, mental health facilities, and social services.

The Nature of Chronic Homelessness

The United States Department of Housing and Urban Development (HUD) defines a chronically homeless person as an unaccompanied individual with a disabling condition who has been living in a place not meant for human habitation or in an emergency shelter for at least one year or who has had at least four episodes of homelessness in the past 3 years.⁹

The East Tennessee Coalition for the Homeless has sponsored research on homelessness in the region during the past 20 years.¹⁰ These studies offer some insights into the characteristics and problems of chronic homelessness. The most recent research was conducted in February 2004. It included a review of the shelter census to extract an unduplicated count of individuals who stayed in emergency shelter facilities during the period of a month. It also included results from interviews with a sample of 227 individuals in shelters and outside locations conducted during evening/early morning periods. The individuals responded to a 149-item questionnaire that asked about demographics, origins, reasons for homelessness, length of homelessness, family, mental health, substance abuse, foster care, incarceration, employment, housing history, and service needs. Among the 227 subjects, 88 had been homeless for more than one year. Analysis of these data offers an interesting comparison of the chronic homeless (more than one year) and acute homeless (one year or less) experience. (See Table 1.)

“We must continue to raise awareness that these individuals are in need of our help, and we owe it to them, ourselves, and our community to assist in mending their hurt.”
—Mayor Mike Ragsdale

⁹ A disabling condition is defined as one or more of the following: a diagnosable substance dependency, mental illness, developmental disability, or chronic physical illness or disability.

¹⁰ Homelessness in Knoxville/Knox County 2004.

Table 1: Characteristics of Knox County Homeless 2004

Item	Acute Percent (n=139)	Chronic Percent (n=88)	Overall Percent* (n=227)
Age:			
Under 18 years	10	--	6
18–30 years	28	13	22
31–60 years	63	85	71
over 60 years	--	2	1
			Mean: male = 42.1 female = 36.3
Gender:			
Male	78	71	75
Female	22	30	25
Race:			
White	78	64	72
Black	17	29	21
Other	5	7	7
Military Service:			
Veteran	21	21	21
Marital Status:			
Single/never married	37	34	36
Married	8	10	9
Divorced/separated	47	55	50
Widowed	7	1	5
Education:			
8 years or less	6	7	6
Some high school	28	25	27
High School graduate including GED	45	43	44
Post high school	21	25	22
*Due to rounding error, all totals may not equal 100.			

Table 1 suggests that the chronically homeless individual is more likely to be above the age of 30 and a person of color in comparison to those experiencing an acute homeless episode of one year or less. The extent of homelessness for the chronic group ranged from slightly over one year to thirty years. The Knoxville studies have identified a number of interacting factors that contribute to homelessness:

1. lack of affordable housing,
2. mental illness (this has been exacerbated by the trend in communities toward

deinstitutionalization),

3. lack of employment skills along with changes in the labor market and economy,
4. substance abuse,
5. lack of education, and
6. personal crises (e.g., abuse, deviance, death).

Table 2 provides a comparison of the responses from those individuals identified as acute or chronically homeless.



ployed as the causes for the homeless episode. This illustrates the complexity of factors leading to each situation. Interestingly, 32% stated that they had a job, while 35% reported a need for job training.

When asked about family, 72% of those homeless for more than one year reported that they have children, 60% of this chronic group had children under the age of 18, and 13% of these with children under 18 years had their children with them.

As shown in Table 2, the causes of homelessness cited are likely to be overlapping. The multiple responses indicated that a homeless individual usually presents several causal factors and the complexity of the problem must be recognized. For example, one respondent could report “lack of job” and “no money for housing” along with various reasons for not being em-

The 2004 study of homelessness in Knoxville and Knox County asked a number of other questions about personal characteristics and experiences since becoming homeless. Table 3 supports many of the assertions about chronic homelessness and the use of available resources.

Table 2: Causes of Homelessness

Cause	Acute percent (n=139)	Chronic Percent (n=88)	Overall Percent* (n=227)
Alcohol	12	33	20
Drugs	27	25	26
Lack of Housing:			
No money for housing	13	16	19
Evicted	10	5	8
Family Relationships:			
Family/Relationship problems	22	11	18
Abuse	23	2	15
Divorce/Separation	17	12	3
Health/Mental Illness	12	7	10
Youth Offenses/Corrections	19	6	14
Prefer	--	3	1
*Totals do not equal 100 due to multiple responses.			

Table 3: Comparison of Individuals Experiencing Acute and Chronic Homelessness

Item	Acute percent (n=139)	Chronic percent (n=88)	Overall percent (n=227)
Grew up in TN	50	41	47
Reasons for Coming to Knoxville			
Shelters	20	30	22
Employment	27	31	29
Family	28	18	24
Consider Knoxville/Knox County Home	68	83	77
Plan to Stay	68	74	73
Early Experiences			
Homelessness during childhood	6	6	6
Foster care	15	19	17
Housing			
Evicted during past 2 years	22	19	21
Denied: Criminal activity/Poor payment	12	26	17
Homelessness:			
Prior episodes	44	52	47
Usually sleep in shelter	80	74	78
Stayed with friends	71	52	64
Spent time in other counties during past 2 years	58	37	50
Treatment History			
Medical hospitalization since homelessness	23	49	34
Mental illness treatment	60	47	55
Mental illness hospitalization * (among those treated)	57	71	63
Still taking medicine *	53	38	47
Alcoholic	21	46	32
Addicted to other drugs	20	41	29
Inpatient for substance use *	49	54	51
Incarceration:			
Public intoxication arrest	24	55	36
Jail time	60	73	65
Prison	16	18	17

*Footnote: Percentages for those who identified self as having received treatment.

For example, those who have been homeless for more than one year are likely to have been hospitalized for a medical or mental illness. Likewise, the sample group reports a high incidence of substance use and treatment as well as arrests for public intoxication. In addition to exploring characteristics of the homeless population, the study asked respondents about their use of available services and resources. Table 4 summarizes reported resources used by the homeless sample. (See Table 4.)

Certain themes were consistently expressed in presentations by and discussions with service providers.

The following points encompass the observations and recommendations made by the service systems and community representatives.

Guiding Principles and Strategies

The task force examined both the current condition of homelessness in the region and the state of service systems in relation to this ongoing problem. Throughout the course of presentations and discussions about homelessness in Knoxville and Knox County with a variety of service providers and community representatives a number of themes were identified. These themes revolved around the characteristics of chronic homelessness and the existing fragmentation of services.

1. The rationale for focusing on chronic homelessness has been well documented, especially the finding that the chronically homeless population uses a disproportionate amount of available resources. These individuals tend to have multiple problems, and generally no single agency is capable of providing comprehensive rehabilitation or support services that would enable them to secure and maintain stable housing.
2. Leadership is the starting place for solving chronic homelessness and preventing future homelessness. Knoxville and Knox County lack an empowered authority that can take ownership of the implementation of a strategic plan as well as the mobi-

Table 4: Comparison of Resources

Item	Acute Percent (n=139)	Chronic Percent (n=88)	Overall Percent (n=227)
Family Family in Area	56	33	47
Money Government Assistance	17	19	18
Handouts	11	17	13
Work	58	76	65
Resources TennCare	50	31	43
Driver's License	45	26	38
Social Security Card	82	78	81

lization of service providers and other stakeholders (e.g., community leaders, educators, housing developers, government officials, and private business owners) to work toward solutions.

3. Solutions require a shift from well intended, but often haphazard efforts from multiple agencies (and case managers) to a coordinated, focused approach that effectively supplies chronically homeless people with permanent supportive housing.
4. Rather than homeless individuals shifting among various programs and services, too often recycling from institutions to the street and back, the aim must be to move people into permanent housing. Such housing should include permanent supportive housing with accompanying social services and healthcare.
5. Homelessness is a community problem. The most successful efforts for ending chronic homelessness, according to the ICH, have broad support and participation from the public, private, and non-profit sectors.

6. Agency and program outcomes must focus on housing placement and stabilization or retention. Through coordination of service providers and utilization of the Homeless Management Information System (HMIS)¹¹ accountability can be increased and resources allocated more effectively.

The task force identified guiding principles to encourage change and successful outcomes in communication, solutions, leadership, and client accountability.

During the planning process, the task force identified a number of key guiding principles. These principles were developed and compiled in response to recommendations of service providers and experts in the field and reflect some of the best practices observed in other communities across the United States. These include:

In General

- Focus on the client.
- Act for the good of the whole.
- Be sensitive to the fact that change is often difficult.

In Developing Solutions

- Examine “Best Practices” from other communities.
- Determine who does what best.
- Build on strengths and experience.



¹¹ The Homeless Management Information System (HMIS) is a web-based system that links agencies together via the Internet. The system provides data on the number of homeless persons and allows for coordinated case management.

- Set realistic goals with measurable results.
- Build in accountability for both provider and client that is clear and that leads to specific outcomes.
- Find and commit the resources and staff for full implementation.
- Identify and reduce enabling behaviors that encourage homelessness.
- Discontinue the tacit acceptance of emergency shelter as permanent housing.

These guiding principles lead to and are reflected in the ten-year plan’s primary strategies:

In Determining Leadership

- Be collaborative and inclusive, with government, business, foundations, and service agencies all present and accountable.
- Be independent and free of outside influences and extraneous program distractions. (Wear only one hat.)
- Design an authority structure and sanctioning process that is recognized by all.

In Defining Accountability

- Require accountability in which performance is evidence based. Set a schedule for periodic evaluation of program success.
- Identify and implement changes needed to correct the flaws in the existing system.
- Focus on the chronically homeless population.
- Develop an empowered, accountable authority to lead (or own) the implementation of the plan.
- Increase coordination of and access to existing services to prevent and reduce homelessness.
- Move from institutionalization of homelessness to a “housing first” methodology with programs and services that maintain permanent housing.
- Involve a cross section of the community in ongoing problem solving.
- Concentrate resources on programs that offer measurable results.



These strategies represent a collection of ideas from a wide range of community representatives. They are informed by the task force's study of "Best Practices" that have been developed and implemented in other communities that are actively working to end homelessness.

Ownership

Early in the planning process the task force raised the issue of ownerships, specifically what body would be empowered with the authority to oversee the implementation of the strategic plan.

The task force members were unanimous in their belief that eventual success of a ten-year plan would depend on having a designated body or organization responsible for implementation.

The task force identified the following questions concerning ownership:

1. What body or organization will implement this plan?
2. What interests are represented on that body?
3. Who chooses the membership?
4. How many people should be a part of that body?
5. To whom and how will this body be held accountable?
6. How will implementation be carried out?

In addition to discussion and implementation of the plan, the task force identified other ownership functions such as:

1. increase coordination and more responsive management of homeless services,
2. enhance government and non-profit agencies' capacity to raise funds and attract additional resources,¹²
3. establish funding priorities for programs to reduce and end homelessness, and
4. enhance participation of a wide range of community sectors in efforts to address homelessness.



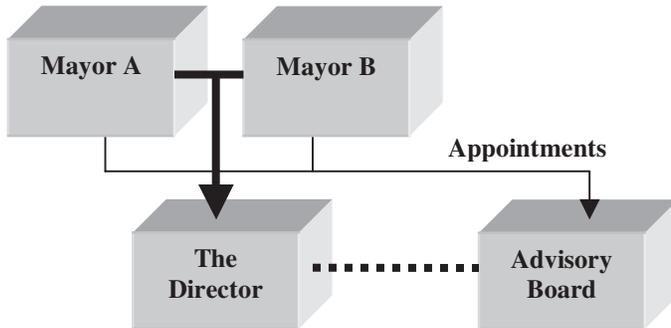
The task force studied several possible models that would address ownership and implementation of the plan. There was a general agreement that any model would establish an agency through a joint city-county effort. This agency would consist of an executive director appointed by the mayors and support staff (e.g., service coordinator and secretary). Additionally, the task force recommends the establishment of an advisory council whose members would be appointed by the mayors, and would represent a cross section of the community, including public and private service providers, non-profit organizations, and donors.

¹² Becoming more competitive and effective in securing grant and foundation funding is seen as essential. For example,
•The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded \$59.5 million in treatment grants for homeless persons with mental-health and alcohol and other drug problems.
•Thirty awards in 20 states are designed to expand and enhance treatment services for homeless people, building on 34 grants of a similar nature in 2004. The average grant size is \$400,000 per year for 5 years.

The Mayoral Model

The task force’s recommended model of ownership was termed the “Mayoral Model”. In this model the director is appointed, with this individual serving in a position directly accountable to one or both Mayors. An advisory board representing key interests throughout the community would be appointed to advise and assist the director in implementing this plan. Figure 1 illustrates a model of this structure. It is anticipated that this advisory board may evolve into functioning as a governing board.

Figure 1: Mayoral Model



The model emphasizes community-wide participation. The advisory committee would be composed of representatives from city and county governments, emergency shelters, social service providers, the Homeless Coalition, medical and mental health services, law enforcement, the business sector, neighborhoods, and faith-based organizations.

The Ten-Year Plan: Strategies

In appointing the committee to develop a ten-year plan to end chronic homelessness, Mayor Bill Haslam stated, “It starts with saying that we’re not going to keep doing it like we’ve done it before.” Ending chronic homelessness requires participation by all stakeholders: local

government, public and private social service providers, mental health and correctional facilities, and representatives from a cross section of the community. The plan, while challenging the community to be more proactive in addressing chronic homelessness, also promotes higher levels of accountability and responsibility among the homeless.

“It starts with saying that we’re not going to keep doing it like we’ve done it before.” —Mayor Bill Haslam

The following are strategies that offer a different approach to the problem of chronic homelessness.

1. Move People into Housing First

The most critical issue facing homeless people—the lack of permanent housing—must be the first and most important issue to be addressed. The concept of “housing first” is considered both a philosophy and structure for the ten-year plan. The concept itself is straightforward: if a chronically homeless individual is able to quickly obtain stable, appropriate, permanent housing, then the issues of mental illness, chemical addictions, education, and employment become eminently more manageable.

A “housing first” strategy advocates for permanent housing to be the first and most important issue to be addressed.

The simple notion of having even a small, modest place to call one’s own makes facing those

other issues achievable. The approach in the current “continuum of care” model is done in the reverse and, for many chronically homeless individuals, it has been unsuccessful. In this model of treatment, permanent housing is reserved as an incentive, achievable after certain prerequisites are met. These requirements might be associated with efforts the homeless individual makes to resolve secondary issues related to mental illness, chemical addictions, education, and employment. However, the instability of emergency shelter and transitional housing is physically and psychologically disruptive enough to defeat any efforts to successfully overcome these acknowledged problems. Attempts to engage the chronically homeless in this system result in repeated cycling through emergency and transitional programs with little success and, ultimately, continued homelessness.

The “housing first” approach combines affordable, permanent housing with the support services necessary to remain in permanent housing. A lesson learned is that without the stability of permanent housing, supportive services alone will not yield sufficient results. It is equally important to realize that permanent housing alone will be equally unsuccessful, if not coupled

with appropriate supportive services. The need for comprehensive supportive services is underscored by the Knoxville studies’ consistent findings that many individuals placed into housing without needed support simply recycle back into homelessness. (2004).¹³ Similarly, studies conducted in Portland and Multnomah County, Oregon, found that, after 12 months, only 40% of those leaving transitional housing remained in permanent housing.¹⁴ In contrast, retention rates showed that with a “housing first” approach there were between 80% and 90% of the individuals still in permanent housing after one year.^{15 16}

A number of factors increase the challenge for finding permanent housing. A significant percentage of the chronically homeless population suffers from mental illness, chemical addictions, or both, and cannot or will not meet threshold entrance requirements for the community’s existing housing opportunities. Long periods of homelessness or multiple repeated episodes on the street result in many individuals coming to believe that they are incapable of obtaining or keeping permanent housing. They give up trying.¹⁷ In interviews, many homeless persons told the task force that past criminal behavior and poor payment histories created significant barriers

¹³ Knoxville Coalition for the Homeless

¹⁴ Citizens Commission on Homelessness (2004). Home Again, Portland and Multnomah County, pg 22.

¹⁵ National Alliance to End Homelessness (2004). Summary of Housing First Research. LaFrance Associates, LLC.

¹⁶ Examples of Best Practices Include:

- New Hope Housing: A downtown Episcopal church in Houston began this non-profit agency by buying a single room occupancy (SRO) to provide affordable housing for low-income individuals. They have progressively grown, purchasing a second property and developing plans to build a third facility. They house a wide variety of populations, and the social services they provide on site are modest. Some of their residents have case management provided by one of their partners. New Hope Housing is a model of a faith-based landlord that partners with a variety of agencies who provide more intensive supportive services to their respective clients.
- SRO Housing Corporation is a private, non-profit, community-based organization in Los Angeles’ Central City East/ “Skid Row” with a mission of revitalization by providing clean, safe, and affordable housing, managing public space, and administering needed social support services. SRO Housing Corporation operates “close to the street” by purchasing and renovating existing turn-of-the-century, single room occupancy hotels as well as by constructing new ones. The Panama Hotel and Russ Hotel opened in 1989 and have 221 units. Residents develop an Individual Action Plan (IAP) with a case manager. The caseload for case managers is approximately 25–35.

¹⁷ Burt, Martha, et al. (1999). Homelessness: Programs and the people they serve. Interagency Council on the Homeless.

ers to obtaining permanent housing.

The housing working group, a subgroup of the task force, studied and reported on this aspect of chronic homelessness. Housing providers participated in discussions with a wide range of service providers and other housing experts. The group reviewed best practices and other reports and documents on community housing. This information, coupled with current local data on homelessness, provided a reasonably clear picture of near-term housing needs for this population. However, the housing working group recognized the difficulty of accurately predicting the need for new housing over a ten-year period. Based on data from the Knoxville studies and HMIS, the group projected a need to house 800 chronically homeless persons during the next ten years. The group looked at currently available housing facilities and discussed the possible need to develop new resources. The group did identify a need to create 200 units of affordable housing. They expressed the need to develop an ongoing process to evaluate and monitor housing needs for homeless persons throughout the implementation of this ten-year plan.

The housing strategy includes the following steps:

1. Place 800 chronically homeless persons in housing during the next ten years.
2. Create 200 units of “housing first” appropriate, permanent housing units for the chronically homeless.
3. Evaluate the need for additional units of appropriate, permanent housing units for the chronically homeless on an annual basis and secure funding to meet those needs.

4. Identify and secure funding for the appropriate assertive services to support 200 individuals in housing.
5. Establish a network to provide intensive and assertive support services for individuals newly placed into housing on an ongoing basis.
6. Identify currently available housing properties, accessible to public transit, with management amenable to accepting chronically homeless tenants if appropriate support services are provided.¹⁸

Affordable housing is in short supply throughout our community. In addition, there is a need for a greater number of units and a wider range of accommodation styles for family occupancy. Availability of appropriate affordable housing is especially critical in order to prevent persons who are situationally or episodically homeless from becoming chronically homeless. Housing with appropriate supportive services to help individuals through major transitions as they are discharged from foster care, prison, jail, and mental institutions is woefully inadequate. The lack of availability of supportive housing increases the demand for emergency shelter, which, as has been noted, is an inappropriate and inadequate solution for this population. To address the need for affordable housing with supporting services the task force recommends activities such as:

- Identifying existing housing resources for persons transitioning out of institutions.
- Utilizing HMIS to locate housing resources and vacancies, and to facilitate placement.
- Developing procedures to facilitate movement from institutions directly into housing.¹⁹

¹⁸ This recommendation includes effective utilization of nine existing SROs, weekly motels, and efficiency apartments, which currently have high vacancy rates.

¹⁹ Frequently, individuals being discharged go to an emergency shelter rather than into housing. Some may have additional barriers because of past offenses or lack of funds.

- Creating new supportive transitional housing opportunities for persons with special needs (e.g., individuals exiting psychiatric

institutions, individuals exiting detox and/or substance abuse treatment, individuals exiting correctional facilities, and at risk youth leaving state custody).



Appropriate housing opportunities must be available for everyone. Each individual in this system is just that—an individual. Housing and services should be sought to meet the needs of the individual, providing as much as is needed to help the individual maintain appropriate housing, while not mandating services or obligations that are unnecessary for that individual.

The housing work group and the entire task force were impressed with the Common Ground²⁰ projects in New York City. The president and founder of Common Ground, Rosanne Haggerty, led a retreat in Knoxville focusing on her group’s work and held a lively discussion on Common Ground’s successes and challenges. Of particular interest was the purchase and renovation of the Times Square Hotel into a 652-unit supportive housing facility with on-site social services. In addition to providing social services and a place to live, Common Ground provides on-site job training and employment opportunities through street-level retail and food service outlets. The hotel houses a diverse population with a wide range of needs and levels of

²⁰ Common Ground is a non-profit housing corporation that is innovative in its approach to managing basic affordable housing and partnering with others to provide supportive services. An example of their properties is The Christopher that houses three separate housing programs.

- The Foyer targets young adults (ages 18–24) who are “aging out” of foster and residential care and are homeless or at risk of homelessness. Support services for Foyer residents are provided by Good Shepherd Services, a non-profit social service and youth development agency.
- A 20-unit work-related housing program is designed to help working adults who are homeless attain a permanent job at a living wage and move on to private market housing. Common Ground’s employment service partner is STRIVE, a nationally known workforce development organization.
- The remaining 147 efficiency apartments provide affordable housing to low-income working people and formerly homeless adults, including those with special needs. Clinical support services for tenants are provided by the Center for Urban Community Services (CUCS), which offers case management, counseling, vocational assistance, and coordination of medical health care.

Common Ground also manages The Prince, which actually occupies two leased floors of a lodging house. Each resident is provided with private sleeping “cubicles” left over from the building’s former life as a traditional Bowery lodging house.

resources. While the task force did not make a specific recommendation to replicate such a facility, there was a strong interest in exploring a small-scale version of this type of project.²¹

2. Stop Discharging People into Homelessness

Institutions such as mental health hospitals and jails usually lack referral services with access to permanent supportive housing. The result is that far too many individuals are discharged directly to emergency shelters or the streets. The Knoxville studies found that 50% of the homeless individuals surveyed said that they had been treated for emotional problems. Approximately 60% of these persons had been inpatient in a psychiatric facility, and even one-third had been discharged directly into emergency shelters or the street.²² Similarly, other studies have found that among all persons discharged from state psychiatric institutions, over 30% will be homeless within 6 months.²³ This pattern is also evidenced in the foster care system as young people are discharged at age 18 and experience a high risk of becoming homeless.²⁴

A good strategy for discharging at risk populations from institutions to permanent housing is both humane and sound fiscal policy.

These institutions are overburdened and bound by limited resources. Mental hospitals do not have sufficient funds to provide long-term treatment for indigent patients. Requirements placed on these institutions demand a focus on rapid stabilization of indigent clients followed by discharge as soon as possible. The unintended consequence of this is a rapid release of mentally ill individuals who are poorly equipped to secure housing or cope with life on the streets. While this practice reduces the financial burden on mental institutions, the costs are shifted to shelters, jails, and hospital emergency rooms. This practice is neither humane to the patient nor cost-effective to society and, ultimately, the taxpayer assumes the cost of an insufficient system. Similarly, correctional facilities currently release prisoners to the street. Criminal recidivism is a likely result. In addition, drug and alcohol addictions can quickly recur or occur. Those consequences of homelessness shift costs to systems that are not designed to efficiently address the needs of former offenders. Finally, limitations of the foster care system currently result in matriculation of youth directly to the streets. Unprepared for independent living and incredibly susceptible to destructive, costly behaviors and lifestyles, young people find themselves homeless and vulnerable.²⁵ To stem the tide of individuals most likely to become chronically homeless, these systems must cease the discharge of people directly to the streets.

The ten-year plan task force recommends that

²¹ Anderson, George M. (2004). A Daring Faith-Based Strategy. *America*, 5(191), 10–11.

Sittenfeld, Curtis. (2003) What Would it Take to End Homelessness? *Fast Company*. January, 66, 42.

Give Them Shelter. *Architecture*. April 30, 2004.

²² Knoxville Coalition for the Homeless (2004).

²³ Belcher, J. & Toomey, B.G. (1988). Relationship Between the Deinstitutionalization Model, Psychiatric Disability, and Homeless. *Health and Social Work*, 13(2), 145–153.

²⁴ The National Coalition for the Homeless (1998). *Breaking the Foster Care–Homeless Connection*. Safety Network, 1–7.

Robertson, M.J. & Toro, P.A. (1998). *Homeless Youth: Research, Intervention, and Policy*. The 1998 National Symposium on Homeless Research.

²⁵ Burt, Martha, et al. (1999). *Homelessness: Programs and the people they serve*. Interagency Council on the Homeless.

the community establish an institutional discharging strategy that includes the following steps:

1. Seek agreement from institutions to stop discharging individuals to emergency shelters or the street.
2. Develop a systematic discharge procedure whereby individuals to be discharged from a hospital, jail, and foster care are linked to appropriate community services before discharge.
3. Connect individuals who are homeless or at risk of becoming homeless to permanent housing and a case manager prior to discharge.
4. Advocate for a state plan concerning institutional discharge.



3. Increase Coordination and Effectiveness of Service

Homelessness is an extremely complex problem. While there are no simple solutions, the nature of homelessness underscores the need for different agencies and sectors of the community to work together in seeking solutions. The existing services delivery system has been criticized as being ineffective, fragmented, and too frequently duplicating services. The task force reviewed the current system through meetings

with providers, agency executives, and homeless persons. This examination resulted in a conclusion that service effectiveness can be increased. Specific areas of attention include:

1. coordinated case management;
2. outreach and engagement;
3. single point of entry, and
4. designated agency function.

Coordinated Case Management

A critical component for ending chronic homelessness is a system that provides coordinated, consistent, and ongoing case management. Currently, the case management system for the homeless population is fragmented. A homeless person may be assigned a number of case managers by different agencies that, while doing good work, labor independently of other service providers. This fragmented service system is burdened by large caseloads, as well as high turnover rates among case managers.

The ten-year plan emphasizes redesigning the case management system to identify a service coordinator whose central function would be to coordinate the efforts of various service providers (case managers).

Outreach and Engagement

In addition to increased coordination, one of the most challenging aspects of reducing chronic homelessness is outreach and engagement. The chronically homeless tend to be heavy consumers of services, but this is often on a “piece-meal” or crisis basis. While heavy consumers of services, many of these persons are socially isolated and alienated from the community. Thus, an early task encountered by outreach workers and case managers is to effectively engage the homeless in a manner that allows them to share ownership in securing appropriate services and housing.

Effective engagement and outreach is a necessary part of the long-range goal of placing homeless individuals in housing and treatment.

The ten-year plan acknowledges the importance of outreach and engagement by recommending the development of a comprehensive and assertive outreach team. This team could serve as the first point of social service contact for the homeless who reside in a shelter, on the street, or in a place not meant for habitation.

Assertive engagement is often necessary for people who suffer from serious and enduring mental health problems as well as those with high levels of poor social functioning. These people have difficulties in engaging with services. Chronically homeless individuals are often in need of such interventive engagement.

The goal of the assertive outreach team would be to provide an integrated, comprehensive, client-centered resource focused on placing homeless individuals into housing first and then into appropriate treatment programs. In a coordinated system, homeless individuals would be protected from the experience of being passed on to multiple case managers and of having to undergo multiple or repetitive assessments. The outreach team, working in conjunction with the single assigned case manager, can effectively move the client to multi-disciplinary services.

The task force envisions an outreach team as being composed of people from a variety of service backgrounds such as social work, law enforcement, and psychiatric nursing. These individuals, working in tandem with the service coordinator, would initiate and continue the case management function after placement into housing. The teams could establish flexible or non-

standard service locations and hours in order to assure service availability to this particular population.

The establishment of avenues for rapport and trust allow for the accomplishment of the primary goal of outreach and engagement, which is to initiate a process whereby the chronically homeless person is given the opportunity to take advantage of placement in appropriate housing.

The outreach workers will work closely with the service coordinator to assure that the best housing placement options are made available to each homeless client. Effective case management and outreach is enhanced by appropriately trained, well prepared staff. Staff must be trained to effectively engage a wide range of persons and situations—juveniles and adults, mentally ill, substance abusing, and former offenders.

Several issues have been identified as concerns of the task force in relation to the work of outreach teams. First, encouraging treatment options rather than securing housing first is a possibility, but is reserved for extreme circumstances in which substance abuse or mental health concerns would render “housing first” as not being a viable option.



Second, overcoming chronic homelessness is based on effective client engagement, housing placement of the engaged, and maintenance of housing for more than 6 months. When a homeless individual fails to achieve this, the outreach team/provider agency should attempt to re-program the strategy and outreach techniques.

Finally, certain agencies such as The Knoxville-Knox County Community Action Committee, the Helen Ross McNabb Mental Health Center, and Cherokee Health Systems already have been identified as having appropriate staff and services to become approved service providers. However, the task force is wary of relationships (such as with TennCare or third party payers) that undermine autonomy that allows for innovative strategies to deliver services.

Single Point of Entry

Too frequently homeless persons face a matrix of services without a clear, consistent point of entry.

A sound strategy for coordinating services to the homeless includes a single point of entry into a unified system of service provision.

It is crucial that once a homeless individual has requested services from a provider within

the Knoxville and Knox County system, he or she will receive consistent help, coordinated to quickly move that individual toward the goal of appropriate permanent housing. Under the current system an individual frequently finds assistance at one shelter or service provider, leaves, and then seeks assistance again at another shelter or service provider while making little progress toward finding permanent housing. A single point of entry into the system would assure progress towards the goal of housing and stabilization. Setting up a single service entry point does not demand that a client request services at a single physical location. The HMIS allows cooperating agencies to work together to seamlessly initiate and maintain an individualized service plan for a homeless individual or family group.²⁶ In the past, some criticisms have been expressed in regard to service plans, treatment plans, and care plans, saying that they are duplicative, overlapping, and lead to inefficiency. And in fact, some homeless individuals have developed survival strategies that push them to travel from agency to agency to maximize personal benefits. Often the added benefits do nothing to resolve the episode of homelessness. In fact, the benefits sometimes actually do promote chronic forms of homelessness. This inefficiency in the delivery of services can be reduced or eliminated by full implementation of the HMIS and the service coordination system.

Implementation of the HMIS information sharing database will serve to keep every service

²⁶ Examples of best practices are:

- New York City’s Hard-to-Place Task Force is an interagency coordinating body focusing on the needs of long-term shelter stayers. It has work groups that cross agency lines, involve people with a variety of levels of responsibility (from line staff to decision-makers), and include external partners—all in the same room at the same time. This allows problems to be readily identified and solutions implemented swiftly. It has a very small staff dedicated to only this issue, and it has created “Project MatchUp” that links newly opening supportive housing to the most challenging shelter clients.
- Streets to Home (S2Hi) brings together 17 of the community’s outreach teams, hospitals, substance abuse and mental health professionals, veterans’ organizations, city offices, Business Improvement Districts, and other service providers. S2Hi uses an inter-agency database and monthly joint case conferences to maximize the use of existing resources and addresses identified gaps.

provider informed of what services are being utilized by homeless individuals. Implementation of the service coordinator concept will help to reduce inefficiencies and wasted resources while using available case management personnel more effectively.

Designated Agency Function

In recent years, the major homeless emergency shelter and service providers, particularly Knox Area Rescue Ministries (KARM), Salvation Army, and Volunteer Ministry Center (VMC), have made steps in defining their respective core functions and have worked in cooperation to reduce duplication of services. The formation of the Emergency Shelter Providers Network (ESPN) has improved communication and reduced duplication; for example, the Salvation Army is no longer providing one-night (transient) shelter, with Knox Area Rescue Ministries assuming responsibility for this type of shelter. To build on this, there is a need for continued effort to define focus and domain among the emergency shelter providers. Continued collaboration and cooperation will lead to more efficient services and perhaps more importantly, allow for meeting currently unmet services needs.

The three emergency providers, KARM, Salvation Army, and VMC have moved toward better defining their specific functions. Knox Area Rescue Ministries emphasizes emergency shelter and services, including special programs such as the Abundant Life Kitchen. Salvation Army is focused on its Rehabilitation programs, such as Bootstraps, and services to families. Volunteer Ministries has identified housing and medical services as central along with the day center. Each of these agencies provide more extensive services; however, these identified ones are specifically directed to the homeless population.

While these agencies provide needed services to the homeless population, the ten-year plan calls for focusing on “how do we end chronic homelessness?” The ten-year plan has identified strategies dedicated to ending chronic homelessness, however, for the plan to be successful, these major homeless service providers must take leadership roles in services. This leadership involves taking responsibility to ensure that needs are being addressed, that services are being coordinated, and unnecessary duplication is avoided in an area. It does not mean that an agency would be the sole provider of services, but rather that services are being provided in the most effective and efficient ways possible. The task force discussions generated five areas that would benefit from designated leadership:

- A. housing and support services
- B. emergency food and shelter services
- C. transitional lodging and stabilization services
- D. economic opportunity and training services
- E. systems coordination and plan implementation

In addition to considering areas of leadership and their service focus, boards and their organizations must think about addressing unmet needs. For example, a central recommendation in the ten-year plan is the adoption of a “Housing First” approach that includes emphasis on supportive housing. While housing can be developed to achieve this goal, it is essential for an agency or agencies to take a leadership role in providing the necessary support to enable persons to remain in housing. These supportive services may include case management, life skills training, employment training and placement, mentoring, as well as a range of activities to increase community integration and stabili-

zation. Likewise, a change to a Housing First approach will be enhanced by a specific agency taking on a housing broker role, providing a central resource for monitoring existing available housing and linking persons with appropriate housing.

Whereas the task force did not view its role as defining specific service functions and roles for the three major agencies, there was agreement that more clearly defining their service areas and leadership roles is a critical and necessary task. The task force appreciated that the question of leadership in an area is one that the respective boards of directors must address, and this process of deliberation requires time. Initially, this appears to be an overwhelming task. However, as noted, these organizations have already made strides toward identifying their potential areas as suggested by VMC's efforts in developing housing and support services, KARM's emphasis on emergency food and shelters, and Salvation Army's provision of transitional lodging and stabilization services. The recommended director position (mayoral model) should provide leadership in overall systems coordination and implementation of the plan.

In examining the question of designated agency function, several members of the task force met with the executive directors of the three agencies along with a representative from their boards of directors. Recognizing that any process of change takes time, there was an expressed willingness by those in attendance to take these issues back to their boards and actively consider focus, leadership, and to consider new responsibilities in addressing unmet needs in order to further the overall goals of this ten-year plan.

4. Increase Economic Opportunities

Lack of employment, income, and economic opportunity are often identified as major causes of homelessness. Although many homeless individuals report being employed or having occasional work,²⁷ many of the jobs they hold are of such a nature and skill level that they do not provide adequate wages and benefits for self-sufficiency.²⁸ As part of the effort to solve chronic homelessness, it is crucial to maximize income and achieve economic stability. The potential of offsetting the costs of supportive services and housing through the individual client's own income and productivity exists. Realizing that potential is good for both individual and



community. The effort to achieve maximum income begins at the time of client intake into the system of homeless services. The intake process must include a comprehensive assessment of eligibility for available benefit programs, and an assessment of education and current employability in order to determine needs for further training. In addition to determining

²⁷ Burt, et al. report that 44% of the homeless population are employed.

²⁸ Mischel, Bernstein, and Schmidt, (1999) indicated that the value of minimum wage has not kept up with growth. Additionally, a decline in manufacturing jobs and a corresponding increase in low paying service employment, globalization, decline in union bargaining power, and an increase in temporary work have been factors in wage decline.

the individual's income potential, the ability to manage funds must also be addressed. With case management and basic financial management assistance, some clients will be able to manage their financial resources. For others, a "re-sponsible payee" service may be required. The guardianship program would serve the client by assuring that benefits and income received are appropriately managed to meet individual expenses. For clients with significant mental illness, addictions, or other issues, a financial guardianship program may be the most effective method to assure that the client's limited fiscal resources are not squandered or stolen.

Repeated episodes and extended periods of homelessness serve to decrease prospects of employment.

Repeated episodes and extended periods of homelessness serve to decrease the prospects of employment as the consequences of prolonged idleness may include greater loss in work habits, responsibility, and commitment to employment. The ten-year plan recognizes that people who are chronically homeless will need greater access to resources that provide employment training and placement. For many, the root causes of their homelessness may indicate a skill level—for both work and life skills—that is below the minimum expectations of most employers. While it appears there are many employers who are willing to assume some risk by offering employment to the homeless, that risk is, nonetheless, limited by the employer's bottom line. An employee whose attendance is unreliable or whose work skills remain consistently below job requirements will quickly run out of "second chances" with even the most understanding employer.

Employers who assume the risk of hiring a homeless individual need assurance that the person has basic work skills and personal reliability.

To help mitigate an employer's risk, the task force recommends the establishment of a basic skills training and certificate program. Upon completion of the basic skills training programs, clients would be issued a certificate. This certificate would document basic standards of work skills and personal reliability that will have been learned and met by recipients of the certificate. By building adequate levels of expectations into the participating training programs, employers would see certificate program graduates as less of a risk, despite their past history or status as homeless.

New programs targeting individuals who require basic life and work skills training combined with marketable vocational training are also needed to help the chronically homeless bridge the gap. Programs such as the Abundant Life Kitchen Program provided by Knox Area Rescue Ministries and Second Harvest Food Bank serve as examples of such employment training courses. One program offers culinary training. Expansion of this program and others targeted toward practicable vocations is an important step. Training combined with supportive case management is essential for helping homeless people maintain stable employment or work training. Additionally, for homeless families, childcare and affordable transportation are critical for gaining and maintaining employment.

To address benefits, education, and employment needs of the homeless, as many resources as possible should be brought directly to the



homeless. Satellite offices for these programs should be located in or near shelters and primary homeless service locations. Technologies such as teleconferencing, computers, and Internet access should also be utilized to bring training and educational opportunities to the homeless. Use of these resources will maximize client exposure to opportunities while minimizing transportation costs and logistical complications that often serve as barriers to the homeless who are seeking employment.

The recommended strategy to increase economic opportunities that assist homeless persons to achieve their maximum economic self sufficiency include the following steps:

1. Include comprehensive intake assessment for employability, education, and eligibility for benefits in all intervention planning.
2. Establish income management and financial guardianship programs.
3. Support and expand existing employment and educational training programs to target the chronically homeless population.
4. Establish a pre-employment basic skills certificate program.
5. Bring benefit, employment, and educational programs to the clients through satellite

offices and use of telecommunications technology.

6. Encourage the business community to provide employment opportunities and mentoring programs by providing supportive services to employers and tax incentives.

5. Implement New Data Collection Methods

In June 2004, the University of Tennessee College of Social Work was awarded a grant by HUD to develop and implement a Homeless Management Information System (HMIS). The HMIS is a centralized Web-based system that provides a database of homeless information. Shelter, housing providers, service agencies, and others who work with the homeless can share client information within the strictest bounds of privacy and confidentiality (HIPPA compliant). The system is designed to maximize service coordination. HMIS also provides aggregate data that is crucial in assessing needs, service effectiveness, and accountability.

The HMIS reflects community partnerships with the University of Tennessee College of Social Work, the City of Knoxville, Knox County, the East Tennessee Coalition for the Homeless, the United Way of Greater Knoxville, and private industry (Comcast is providing Internet access for the project). As of July 2005, nine agencies are currently using the HMIS and four additional agencies are scheduled for connection. There are now approximately 2,000 individuals registered in the HMIS. United Way has supported the deployment of the HMIS by awarding fully participating agencies a \$1,000 bonus.

The HMIS offers a number of benefits for addressing chronic homelessness. It is an enabling collection of accurate and timely data on numbers of homeless persons in the community, patterns of homelessness, and demographic characteristics. The system will provide a resource

for better coordination of case management. Additionally, HMIS will provide information on effective interventions and service delivery as well as providing data to guide agency and community planning for improved and targeted services delivery.

The HMIS strategy includes the following steps:

1. Expand HMIS to include hospitals, housing providers, the health department, mental health and substance abuse treatment providers, and correctional facilities.
2. Use HMIS data to evaluate outcome data on services delivery.
3. Use HMIS to provide a single point of entry for homeless services.
4. Use HMIS to increase case management and the coordination of care between homeless services providers.
5. Use HMIS to link housing resources and availability.
6. Expand the base of community matching funds support for the HUD HMIS.

6. Develop Permanent Solutions

The current service system for homelessness has an emergency orientation. Services respond on an emergency or crisis basis rather than being directed at permanent solutions. Few homeless persons are placed and supported in long-term housing. Many are using the emergency shelters as long-term housing. These shelters, designed to provide temporary housing, have been overwhelmed by persons who are chronically homeless.

A contributing factor to the use of emergency shelters for long-term housing has been the



heavy incidence of mental illness and substance abuse among the chronically homeless. Approximately 50% of homeless persons in Knoxville report a history of mental health treatment, and 42% self report being alcoholic (32% using and 10% in recovery). Forty-eight percent report other drug use.²⁹ Frequently, these individuals are in a “revolving door” system of care, recycling from institutions to emergency shelters or the streets. According to the Knox County Attorney General’s office, arrests for public intoxication in Knoxville and Knox County range between 3,800 and 5,000 per year, approximately 13% of the total yearly arrests. Fewer than 80 individuals, each arrested 6 or more times, account for 25% (1,250) of those arrests. Seven individuals have 100 or more arrests during the past five years. Almost all these individuals have serious substance addictions and most have co-occurring mental illness.

Approximately 50% of homeless people in Knoxville report a history of mental health treatment.

A large percent of these individuals are chronically homeless. The justice system in Knoxville and Knox County, without treatment resources,

²⁹ Homelessness in Knoxville/Knox County, 2004.

rotates these individuals through the courts with little effort to address the underlying causes of their repeated arrests, resulting in a waste of time and money, with little being accomplished.³⁰ This service utilization is not only inefficient, but is also costly.³¹ An episode observed by several committee members, as described below, illustrates this cost:

Several homeless men were seen at 8:00 a.m. on Cumberland Avenue sharing a bottle of cheap liquor. Later in the morning, one of these individuals, who was very intoxicated, was riding the trolley, but when the trolley stopped in front of the City-County Building, the individual was unable to get off the trolley on his own. A Knoxville Area Transit (KAT) supervisor was called and, along with the trolley driver, attempted to assist the individual. A policeman was called because the man was too drunk to stand. This policeman offered transportation to a shelter, but the homeless man sprawled out on the sidewalk. The trolley driver, supervisor, and policeman spent approximately 45 minutes trying to resolve the situation, but had no alternative to calling Rural Metro for ambulance service and transportation to an area hospital emergency room. The homeless individual would remain at the ER for approximately 6 hours (if not admitted for overnight). In all likelihood, this pattern will be repeated by this same individual, and by others. When considering the cost of down time for the trolley, the driver, KAT supervisor, policeman, the ambulance run, and emergency

*room, it is not surprising to conclude that the annual cost of public services will exceed \$40,000 dollars.*³²

As the example illustrates, currently Knoxville addresses public intoxication among the chronically homeless population mainly through law enforcement and emergency medical interventions. This results in resources being tied up in emergency response (e.g., E911, emergency room, and ambulance service) dealing with intoxicated individuals. Transportation of intoxicated individuals to the hospitals or jails is very time-consuming for law enforcement. In addition, with this approach there is little legal enticement for homeless individuals who are alcoholic to seek substance abuse treatment. To change this practice, the task force recommends a new strategy of developing alternatives to incarceration or hospitalization of intoxicated individuals.³³ A recommendation from the law enforcement, criminal justice sector was to develop an appropriate legally sanctioned process for holding chronically homeless persons with serious addiction conditions from several days to several weeks to enhance involvement in treatment. Any such measures must insure that legal rights are protected. The permanent strategy includes the following steps:

1. Establish a detoxification facility that is directly related to the courts and provides:
 - intensive case management and strong connection to the service coordinator;

³⁰ Knox County Attorney General. Personal Communication. February 17, 2005.

³¹ A study in 2001, conducted by Culhane, et al., from the University of Pennsylvania, examined service utilization of 4,679 homeless mentally ill individuals in New York City. The average cost to the public for emergency interventions was \$40,449 per year. Culhane, Metraux, & Hadley (2001). The impact of supportive housing for homeless persons with severe mental illness on the utilization of public health, corrections, and emergency shelter systems: The New York/New York Initiative, Housing Policy Debate.

³² Culhane, D.P., Metraux, S., & Hadley, T. (2001). The New York/New York agreement cost study: The impact of supportive housing on services use for homeless mentally ill individuals. New York: Corporation for Supportive Housing.

³³ The Salvation Army of Dallas established a strong connection between their detox program and court system that included an actual lock-down with judges coming to the shelter to sentence people to treatment. The City of Hillsboro has a program that emphasizes case management—the officers take people directly to the detox facility. The City of Tampa recognizes that the hammer of enforcement is not always most effective, emphasizing a softer approach with less enforcement and more identification of resources that can help.

- a walk-able, central location convenient for officers;
 - sufficient staffing with medical and security personnel; and
 - a transportation component.
2. Integrate law enforcement, ambulance, hospitals, or other service providers that regularly interact with the chronically homeless population through HMIS. HMIS would be used as an implementation tool to identify patterns and integrate service plans.

The task force suggests developing alternatives to incarceration or hospitalization of intoxicated individuals.

As recommended earlier, the success of an alternative resource (i.e., detox facility) would be enhanced by an aggressive outreach team that could engage intoxicated individuals and assist them in reaching the facility.³⁴ This team also could be an important resource for issues of chronic homeless individuals loitering and drinking in neighborhoods. Therefore additional steps are:

1. Develop an aggressive outreach team.
2. Use outreach teams to identify homeless individuals within neighborhoods and link the individuals to social services.

Educate residents of neighborhoods frequented by homeless persons to know how to respond and who to call when they observe behaviors and patterns that need to be addressed.

7. Strengthen Partnerships with Faith-Based Organizations

Faith-based organizations have played a central role in providing help and support for the homeless as far back as history has been recorded. The calling to serve is a core reason many people strive to end homelessness, whether that calling is based on reading of scripture or on other systems of values. Faith-based agencies generate and utilize a wide range of volunteers who seek to help the homeless persons find needed food, clothing, shelter, and hope for a better life. The ten-year plan to end chronic homelessness recognizes the importance of partnerships with faith-based organizations and the task force considers them to be one of the critical components in the plan to develop permanent solutions to homelessness.

Homeless individuals need to hear the clear message that help is available.

The recommendations contained in the plan are based on a study of successful approaches taken in other communities and on research concerning the causes and solutions for homelessness. Central to all the recommendations is coordination throughout the community to focus efforts efficiently and effectively, to avoid working at cross purposes, and to provide each homeless individual with the clear message that help is available and that this community will work as one to improve that individual's situation.

In Knoxville, many of the major providers serving the homeless are faith-based organizations. They include Knox Area Rescue Ministries, the Salvation Army, the Volunteer Ministry Cen-

³⁴ The City of Tampa had a small, diverse outreach team of professionals who engaged the street homeless.

ter, and Catholic Charities. Many individual churches provide meals and other services. For example, Second United Methodist Church and Church Street United Methodist Church provide meals. Likewise, the Love Kitchen and Lost Sheep Ministry have provided outreach and meals for a number of years. The Concord United Methodist Church and Concord Mennonite Church joined together to offer a Monday lunch and clothing closet. “Preacher Bob” leads the Highways and Byways Ministry that provides meals and outreach, while the Wings of Hope Ministry offers services to those in outside locations. Water Angels is also an active ministry providing a wide range of support services. Other churches have joined together and are represented through organizations such as the Knoxville Inner City Churches United for Progress (KICCUP), Knoxville Interdenominational Christian Ministerial Alliance (KICMA), and the Compassion Coalition. More recently, the Hospitality Network has become operable and provides shelter to homeless families.

Faith-based organizations play a crucial role in the effort to end chronic homelessness by treating the individual with dignity and understanding.

The food and feeding programs offered by faith-based organizations, the shelters, and other social service organizations are ensuring that homeless individuals do not go hungry. It is without question that street outreach ministries play a crucial role in the effort to end chronic homelessness in that they are often a first contact with the chronically homeless, one where the homeless individual is afforded dignity and understanding, and one where the contact occurs on the homeless individual’s turf and terms. There are concerns, however, that uncoordinated efforts do not address the long-term need

to solve homelessness and that offering food, clothing, and other goods to homeless individuals in some respects is enabling homelessness rather than encouraging the establishment of permanent housing. For example, one agency may be working with an individual, striving and requiring their participation in self-betterment programs, such as addiction treatment or life-skills training while receiving food and clothing. When given the choice, however, that homeless individual may opt to take the food and clothing that does not come with a requirement to participate in treatment or classes. In these circumstances, the unconditional giving only addresses the immediate need for food or clothing, leaving the underlying causes of homelessness to continue.

It is important that there is a coordinated effort among faith-based organizations to provide supportive and permanent housing.

As noted, the faith-based organizations have a critical role to play in ending chronic homelessness. Particularly important is that there be a coordinated effort among faith-based organizations and a greater coordination among shelters and social service providers. Since there are a number of food resources, but a shortage of affordable and supportive housing, faith-based organizations should be encouraged to consider redirecting efforts toward supportive and permanent housing. The strengthening of partnerships with faith-based organizations should include the following steps:

1. Developing strategies to increase coordination of services provided by faith-based organizations and with those of other existing service providers.
2. Working with faith-based programs to find ways for more effective and efficient



utilization of their resources, particularly in providing housing.

3. Developing a comprehensive educational campaign to help churches maximize their impact on the chronic homeless problem (providing a “hand up” instead of a “hand out”).
4. Involving existing associations such as KICCUP, KICMA, and the Compassion Coalition in coordinating communications with faith-based organizations.

Actions taken in Chicago, Illinois, represent a best practice in coordination of outreach ef-

forts.³⁵ Since this effort began, the City of Chicago is reporting successful relationships among organizations, with the faith-based groups and the Chicago Department of Human Services (CDHS) working in unison towards the goal of ending chronic homelessness. The Knoxville and Knox County Ten-Year Plan to End Chronic Homelessness proposes to similarly engage faith-based community organizations and street ministries. To succeed in ending chronic homelessness, organizations and individuals at all levels of this effort must work together. The Chicago model demonstrates that it can be done.

8. Recognize Homelessness as a Community Challenge

Ending chronic homelessness is a challenge for the entire community. While there are no simple solutions, ending homelessness will require a cooperative effort that includes government agencies, private and public services, businesses, faith-based organizations, and neighborhoods. Too frequently, homelessness is viewed as the responsibility of emergency shelters and/or other service providers rather than a community responsibility.

³⁵ The Chicago Department of Human Services (CDHS) met with faith-based and community organizations and explained the City’s efforts to engage the chronically homeless and get them involved in programs that would lead to stability, housing, and self-sufficiency. The faith-based community organizations recognized that their mission was the same as the City’s, and a new level of cooperation was achieved. The CDHS proposed several actions that faith-based organizations could take to make their own efforts more effective:

1. Call CDHS when planning to distribute food on the street so the City could have outreach workers present and could use the opportunity to engage homeless people. CDHS assured the organizations that they would send staff, their mobile clinics, and other resources as appropriate.
2. CDHS offered to connect the organizations with shelter and daytime programs that serve homeless people. They suggested that the community organizations “adopt” one or more of these programs and work with their social workers to leverage donations and produce a more lasting outcome.
3. Chicago’s Plan to End Homelessness introduced several activities to get faith-based and other organizations involved. Structured goals and programs included four initiatives:
 - a. Conduct used-furniture drives to provide furniture for homeless people who are moving into permanent housing.
 - b. Sponsor a homeless family by providing a rent subsidy and other support.
 - c. Contribute to the Chicago Homeless Prevention Fund.
 - d. Educate organization membership on the issues of Homelessness and how to end it.

Ending chronic homelessness is a challenge to the entire community that has no simple solutions.

There is a limited public awareness about issues concerning the chronically homeless. The general public often does not recognize the true cost of homelessness in the community to social services, churches, hospitals, insurance, and governmental agencies, but perhaps more important, the cost in terms of the loss of human potential.

The community challenge strategy includes the following steps:

1. Develop a coordinated public service announcement (PSA) campaign—possibly including a number to call when dealing with problems (e.g., drunkenness, etc.).
2. Coordinate existing agencies to provide joint PSAs to reduce advertising costs.
3. Work with media to ensure that agencies speak with one voice, through multiple messages that emphasize how chronic homelessness is a community problem and everyone’s priority.
4. Coordinate PSAs with faith-based organizations—churches, KICCUP, KICMA, and Compassion Coalition.
5. Involve neighborhoods to effectively reduce the number of homeless in neighborhoods and community wide.

In developing the ten-year plan, the task force received considerable input from neighborhoods about public intoxication, loitering, and panhandling. Some neighborhoods, especially those in the inner-city, felt that they experience a disproportional amount of problems associated with the chronically homeless population. The actions that have been identified in the plan, including moving to a housing first strategy, better

coordination of services, and establishment of a detox facility, will reduce or eliminate many of these concerns. At the same time, a variety of action steps may be considered including:

- Encourage a community review of the aggressive panhandling ordinance.
- Establish avenues for public education about panhandling.
- Solicit the cooperation of store clerks and bartenders regarding not selling alcohol to mentally ill individuals (consistent with an existing ordinance) and those who abuse alcohol and drugs.
- Utilize outreach teams to contact homeless individuals in neighborhoods with the purpose of linking the individuals to social services.
- Educate residents of neighborhoods to know how to respond and who to call for assistance.

Homelessness is a community issue. Perhaps the greatest danger is community acceptance of homelessness as inevitable rather than an urgent social issue demanding increasingly effective solutions.

9. Prevent Homelessness

The Interagency Council speaks of prevention as “closing the front door” to homelessness. Homeless prevention is any action that prevents an individual or family from losing their housing. Providing services and assistance that contributes to housing stability, such as assistance with rent or house payments, utility bills, medical treatment, and transportation can be preventive. Likewise, early intervention when crisis occurs can prevent homelessness. It is especially important to identify those at risk and provide services that support these persons in maintaining housing stability. Early intervention

can prevent homelessness through education and advice, negotiation with landlords to avoid evictions, and discharge planning protocols that prevent homelessness. Another level of prevention is stopping recurring homelessness through case management and supportive housing.

Regardless of the level of prevention— identifying persons at risk, early intervention or breaking the cycle of chronic homelessness—it is critical to utilize strategies that have been demonstrated to be effective. There is an increasing understanding of evidence based practices (i.e., determining what works with them). As new strategies are selected, it is also imperative that existing programs measure their outcomes in addressing homelessness.

The actions identified in the plan—particularly housing first, stopping discharges to the street, and coordinated case management—will have a strong preventive effect on chronic homelessness. The prevention strategy includes the following steps:

1. Identify persons at risk for homelessness and link with social services;
2. Develop services that support housing stability, such as rent and utility assistance.
3. Break the cycle of recurrent homelessness through intensive case management and supportive housing;
4. Develop discharge protocols for mental health, correctional, and youth institutions that prevent homelessness;
5. Recognize youth transitioning out of state custody as housing special needs;
6. Consistently evaluate and measure which programs and strategies are effective in preventing and reducing homelessness.

It is especially important to develop preventive strategies for youth transitioning out of foster care and state custody. Recent studies suggest

that over one-fourth of youth transitioning out will be homeless within a year. The Knoxville Youth Transition Council has offered supportive recommendations, including the following steps:

- Develop supportive transitional housing specialized to meet the immediate needs of homeless youth.
- Develop a “one stop shop” that would act as a community resource center for homeless and at risk youth, providing social support, and resource information.
- Develop supportive job resources that would combine job training opportunities with a paycheck.
- Develop school programs that partner with families and the community to prepare youth for making the transition to self-sufficiency.
- Establish a community youth council made up of homeless or previously homeless individuals or those otherwise at risk who could advise the community on the needs of this population, make recommendations, and provide support and services for homeless youth.
- Encourage information sharing, networking, and collaboration among the entire community to make better use of resources and expertise that already exist.
- Seek alternative funding streams for ventures that address the needs of transitioning youth.
- Develop a mentoring program model to match caring adults with transitioning youth to assist and support youth in the process of becoming self-sufficient.

Conclusion

Homelessness is a major challenge for Knoxville and Knox County. While there are no simple solutions, the complexity of homeless-

ness underscores the need for all sectors—social and health services, government, businesses providers and consumers, neighborhoods, and churches—to work together toward solutions. The city and county mayors’ appointment of a task force to develop a Ten-Year Plan to End Chronic Homelessness is an important step in system transformation and development. Likewise, the development of the HMIS is a promising resource.

Chronic homelessness points to the shortage of affordable supportive housing, mental illness, substance abuse, and the lack of employment and other skills necessary for self-sufficiency. The Ten-Year Plan to End Chronic Homelessness recognizes the need for a comprehensive, coordinated, and continuous effort. Without an ongoing commitment at the federal, state, and local levels to solving the problems, there will be little success.

This plan offers a framework for ending the institution of homelessness. By increasing the availability of permanent housing, providing coordinated case management, and linking homeless persons to community resources, Knoxville

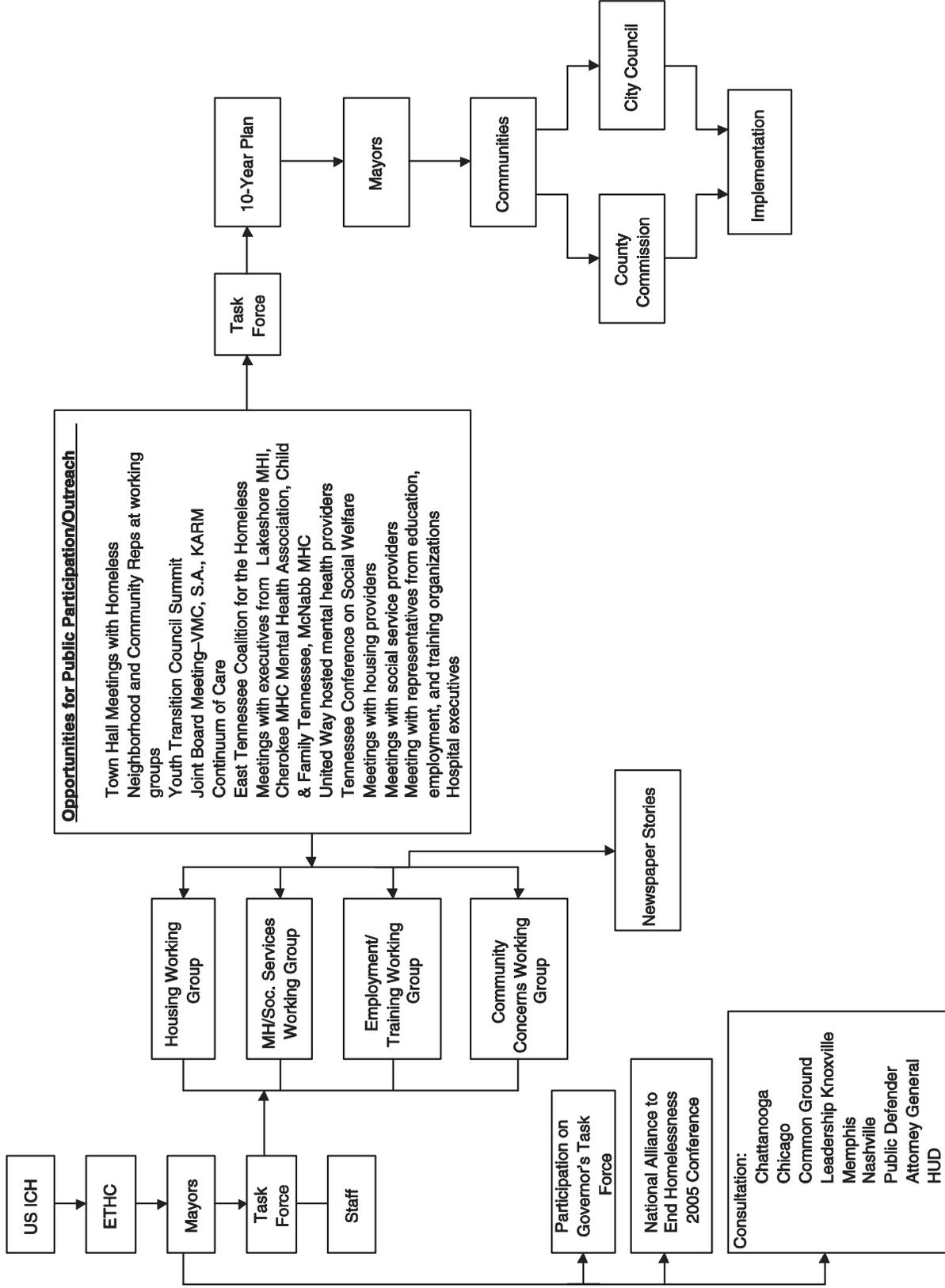
and Knox County can reduce chronic homelessness and perhaps more importantly, prevent others from becoming chronically homeless.

The Ten-Year Plan to End Chronic Homelessness is the beginning of a long-term process. It recognizes the need for adjustments and changes, as well as new innovations to support the community effort to end chronic homelessness. The process that developed this plan—individuals and organizations identifying problems, pointing out barriers, and suggesting solutions—represents an important move toward coordination and systematic change. By continuing to work together and implement a plan, the community can end chronic homelessness and reduce all homelessness within ten years.

The task force was concluding its work as the country experienced the devastation brought by Hurricane Katrina. Never before have so many evacuees existed within the United States. The strategies that have been identified in this report are relevant and applicable to providing services to this group of people. These evacuees are a risk group for homelessness and it is essential that we intervene in an effective manner.

Appendix A: Process

Process



Appendix B: Implementation

Implementation Table

Tasks	Responsible Person/Org	Desired Outcome	Time Frame
<p>Action Step 1: Move People into Housing First</p>			
Place 800 chronically homeless persons in housing during the next ten years.	Homelessness Services Director (HSD)	Previously chronic homeless persons are in stable housing.	Ongoing during ten years
Create 200 units of “housing first” appropriate, permanent housing units for the chronically homeless.	Public and private housing providers, case management and support service providers.	Availability of 200 units of appropriate, permanent housing for chronically homeless individuals. Housing is selected from available stock, or rehabilitated existing housing, or new construction, but must be coupled with case management and support services as appropriate for each individual. Housing is distributed throughout the city and county.	First two years of plan implementation
Evaluate the need for additional units of appropriate, permanent housing units for the chronically homeless on an annual basis and pursue funding to meet those needs.	HSD, Ten-Year Plan Advisory Board, housing providers	Current inventory of housing needs and stable funding are available.	Annual process
Identify and secure funding for the appropriate assertive services to support 200 individuals in housing.	HSD, Ten-Year Plan Advisory Board, housing providers	Stable housing is made possible through availability of supportive services.	First two years of plan implementation
Establish a network to provide intensive and assertive support services to individuals newly placed into housing on an ongoing basis.	Case management coordinator, mental health and other support service providers	Clients to service staffing ratio averaging 10:1, so formerly homeless individuals are able to stay in housing because support needs are being met.	Ongoing, coupled with housing tasks noted above
Identify currently available housing properties, accessible to public transit, with management amenable to accepting chronically homeless tenants if appropriate support services are provided.	HSD, Ten-Year Plan Advisory Board	Appropriate housing is provided in existing SROs, weekly motels, and efficiency apartments, and tenants maintain stability through needed support services.	First two years of plan implementation

The Homelessness Service Director (HSD) refers to the person appointed by the City and County Mayors who is responsible for implementation of this plan.

The Case Management Coordinator (CMC) refers to the agency designed to provide service coordinators as described on page 19 of the plan.

Primary Providers refers to Knox Area Rescue Ministries, the Salvation Army and Volunteer Ministry Center.

Secondary Providers include mental health, medical, and social service providers who serve the homeless, but do not have homelessness as their central or exclusive focus.

HMIS refers to the Homeless Management Information System.

Tasks	Responsible Person/Org	Desired Outcome	Time Frame
Action Step 2: Stop Discharging Into Homelessness Seek agreement from institutions to stop discharging persons to the street.	HSD, Ten-Year Plan Advisory Board, hospitals, mental health hospitals, and state agencies	An agreement is in place and observed by all applicable agencies to assure that institutional discharge does not result in homelessness.	First two years of plan implementation
Develop a systematic discharge procedure whereby persons to be discharged from a hospital, jail or foster care are linked to appropriate community services before discharge.	HSD, Ten-Year Plan Advisory Board, hospitals, mental health facilities, state agencies, East Tennessee Coalition for the Homeless, corrections and foster care agencies	Discharge planning and implementation includes linkage to community services as necessary to help clients maintain housing.	First two years of plan implementation, with ongoing assessment and modification as needed
Connect individuals who are homeless or at risk of becoming homeless to permanent housing and a case manager prior to discharge.	Case Management Coordinator (CMC), discharging institutions, community mental health centers, and state agencies	Discharge planning and implementation includes identification of and placement in appropriate housing, coupled with case management as necessary to help clients maintain housing.	First two years of plan implementation, with ongoing assessment and modification as needed
Advocate for a state plan concerning institutional discharge.	HSD, Ten-Year Plan Advisory Board, and State Interagency Council on Homelessness	The State of Tennessee develops and fully implements a practical discharge planning policy for all applicable state institutions and agencies.	Immediately and ongoing, as the State Interagency Council on Homelessness develops Tennessee's Ten-Year Plan
Action Step 3: Increase Coordination and Effectiveness of Service			
Establish a procedure for assigning a single service coordinator for the homeless client who would assume long-term case management for all services without regard to the site of delivery.	HSD, CMC, and HMIS system coordinator	Homeless clients receive coordinated case management throughout the system.	First two years of plan implementation
Develop coordinated assertive outreach teams to link clients to the service coordinator and supportive services, initiate comprehensive evaluations and treatment plans, and, using the "housing first" model, begin the process of finding appropriate housing.	HSD, Ten-Year Plan Advisory Board, CMC	Grant funding is secured to provide for assertive outreach teams that seek out the chronically homeless and bring them into a coordinated system designed to place and keep them in housing.	First three years of plan implementation

Tasks	Responsible Person/Org	Desired Outcome	Time Frame
Establish a single service entry point for the coordinated service system, utilizing the functionality of the central Homeless Management Information System (HMIS) database.	HSD, CMC, and HMIS system coordinator	HMIS system provides a single entry into the system, regardless of the client's physical location.	First three years of plan implementation
Coordinate the major agency shelter and service providers to clearly define the leadership roles of each, and to eliminate duplication of services to the greatest extent possible.	HSD, ten-year Plan Advisory Board, Executive Directors and Boards of the primary providers	Primary homeless shelters and service providers serve their clients cooperatively and collaboratively maximizing the effectiveness of limited community resources.	First two years of plan implementation, then ongoing
Action Step 4: Increase Economic Opportunities			
Include a comprehensive intake assessment for employability, education and eligibility benefits in all intervention planning.	HSD, CMC, and HMIS system	Upon intake into the system, assessment income and economic stability status and needs and a structured plan is created to maximize current and future economic opportunities.	First two years of plan implementation
Establish income management and financial guardianship programs.	HSD, CMC, primary and secondary providers	Case management is provided to assure clients make application for applicable income benefit programs, including appeals as necessary, financial management assistance is provided to help establish financial stability, and a 'representative payee' service is provided for those who require additional financial oversight.	First two years of plan implementation
Support and expand existing employment and educational training programs to target the chronically homeless population.	HSD, CMC, HMIS system, Homeless service providers, Pellissippi State Community College, Knox County Schools, and career centers	Based on individually assessed needs, clients can receive customized education and job training programs, including life skills, access to GED programs that take into account individual strengths and weaknesses, employment training programs that teach job-specific skills coupled with life skills and basic job retention skills.	First three years of plan implementation
Establish a pre-employment basic skills certificate program.	HSD, CMC, and service providers	Basic skills certificate indicates to prospective employers that the bearer has learned the social and professional skills needed to be a reliable employee.	First three years of plan implementation

Tasks	Responsible Person/Org	Desired Outcome	Time Frame
Bring benefit, employment, and educational programs to the clients through satellite offices and use of telecommunications technology.	HSD, CMC, shelters and service providers, employment and training providers	Satellite offices of employment and training programs within the centrally located shelter system, target service to the homeless, and enable easy and frequent access to these programs. Technological resources such as video links and internet-based programs provide easy access to educational opportunities and enable multi-site offerings at reduced costs.	First three years of plan implementation
Encourage the business community to provide employment opportunities and mentoring programs through use of supportive services and tax incentives for employers.	HSD, primary and secondary providers, career centers, and business associations	Employers provide homeless and formerly homeless persons with jobs as a result of maximizing available resources that can defray the employers risks in offering those jobs.	First year of plan implementation, ongoing

Action Step 5: Implement New Data Collection Methods

Expand HMIS to include hospitals, housing providers, the health department, mental health and substance abuse providers, and correctional facilities.	HMIS coordinator and HMIS Advisory Committee	Shelters, housing, medical, mental health, and social service providers participate in HMIS to prevent homelessness for those at risk, and to better link homeless persons to stable housing.	First four years of plan implementation
Use HMIS data to evaluate outcome data on services delivery.	HMIS coordinator and Ten-Year Plan Advisory Board	HMIS data measures effectiveness and accountability of the homeless service providers, offering feedback needed to continually strengthen the service delivery system.	Immediately and ongoing
Use HMIS to provide single point of entry for homeless services.	HMIS coordinator and primary and secondary providers	HMIS system provides a single entry into the system, regardless of the client's physical location.	First three years of plan implementation
Use HMIS to increase case management and the coordination of care between homeless service providers.	HMIS coordinator and CMC	Homeless clients receive coordinated case management throughout the HMIS system.	First two years of plan implementation
Use HMIS to link housing resources and availability.	HMIS coordinator and housing providers	HMIS system provides current information on available housing, allowing for faster housing placement.	First two years of plan implementation

Tasks	Responsible Person/Org	Desired Outcome	Time Frame
Expand the base of community matching funds support for the HUD HMIS	HMIS coordinator, HSD, and Ten-Year Plan Advisory Board	As HMIS becomes fully implemented, this cost saving resource for the community will be supported to a greater extent through local resources.	Immediate and ongoing throughout plan implementation.
Action Step 6: Develop Permanent Solutions			
Establish a detoxification facility that is directly related to the courts and provides intensive case management, a central location convenient for officers, sufficient staffing, and transportation component.	HSD, local courts and government, mental health and medical facilities, and law enforcement	Funding is secured to establish a comprehensive detoxification facility to address a primary cause of homelessness. The detoxification program provides a more effective outcome-based alternative to repeated hospitalization and incarceration.	First three years of plan implementation.
Integrate law enforcement, ambulance, hospitals, or other service providers that regularly interact with the chronic homeless population possible on HMIS. HMIS would be used more as an implementation tool identifying patterns rather than just an educational database.	HMIS coordinator and Ten-Year Plan Advisory Board	The broader housing, healthcare and social service system participates in HMIS to prevent homelessness for those at risk, and to better link those who are currently homeless to resources that will result in stable housing.	First four years of plan implementation
Develop an aggressive outreach team.	HSD, CMC, primary and secondary providers	An assertive outreach team links intake, case management, medical, mental health and social services directly to the chronically homeless where they are. This assertive service helps those in need to quickly access housing and services, and also makes street homelessness-by-choice become a less viable or acceptable option.	First three years of plan implementation
Use outreach teams to engage homeless in neighborhoods and link to social services.	HSD, CMC, outreach team, and neighborhood associations	An assertive outreach team links intake, case management, medical, mental health, and social services directly to the chronically homeless where they are. This assertive service helps those in need to quickly access housing and services, and also makes street homelessness-by-choice become a less viable or acceptable option.	First three years of plan implementation

Tasks	Responsible Person/Org	Desired Outcome	Time Frame
<p>Action Step 7: Strengthen Partnerships with Faith-Based Organizations</p>			
<p>Develop strategies to increase coordination of services provided by faith-based organizations and with those of other existing service providers.</p>	<p>HSD, Faith-based organizations such as churches, KICCUP, KICMA, and Compassion Coalition</p>	<p>All stakeholders work as partners toward the goal of ending chronic homelessness.</p>	<p>First year of plan implementation, ongoing</p>
<p>Work with faith-based programs to find ways for more effective and efficient utilization of their resources, particularly in providing housing.</p>	<p>HSD, Faith-based organizations such as churches, KICCUP, KICMA, and Compassion Coalition, denomination governance bodies</p>	<p>Faith based and community organizations maximize available resources to not only meet short-term needs, but also to reach the goal of ending chronic homelessness in our community.</p>	<p>First year of plan implementation, ongoing</p>
<p>Develop a comprehensive educational campaign to help churches maximize their impact on the chronic homeless problem (“hand up” vs. “hand out”).</p>	<p>HSD, Faith-based organizations such as churches, KICCUP, KICMA, and Compassion Coalition</p>	<p>Congregations that wish to help end chronic homelessness are provided more options and opportunities to contribute significantly to meeting this goal.</p>	<p>First two years of plan implementation</p>
<p>Involve the Faith-based associations (e.g., Compassion Coalition, KICCUP, and KICMA) in coordinating communications.</p>	<p>HSD, KICCUP, KICMA, Compassion Coalition, and denomination associates and boards</p>	<p>The Faith-based associations that serve as a community resource and provide leadership in the faith community and guidance to the implementers of this plan.</p>	<p>First year of plan implementation, ongoing</p>
<p>Action Step 8: Recognize Homelessness as a Community Challenge</p>			
<p>Develop a coordinated public service announcement (PSA) campaign – possibly including a number to call when dealing with problems (e.g. drunkenness, etc.).</p>	<p>HSD and East Tennessee Coalition for the Homeless</p>	<p>Working with the implementers of this plan, the East Tennessee Coalition for the Homeless provides information to the community at large on how to work toward ending chronic homelessness.</p>	<p>First two years of plan implementation, ongoing</p>
<p>Coordinate existing agencies to provide joint PSAs to reduce advertising costs.</p>	<p>HSD and East Tennessee Coalition for the Homeless</p>	<p>Working with the implementers of this plan, the East Tennessee Coalition for the Homeless provides information to the community at large on how to work toward ending chronic homelessness.</p>	<p>First two years of plan implementation, ongoing</p>

Tasks	Responsible Person/Org	Desired Outcome	Time Frame
Work with media to ensure that agencies speak with one voice, through multiple messages that emphasize how chronic homelessness is a community problem and everyone's priority.	HSD, East Tennessee Coalition for the Homeless	The community is better informed about homelessness and how to participate in the effort to end chronic homelessness.	First two years of plan implementation, ongoing
Coordinate PSAs with Faith-based associations (e.g., Compassion Coalition, KICCUP, KICMA).	HSD, East Tennessee Coalition for the Homeless	Faith-based associations and the East Tennessee Coalition for the Homeless provide ongoing information to the community about working together to end chronic homelessness	First two years of plan implementation, ongoing
Involve neighborhoods to effectively reduce the number of homeless in neighborhoods and community wide.	HSD, East Tennessee Coalition for the Homeless	Neighborhoods actively support services for the homeless and homeless individuals have day programs and activities designed to end homelessness.	First two years of plan implementation, ongoing
Action Step 9: Prevent Homelessness			
Identify persons at risk for homelessness and link with social services.	CMC, HMIS coordinator, and agencies best positioned to provide prevention services	Available data identifies groups at risk and early intervention prevents homelessness.	First four years of plan implementation, ongoing
Develop services that support housing stability, such as rent and utility assistance.	HSD, Ten-Year Plan Advisory Board, and social service agencies	Loss of housing is prevented through emergency rent and utility assistance programs at a significant savings over the cost of finding and reestablishing housing after homelessness occurs.	First two years of plan implementation, ongoing
Break the cycle of recurrent homelessness through intensive case management and supportive housing.	CMC, primary and secondary agencies	Emergency assistance programs for rent and utilities are made more cost effective through provision of preventive case management designed to help clients avert crisis situations in the first place.	First two years of plan implementation, ongoing
Develop discharge protocols for mental health, correctional, and youth institutions that will prevent homelessness.	HSD, Ten-Year Plan Advisory Board, mental health facilities, correctional institutions and child custody facilities, and East Tennessee Coalition for the Homeless, CMC	Discharge planning and implementation includes linkage to community services as necessary to help clients secure and maintain housing.	First two years of plan implementation, with ongoing assessment and modification as needed

Tasks	Responsible Person/Org	Desired Outcome	Time Frame
Recognize the special needs of youth making the transition out of state custody.	HSD, Tennessee Department of Children's Services, and Youth in Transition Council	Youth coming out of state custody are provided the contact network and resources needed to successfully begin life as young adults. Help is provided to fill the gap of missing family-based support networks.	Throughout plan implementation
Consistently evaluate and measure which programs and strategies are effective in preventing and reducing homelessness.	HSD, Ten-Year Plan Advisory Board, HMIS coordinator, and all primary and secondary providers.	Success is better assured through ongoing review of programs and strategies as broader community circumstances continue to change. Strategies will be changed as needed in response to empirical evidence, as well as to changes in the broader social system, economy and environment.	Throughout plan implementation

Appendix C: Glossary

Glossary

CDBG (Community Development Block Grant Program): Authorized by the Housing and Community Development Act of 1974 replacing several community development categorical grant programs. CDBG provides eligible metropolitan cities and urban counties (called “entitlement communities”) with annual direct grants that they can use to revitalize neighborhoods, expand affordable housing and economic opportunities, and/or improve community facilities and services, principally to benefit low- and moderate-income persons.

Consolidated Plan: Developed by local and state governments with the input from citizens and community groups, the Consolidated Plan serves four functions: 1) it is a planning document for each state and community, built upon public participation and input; 2) it is the application for funds under HUD’s formula grant programs (CDBG, HOME, ESG, and HOPWA); 3) it lays out local priorities; 4) it lays out a 3-5 year strategy the jurisdiction will follow in implementing HUD programs.

Continuum of Care: A program to help more than 330,000 homeless Americans get housing, job training, child care, and other services. The Continuum of Care, which is the centerpiece of the federal policy on homelessness, stresses permanent solutions to homelessness through comprehensive and collaborative community planning. In 1997, the Continuum of Care was one of 25 finalists, out of 1,400 competitors, for the prestigious Innovations in American Government Award that is awarded by the Ford Foundation and the Kennedy School of Government at Harvard University. HUDWEB 1/4/99

ESG (Emergency Shelter Grant): A federal grant program designed to help improve the quality of existing emergency shelters for the homeless, to make available additional shelters, to meet the costs of operating shelters, to provide essential social services to homeless individuals, and to help prevent homelessness. HUDWEB, Continuum of Care and Veterans Programs Glossary

Federal Home Loan Bank Board (FHLBB): Supervises Federal Home Loan Banks, which supply member banks with credit to enhance their services as savings depositories and as lenders of mortgage funds.

HOME: Provides funds to local governments and states for new construction, rehabilitation, acquisition of standard housing, assistance to home buyers, and tenant-based rental assistance.

HOPE III: Provides financial assistance for the creation of home ownership opportunities for low to moderate income, first-time home buyers utilizing single family properties.

HOPE VI: HOPE VI, or the Urban Revitalization Program, enables demolition of obsolete public housing, revitalization of public housing sites and distribution of supportive services to the public housing residents affected by these actions.

Homeless Person: In general is:

1. an individual who lacks a fixed, regular, and adequate nighttime residence; and
2. an individual who has a primary nighttime residence that is—
 - a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
 - an institution that provides a temporary residence for individuals intended to be institutionalized; or
 - a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

A ***chronically homeless person*** is an individual who has been homeless for over a year or has been homeless multiple times over a period of several years.

Housing Finance Agencies (HFA): State or local agencies responsible for financing and preserving privately owned low- and moderate-income housing within the state or locality. In our state it is THDA (Tennessee Housing Development Agency).

Low Income: Income that does not exceed 80% of area median income.

Low Income Housing Tax Credits (LIHTC): A way of obtaining financing to develop low-income housing. Government programs provide dollar-for-dollar credit toward taxes owed by the housing owner. These tax credits can be sold, or used to back up bonds that are sold, to obtain financing to develop the housing.

Notice of Funding Availability (NOFA): Published in the Federal Register to announce competitive funding programs.

Public Housing: Apartments for low-income people operated by local housing agencies. Public housing is limited to low-income families and individuals. HUD sets the lower income limits at 80% and very low income limits at 50% of the median income for the Knoxville metropolitan area. A Public Housing Authority (PHA) determines tenant eligibility based on: 1) annual gross income; 2) whether the applicant qualifies as elderly, a person with a disability, or as a family; and 3) U.S. citizenship or eligible immigration status. If the applicant is determined to be eligible, the PHA will check references to make sure the individual and/or family will be good tenants. PHAs will deny admission to any applicant whose habits and practices may be expected to have a detrimental effect on other tenants or on the project's environment.

Section 8 Housing Choice Vouchers (formally called "Section 8"): Issued to tenants by Public Housing Authorities (PHAs) to allow individuals to find his/her own place to rent, using the voucher to pay for all or part of the rent. To be eligible, individuals can earn no more than the Housing Assistance Payments Program, authorized by the Housing and Community Development Act of 1974.

Section 202: Grants and annual operating funding for the construction or rehabilitation of housing for the elderly.

Section 811: Grants and annual operating funding for the construction or rehabilitation of housing for persons with disabilities.

Shelter Plus Care (S+C): The Shelter Plus Care Program provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded from sources outside the program. Shelter Plus Care (S+C) is a program designed to provide housing and supportive services on a long-term basis for homeless persons with disabilities (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome (AIDS) or related diseases) and their families who are living in places not intended for human habitation (e.g., streets) or in emergency shelters. The program allows for a variety of housing choices, and a range of supportive services funded by other sources, in response to the needs of the hard-to-reach homeless population with disabilities.

Single-Room Occupancy (SRO): The Supportive Housing Program promotes the development of supportive housing and supportive services, including innovative approaches that assist homeless persons in the transition from homelessness and enable them to live as independently as possible. SHP funds may be used to provide transitional housing, permanent housing for persons with disabilities, innovative supportive housing, supportive services, or safe havens for the homeless.

Ten-Year Plan: A detailed method, formulated beforehand, of accomplishing something over a period of one hundred and twenty months or three thousand six hundred and forty-five days or eighty-seven thousand, four hundred and eighty hours or...well, you get the drift.

Youthbuild: A HUD initiative that funds programs that help young high-school dropouts obtain education, employment skills, and meaningful on-site work experience in a construction trade. HUD Website @www.hud.gov:80/progdesc/youthb.html

Appendix D: Acknowledgements

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