



The Strategic Framework for Ending Chronic Homelessness in Nashville

**Presented by
The Mayor's Task Force to End Chronic Homelessness**

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Compiled by
 **MANAGEMENT
SOLUTIONS
GROUP LLC**

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Preface

In April 2004, Mayor Bill Purcell appointed a twenty-six member task force to develop Nashville's 10 year plan that will meet the federal government's goal to end chronic homelessness. The task force includes a broad array of interests many of which had never been at the table together discussing the issue. Members include advocates for the homeless, representatives of the faith community, downtown property owners, government officials, business and political leaders.

This Strategic Framework highlights the key issues and the task force recommendations after working over a four- month period. It is best understood as a framework for strategic directions the task force has identified. It is a solid foundation on which to build a more complete plan for addressing the complexities of chronic homelessness.

The recommendations that are outline in this document have been formulated by four separate Work Groups functioning independently: Housing, Health, Economic Stability and Systems Coordination.

The Work Groups have produced significant information beyond what is included in the framework that will be helpful in developing a complete plan. The next stage of the planning process will focus on integrating the recommendations into a more cohesive whole; engaging more community representatives; and adding action steps, funding strategies and outcome measures.

Task Force Members

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Introduction

A Call to Action

Homelessness – especially chronic homelessness – constitutes a multi-faceted challenge facing communities across our nation. The homeless are a visible reminder that some citizens do not possess one of the most basic ingredients of human existence – shelter from the elements. Homelessness arises from multiple causes and its complexity can easily confound the government, law enforcement, health care, and social service agencies. And homelessness affects us all – it is, by definition, human suffering that takes place in public: a daily tragedy of the few that touches the many.

In a city like Nashville, recognized across the nation for its excellent quality of life, the plight of our chronically homeless population is especially poignant and problematic. It is not that our community has ignored the problem – far from it. But, at the end of the day, research and programs of the past have not marshaled the commitment, resources, and level of coordination required to solve homelessness in Nashville.

It is time to take up the challenge of chronic homelessness in Nashville. Our federal government has set the goal of ending chronic homelessness. In April of 2004, Mayor Bill Purcell appointed a task force charged with making certain Nashville meets the federal goal within ten years. By bringing community leaders, government, and service agencies together to take on the multiple components of chronic homelessness, Nashville will map a coordinated system to address this important issue.

In the 2004 count of homeless in Nashville, volunteers and Metro officials counted 1,800 homeless individuals, including 900 who met the Department of Housing and Urban Development's definition of chronically homeless.

The U.S. Department of Housing and Urban Development defines a chronically homeless person as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more or has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter during that time.

The United States Interagency Council on Homelessness estimates that chronically homeless persons make up about 10 percent of all homeless persons, but consume 50 percent of available resources.

Nashville boasts a 20-year history of research and planning that has generated increased services for the homeless population. These achievements have been critical yet limited in scope and often fragmented. This ten-year plan will give Nashville a guide to end chronic homelessness, improving the lives of many and improving our community. This is the first time that a broad representation of the Nashville community has convened to create a vision and concrete plan to end chronic homelessness.

Introduction: The Planning Approach

Mayor Purcell named a task force that includes public officials; business and faith communities; social service agency representation; homeless individuals and committed citizens to a five-month job of designing the plan. Individuals who are chronically homeless do not fit one general description. However, they do share common needs, including affordable housing, adequate income, and health care. Given those common needs, the task force divided the planning into four work groups: **housing, health, economic stability, and systems coordination.**

Housing

A variety of housing options that ensure long-term stability must be available to and affordable for, chronically homeless persons. Permanent supportive housing is critical. But to move from chronic homelessness, there must be adequate emergency and transitional housing options as well.

Health

Individuals who experience chronic homelessness need access to a range of comprehensive services that respond to their complex and multiple health and behavioral health care needs. Homeless individuals who meet HUD's definition of chronically homeless may need services such as mental health case management or drug treatment in order to remain in stable housing and maintain employment.

Economic Stability

Most individuals who become homeless are eligible for assistance from public and private systems of care, including benefits that can assure steady incomes. These systems are fraught with obstacles that impede access. Additionally, job training, readiness and placement are needed for chronically homeless persons who are able to work.

Systems Coordination

In addition to the components already discussed, the broad system of services and housing must be as seamless and coordinated as possible. Nashville must continue to develop a system that encourages chronically homeless individuals to enter permanent housing and access services. Service providers must coordinate and communicate to avoid duplication and utilize resources effectively.

The **four work groups** were comprised of key individuals from across the city and were charged with creating a set of recommended goals. To create such a plan requires commitment and ownership from those Task Force work group members as well as from other stakeholders. The four work groups sought input from the homeless, business, faith community, and service providers. They researched other cities' plans and investigated best practices. They assessed current and past efforts in Nashville to impact chronic homelessness. And finally, they agreed to a finite set of recommended goals for the ten-year plan.

By focusing on the chronically homeless population and working to end chronic homelessness all the homeless populations are better served.

Introduction: National Perspective on Homelessness

Who Experiences Homelessness?

According to the National Alliance to End Homelessness, over the course of a year, as many 3.5 million individuals or nearly 11% of the poor population become homeless. "A Status Report on Hunger and Homelessness in America's Cities 2002", a 25-city survey published by the U.S. Conference of Mayors, documented a 19% increase in homelessness, the steepest rise in a decade.

Age

The 2003 U.S. Conference of Mayors' survey of hunger and homelessness in 25 cities found that families with children accounted for 40% of the homeless population. It also found that unaccompanied minors constitute 5% of the urban homeless population.

Gender and Ethnicity

Most studies show that single homeless adults are more likely to be male than female. In the 2003 U.S. Conference of Mayor's survey, single men accounted for 41% of the urban homeless population while single women accounted for 14%.

Like the total U.S. population, the ethnic makeup of homeless populations varies by geographic location. In its 2003 survey, the U.S. Conference of Mayors found that the homeless population in the 25 cities surveyed was 49% African-American, 35% Caucasian, 13% Hispanic, 2% Native American and 1% Asian.

Recent studies in New York and Philadelphia

Studies in New York and Philadelphia identified three patterns of homelessness: transitional, episodic, and chronic.

Transitional Homelessness describes a single episode of homelessness that is relatively short and often occurs in times of economic hardship and/or temporary housing loss. The majority of individuals who fit into this category are families and single adults.

Episodic Homelessness refers to recurrent periods of homelessness. Typically individuals who experience this are younger and use the shelter system, and often have substance addictions. Research indicates that 9 percent of the single adult homeless population fit the pattern of episodic homelessness.

Chronic Homelessness refers to an extended episode generally lasting two or more years. Homeless persons in this category are more likely to have a serious mental illness, sometimes along with a substance addiction, unstable employment histories, and histories of hospitalization and or incarceration.

Source: Culhane, Dennis, Stephen Metraux and Trevor Hadley. *The Impact of Supportive Housing for Homeless Persons with Severe Mental Illness on the Utilization of the Public Health, Corrections and Emergency Shelter System*. Center for Mental Health Policy & Services Research University of Pennsylvania. 2001.

Introduction: Local Perspective on Homelessness

Count of Homeless

On March 24, 2004, volunteers in Nashville helped to identify 447 individuals sleeping outside. On that night, shelter providers throughout the city provided a count of 1,358 individuals residing in their facilities. Together, a total of 1,805 individuals were counted as homeless during this point-in-time survey.

Surveying all homeless persons at a point in time is inherently limited by:

- The transient nature of homelessness
- The change in camp locations
- Incomplete numbers due to cheap motel rental by multiple homeless persons
- Homeless families in cars moving further out of the central service area
- The expansive geographic area of Davidson County as a count area

Gender and Ethnicity

In the March 2004 count, the majority of individuals sleeping outdoors were males. Although it was not always possible for volunteers to ascertain gender, 68% of the unsheltered population was estimated to be male.

As in national data, individuals of color were over-represented among the homeless in both the outdoor count and the count of homeless individuals residing in shelter programs. At least 38% of the individuals sleeping outdoors were confirmed to be African American. 50% of the homeless individuals in shelters were African American. Data from the 2000 Census reports the percentage of African American in Nashville-Davidson County to be 25.9%.

Conditions of the Homeless

When describing the conditions of chronic homelessness, it's important to understand that some of this population will periodically, or even frequently, stay in shelters, while others will often live outdoors. Of the sheltered single homeless population counted on March 24, there is a prevalence of chronicity, substance abuse and mental illness. In the professional estimates of shelter providers responding to Metropolitan Development and Housing Agency's (MDHA's) point-in-time survey, *42% of the homeless single persons sheltered that night met the HUD definition of "chronic"*.

All of the shelter programs serving single individuals indicated that 55% or more of their residents had substance abuse issues. Of the 13 programs, 11 estimated the incidence to be 74% or higher and 6 out of the 13 programs said that 100% of their residents are dealing with these issues. Estimates of single persons sheltered that evening who suffer from mental illness averaged 37%.

The pervasiveness of addiction and mental illness was not only unique to the shelters serving single homeless individuals, but was also noted in shelters serving women and children. In shelters serving single women and families with children, estimates of persons who suffer from mental illness averaged 27%. In these family shelter programs, an average of 51% of the residents were estimated to have substance abuse problems.

Of the 1,358 persons counted in "shelter" programs, 296 fell into the "family/ children" heading which is not quite 22% of the total.

Nashville's Perspective

What's In Place Now?

Over the past 20 years much has been and continues to be done to address the housing and service needs of homeless individuals. As a result of public and private funds and the commitment of hundreds of generous volunteers, the spectrum of homeless programs is broader. In spite of these efforts, there are still chronically homeless persons.

Shelter Beds and Transitional Housing

Emergency shelter beds in Nashville for homeless families, youth and single women currently number 230. Current available shelter beds for single adult males total approximately 912. Bed availability for all homeless individuals is reduced each spring due to the seasonal nature of the Room in the Inn program which shelters up to 200 homeless individuals each night at area congregations and is closed mid-April to mid-November. Nashville's stock of longer-term transitional housing is scarcer: 251 units of transitional housing exist for homeless individuals, and 130 units for homeless families.

Permanent Housing

Nashville currently has an inventory of 807 permanent housing opportunities that are targeted for homeless individuals. 56 units are under development.

Prevention Services

Efforts to prevent homelessness focus primarily on financial assistance to pay rent and utility arrearages. Several agencies offer this form of assistance to individuals and families facing imminent threat of homelessness. Key players include Metro Social Services, Metro Action Commission and the Campus for Human Development. Area churches, Big Brothers and Ladies of Charity also contribute to this prevention effort.

Outreach Services

Outreach workers canvass areas known to be frequented by homeless persons as well as area shelters and feeding programs. Outreach services are provided through local agencies including:

- Metropolitan Health Department
- Metropolitan Development and Housing Agency
- Mental Health Cooperative
- Operation Stand Down
- Oasis Center
- Nashville CARES

Supportive Services

Services available to homeless individuals in Nashville include emergency services, feeding programs, assessment and treatment for mental health issues, alcohol and drug addictions, case management, health care, employment services, educational services, child care, transportation, information and referral, and financial assistance.

Peter B. is a 58-year-old who suffers from severe mental illness. Peter comes to the Lodge for shelter and food and is often delusional and off his medicine. Because of insurance limitations, Peter is denied inpatient psychiatric treatment. Without his medicine, he will not seek outpatient treatment. Not a great deal is known about Peter because of his inability to articulate his history with any cohesiveness. He believes he is a country music star. He sings and plays the guitar poorly. He says he has a house somewhere in a rural Tennessee town that he can't stay in because it bothers him to be confined. He owns an old car that he drove to Nashville. According to him, he has worked all his life and now a lawyer handles his financial affairs. He can't understand this and in telling about it often reacts in angry outbursts. It is not known if he has family or has ever been married, but it doesn't appear he has anyone to care for him. He is a lost and lonely man who appears physically as well as mentally sicker with each visit. He has been coming to the Lodge, on and off, for about a year.

Nashville's Perspective: Past Planning Efforts

This strategic framework for addressing chronic homelessness builds on a long history of planning for the homeless in Nashville. Since 1984, several plans or studies have been conducted on issues related to homelessness.

1984 Council of Community Services

- *Broad based effort*
- *Creation of Nashville Coalition for the Homeless*
- *Resulted in the creation of the Downtown Clinic which was funded by Robert Wood Johnson and Pew Memorial Trust*

1986 MDHA's Task Force on Homelessness

- *Detailed the demographics of the homeless population*
- *Recommendation made resulting in creation of the Guest House and the Campus for Human Development*
- *Encouraged Metro to adopt a policy statement taking responsibility for the homeless in Nashville*
- *Recognized the need for more affordable housing and for a central database of homeless population*

1986 and 1987 The Nashville Coalition for the Homeless and Center City Committee "Plan for Nashville"

- *Addressed issues of housing, mental illness, substance abuse, employment and loss of community among the homeless population*
- *Defined homeless sub-populations*
- *Recognized the need for additional outreach and case management, for affordable housing, for improved access to mainstream services (SSI) and for services for developmentally disabled homeless persons*

1989 Task Force on Affordable Housing

- *Set goal to reduce Nashville's affordable housing gap by 50% by 2000 and produce 14,000 units of affordable housing*
- *Recommended the creation of Affordable Housing Inc.*
- *Recognized the need for increasing housing opportunities for special needs groups*

1998 The Metropolitan Health Department's Voice of the Homeless Survey

- *Surveyed 630 homeless persons at 20 sites over a two month period of time*
- *Found that 60% of those surveyed had lived in Nashville before becoming homeless*
- *Found that 60% reported being first time homeless*
- *Demonstrated that only a small percentage of those surveyed received mainstream benefits*

2001 Downtown Homeless Outreach Initiative Report to the Inter-Departmental Task Force on the Homeless

- *Included outreach efforts focused on downtown Nashville*
- *Focused on the chronically homeless population*
- *Attempted to formally liaison with the downtown business community*

2002 The Metropolitan Health Department Needs Assessment

- *Recognized many of the same needs identified in 1986*

2003 The Providers Survey

- *Suggested the reestablishment of the Nashville Coalition for the Homeless*
- *Recommended creating 100 new permanent housing units for homeless individuals*
- *Recommended increasing the shelter beds for families with older children*
- *Recommended simplifying the enrollment process for benefits such as SSI, food stamps, and TennCare*
- *Recommended quantifying the extent of homelessness in Nashville*

Nashville's Perspective: Past Planning Efforts

2003 Homeless Individuals in Nashville- Pinpointing Numbers and Needs in Davidson County by Vanderbilt University

- *Recommended a focused coordinated strategic plan to be implemented*
- *Recommended the development of a technology based tracking system to store critical information*
- *Recommended the creation of a common intake form for all services to the homeless*

All these efforts had their merit in informing the city, creating segments of needed infrastructure and improving pockets of services. In looking back at all this work, it is evident that to have a significant impact, a clear focus has to be determined, the vision has to be longer than 3-5 years, and the commitment to the plan has to be expanded to include the entire city. The work done dating back to 1984 has brought Nashville to this point where a unified coordinated 10-year plan is the logical next move.

Root Causes of Homelessness in Nashville, Tennessee

This extensive, but not exhaustive, list of factors must be considered when dealing with the chronically homeless.

Lack of Affordable Housing Nashville's housing market does not provide enough units affordable to those on disability, Temporary Assistance for Needy Families or who work minimum wage jobs.

Physical Disability Profound injuries, illness, or birth defects. Socially debilitating physical traits such as disfigurement, dental deficiencies, or obesity.

Mental Illness Schizophrenia, bipolar disorder, chronic depression and other severe and persistent mental illnesses.

Developmental Disabilities Low IQ or head injury that hinder intellectual functioning.

Severe Trauma A history of domestic violence, abuse, combat, catastrophic loss of family, or a similar traumatic event.

Educational Deficiencies The inability to read/write, the lack of basic academic skills or no high school diploma.

Learning Disabilities Dyslexia, ADD and other disorders which interfere with educational and life functioning.

Addiction Drugs, alcohol, sex, gambling and other addictions.

Domestic Violence partner abuse forces victims out of their homes and into shelters or on the streets.

Severe Family Dysfunction Abusive parents, broken homes, multiple residences/caregivers.

No Family or Significant Support System Total lack of family support due to death, alienation, or institutional childhood.

Criminal History The existence of a criminal record that seriously limits opportunity.

Limited Occupational Skill Set The inability to do anything beyond the most basic manual labor.

Life Skill Deficiency The inability to manage the most basic life functions such as hygiene, housing, transportation, finances, and relationships.

Transportation Deficiencies The inability to purchase, maintain, insure, or legally drive a car or obtain transportation through public or private means.

Prior Long Term Institutionalization An extended stay in juvenile institutions, mental hospitals, prison or other institution.

Generational Poverty Two or more generations dependent on public assistance or charity for basic living needs that has fostered an attitude of hopelessness.

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**Based on document from Campus for Human
Development*

Mayor's Task Force to End Chronic Homelessness Strategic Framework

Our vision: *Within 10 years, Nashville will be a community without chronic homelessness by assuring access to safe, affordable and permanent housing with a comprehensive array of supportive services.*

Guiding Principles

1. Permanent Supportive Housing is a priority – individuals moving into housing as quickly as possible

2. Continuum of Supportive Services including health, mental health, substance abuse, outreach and other services are available, tailored to meet an individual's need and recognize a person's ability to change. Services are essential to achieving long-term housing stability.

3. Systems Coordination and collaboration between public and private sector service providers is critical and necessary for long-term success.

4. Self Sufficiency includes access to income assistance (SSI, SSDI,) and/or employment opportunities and is the best way to assure individuals ability to maintain housing and live independently.

5. Community Ownership is understanding that homelessness impacts the whole community – every individual, agency, and business – particularly those operating in the central city. Solutions to end homelessness can and must be found in every public and private sector entity.

6. Voice and Choice of homeless individuals is a must, both in their individual circumstances and in the systems that affect them.

7. Results-Driven framework must be imbedded in all our services, programs, and endeavors. Success must be clearly defined and measured. Only services proven effective will be funded.

8. Prevention strategies included as the only lasting and cost-effective solutions to chronic homelessness.

In creating a set of recommendations, work groups focused on a standardized series of tasks. These tasks included defining key terms and identifying the relevance of the work group area to the guiding principles. Additional research was conducted on the current status of the work group topic in Nashville, existing gaps and barriers, and best practices implemented in other cities. Taking all this into consideration, each work group identified a set of recommendations. The findings and recommendations of the work group efforts are reflected in the following sections of this framework, Housing, Health, Economic Stability, and Systems Coordination.

"Everyone has the right to a standard of living adequate for the health and well-being of themselves and their family, including food, clothing, housing, medical care and necessary social services." Universal Declaration of Human Rights, United Nations

Strategic Framework: Housing

Homelessness is linked to a shortage of housing for individuals and families with very low incomes. The vast majority of individuals experiencing homelessness have incomes that fall far below the typical threshold calculated for most affordable housing. Monthly rents of \$0 to \$160 are the maximum that can be paid by most homeless individuals. Nashville's housing sector for homeless individuals has experienced minimal development in the past two decades.

Key Definitions

Affordable housing is the term used to describe housing opportunities that are available to households earning 80% or less of median family income that do not cost more than 30% of gross monthly income.

Permanent Supportive Housing (PSH) is the term used to describe permanent, affordable housing linked to health, mental health, employment and other support services.

Gaps and Barriers

Addressing barriers to developing housing will be essential to the successful expansion of affordable housing for homeless individuals. Barriers include:

- Harsh attitudes toward homeless individuals from the larger Nashville community
- The "Not in my back yard" syndrome makes it difficult to locate housing for homeless and chronically homeless individuals
- The will to create structures and systems that support housing development for homeless individuals has been limited in Nashville to this point
- Land use policy and zoning restrictions have created costly obstacles
- Hopelessness (chronically homeless individuals often are early in the "stages of change" process, which means that motivation for life-change can be low)
- Chronically homeless individuals are resistant to the current systems of care; at the same time, systems of care have not found successful engagement methods
- Requirements of current housing and shelters do not accommodate chronically homeless individuals who are "treatment resistant" or in early stages of change (i.e., rules and regulations and program expectations)
- Resources needed for very low income housing development have been extremely limited

Strategic Framework: Housing

Best Practices

Permanent supportive housing (PSH) was implemented in the early 1990's. Demonstration studies showed that PSH was very successful at stabilizing tenants in housing with retention rates at about 85% after two or more years. The following are common tenets of PSH programs:

1. The housing is affordable for individuals with SSI income.
2. The housing is permanent (tenant/landlord laws apply, refusal to participate in services is not grounds for eviction).
3. The housing is linked to a broad base of support services.
4. The supportive services are flexible and individualized, not program driven.
5. PSH is grounded in the principles of integration of services, personal control, accessibility, and autonomy.

The most comprehensive case for supportive housing is made by the University of Pennsylvania's Center for Mental Health Policy and Services Research. Researchers tracked mentally ill individuals who were homeless in New York City for two years. Among their conclusions was that supportive permanent housing created an average annual savings of \$16,282 per person by reducing the use of public services, including: 72% savings resulting from a decline in the use of public health services; and 23% savings from a decline in shelter use.

Chronic Homeless Production Chart

Housing Activity	Need	Estimated Cost	Assumptions
Development of newly constructed permanent supportive housing units	486	\$19,440,000	<ol style="list-style-type: none"> 1. Need is based on March 2004 Homeless Count 2. Chronic includes those found during the 2004 Count to either be unsheltered or in a homeless facility and identified by the provider as chronically homeless 3. New construction cost is based on \$40,000 per unit 4. Rehab/Conversion cost is based on \$30,000 per unit 5. Rental assistance cost is based on \$6000 per individual
Rehabilitation/Conversion activities yielding new permanent supportive housing units	486	\$14,580,000	
Rental assistance/subsidies	972	\$5,832,000	
		TOTAL \$39,852,000	

Non-Chronic Homeless Production Chart

Housing Activity	Need	Estimated Cost	Assumptions
Development of newly constructed permanent supportive housing units	397	\$15,880,000	<ol style="list-style-type: none"> 1. Need is based on March 2004 Homeless Count 2. Non-chronic includes those found during the 2004 count who do not meet the HUD definition of chronic homelessness 3. New construction cost is based on \$40,000 per unit 4. Rehab/Conversion cost is based on \$30,000 per unit 5. Rental assistance cost is based on \$6000 per individual
Rehabilitation/Conversion activities yielding new permanent supportive housing units	397	\$11,910,000	
Rental assistance/subsidies	794	\$4,764,000	
		TOTAL \$32,554,000	

Recommendations

1. Develop Permanent Supportive Housing (PSH) Opportunities for Homeless Individuals and Families. PSH is housing made affordable to homeless individuals that has links to health, mental health, employment and other social services. By providing homeless individuals with a way out of expensive emergency public services and back into their own homes, PSH not only improves the lives of its residents but also generates significant public savings. Currently Nashville has an affordable housing inventory of 807 housing opportunities targeted to homeless individuals.

PSH development includes the following features:

- Successful housing options for the homeless population must include a variety of options to promote choice and "goodness of fit"
- Adequate development along the housing continuum includes a combination of scattered-site (single units, duplexes, etc.), modular, congregate living and single room occupancy units
- Development can be accomplished through construction, renovation, or master leasing of existing housing stock
- Low-density, de-concentrated sites are preferred. The Housing Work Group defines low density as fewer than 20 units per development. As the density of housing increases (up to 20 units), supportive services will need to increase in proportion.
- PSH must have access to public transportation, and be located within walking distance of essential services and amenities (food, laundry facilities, bus routes, etc.)
- Establishment of community as peer support is linked to long-term housing stability
- Ongoing assessment and evaluation of adequate housing development for homeless persons will be conducted utilizing annual counts and other monitoring efforts

2. Identify All Existing Funding Sources while developing new funding initiatives to finance the permanent supportive housing. When considering financing for permanent supportive housing, three distinct costs must be kept in mind: funds for housing development (rehab and new construction), funds for rental subsidies (ongoing), and funds for support services (ongoing).

Funding Opportunities to explore:

- Property transfer tax for housing development (THDA -HOUSE Program)
- Support from THDA to develop an innovative pilot housing project that could be used as a state model or "best practice" of homeless housing
- Local housing trust fund with a recurring, dedicated funding source
- Tennessee's federal HOME dollars for Community Housing Development Organizations specifically developing housing for homeless population
- HUD 811, 202, 221 (d) and 236 housing development programs
- Community Development Block Grant (CDBG) and HOME allocations to the Nashville area
- HOPWA, Ryan White, and SAMHSA federal funding
- THDA low income housing tax credits (LIHTC) and bond financing programs
- Federal Home Loan Bank of Cincinnati and Atlanta under the Affordable Housing Program
- Local allocation for low-income housing development
- HUD Continuum funding
- Instate local development fee for housing development
- Development financing through the Nashville Housing Fund as well as local and regional banks
- Faith-based community initiatives and investments

Strategic Framework: Housing

3. Establish leadership committee to secure lead private gifts for housing development. This initiative will be directed by leaders in the public and private sectors. This fund could be administered within an existing nonprofit (i.e., The United Way or The Community Foundation of Middle Tennessee). The faith community, business community, foundations, corporations and individuals will be educated on this philanthropic opportunity. Philanthropic gifts would be focused on the one-time expense of housing development.

4. Develop a community education initiative regarding homelessness in Nashville. The Housing Committee identified public attitude as a primary barrier to housing development. Community education on the permanent supportive housing model will be essential to successful implementation. A broad community education campaign should be initiated early in the housing development phase. To effectively penetrate discrimination, this education campaign will include: the root causes of homelessness, extent of homelessness, human and public cost of homelessness and cost effectiveness of best practice interventions.

5. Address discrimination against homeless individuals, which violates human rights and dignity. If Nashville is to be “One City All People” and housing opportunities are to be developed, discrimination issues must be addressed. We recommend that the Metro Human Relations Commission address homeless discrimination issues including the criminalization of homelessness.

6. Apply to the Nashville Civic Design Center for consultation on housing design that can meet homeless resident and neighborhood needs.

7. Establish an emergency fund for the purpose of preventing chronic homeless individuals and families from relapsing into homelessness after they move into permanent housing.

These interventions would be limited to chronically homeless individuals who are already in the coordinated system of care developed for support services.

Interventions could include supportive services, rental assistance, homemaker services, addiction and mental health treatment. Keeping people in housing is easier and less costly than reestablishing them in housing.

8. Train service providers on the permanent supportive housing model.

Permanent Supportive Housing is a new concept for many Nashville service providers. Training will be needed at the local level to assist providers with implementation and management skills necessary to develop this new service approach. The training needs to include: stages of change, motivational interviewing, harm reduction intervention models, low demand housing operations and management.

Strategic Framework: Health and Behavioral Health Care

Homeless persons have all the same physical and behavioral health problems as individuals with homes, but at greatly elevated rates, with multiple diagnoses and disabling conditions being common. By “health” this report refers to the full complex of physical health, mental health and substance abuse problems. Homelessness inevitably causes or worsens serious health problems.

- Undetected and untreated communicable diseases including HIV/AIDS and tuberculosis threaten the health of other homeless individuals in particular and of the public in general.
- Trauma resulting from violence and conditions caused by exposure to the elements are also common among homeless individuals.
- Twenty-five percent (25%) of homeless persons have some form of physical disability or disabling health condition.
- Approximately 20% of homeless persons have a serious mental illness.
- At least 40% have substance use disorders (Blueprint for Change, DHHS Pub. No. SMA-04-3870 2003).

Profile of Health Care Needs of Homeless Persons in Nashville

Metro Public Health Department analyzed calendar year 2003 encounter data from its Downtown Clinic for the Homeless and encounter data for homeless persons served by Bridges to Care, a program that links uninsured persons in Nashville to safety net providers and hospitals. While not representative of all, these data provide information about the health care needs of a substantial portion of the homeless. As the table below shows, these homeless persons averaged 4 health care encounters per year and behavioral health problems (substance abuse and mental health) were among the top diagnostic groups. Dental problems were also prevalent.

Homeless Patients -- Calendar Year 2003

	Downtown Clinic	Bridges to Care
Av. # Visits/Person	4.1	3.9
Gender	Males = 83% Females = 17%	Males = 66% Females = 33%
Race	Black = 54% White = 41% Other = 5%	Black = 45% White = 54% Other = 1%
Age	18 – 34 (24%) 45 – 54 (31%) 65 and > (2%) 35 – 44 (36%) 55 – 64 (7%)	18 – 34 (26%) 45 – 54 (30%) 65 and > (0%) 35 – 44 (36%) 55 – 64 (7%)
Top Ten Diagnostic Groups (ICD- 9 Codes) based on primary diagnosis (1)	Substance abuse = 23% Mental illness & mental health screening = 16% Physical Health Conditions = 34.5% Dental = 15% Hypertension = 8% Respiratory infection = 4% Diabetes = 3% COPD = 2.5% Injury = 2%	Substance abuse = 12% Mental illness & mental health screening = 10% Physical Health Conditions = 27.5% Dental = 7.5% Hypertension = 5% Respiratory infection = 3% Diabetes = 4% COPD = 2% Injury = 6%

(1) This is the primary problem for which the patient was treated during the visit and therefore does not represent all possible health and behavioral health conditions a person may have at the time.

Strategic Framework: Health and Behavioral Health Care

The harsh reality is that homeless persons are often faced with co-occurring or multiple health and behavioral health problems that increase the difficulty of overcoming their homelessness. Homelessness is prolonged for persons who cannot stabilize and manage their health conditions and who are consequently less likely to maintain their housing or job. Moreover, health care services are markedly less effective when delivered to persons without the basic protections afforded by a home (protection from the elements, sanitary conditions, opportunity to rest, refrigeration for food and medicines): housing *is* health care.

Current Service System

The current homeless service system in Davidson County is comprised of a variety of organizations that provide some type of health or behavioral health care or service to homeless persons. The types of entities include:

- Entities whose sole purpose is to serve the homeless population (e.g., homeless shelters and the Downtown Clinic)
- Entities that offer a range of services but have a component of their service that is targeted to the homeless population (e.g., a homeless outreach service of a community mental health provider)
- Entities that do not target the homeless population but due to the nature of their service provide care to homeless persons (e.g., hospitals, emergency rooms, safety net medical clinics, community mental health centers, substance abuse providers, community social service agencies). Emergency rooms in particular are the most expensive level of care but are frequently utilized inappropriately by homeless and other uninsured persons.
- Entities that provide a public service and in the course of their work must respond to the needs of the homeless population (e.g. EMTs-Fire Department)

Gaps in the Service System and Barriers to Care

Although there are multiple providers of health and behavioral health care in the community who have served the homeless population for many years, there continue to be barriers to care and significant gaps in the existing health care delivery systems in Davidson County. There are several key factors that prohibit or limit homeless persons from receiving proper health care.

- 1. Housing shortage.** Housing is health care. Many of the health problems of homeless individuals relate directly to their lack of housing.
- 2. Lack of access to health insurance and health and behavioral health care.** Homeless individuals often are uninsured and therefore lack access to comprehensive health care. Often they go without care until relatively minor problems become expensive medical emergencies.
- 3. Lengthy disability determination process.** The length of time for a person to complete the eligibility process for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) is a major barrier to the receipt of benefits, which include health insurance and monthly income. Regrettably, persons with substance abuse disorders are often not eligible under current federal law. However, many homeless persons appear to be eligible but are not receiving disability benefits which could help resolve their homelessness.
- 4. Fragmented, uncoordinated and unorganized system of care.** Persons trying to access needed services often face a service system that is not organized effectively or efficiently. They consequently have difficulty knowing what “mainstream” or “homeless-specific” services and benefits are available, or how to navigate the system in order to access services.

5. Lack of single point of accountability for homeless persons with mental illnesses. Fragmentation and lack of clear responsibility within the service delivery system inhibits service providers from providing optimal care.

6. Lack of Needed Services. Certain services are not available to meet the current needs of homeless and other poor persons (e.g., detoxification, dental care, respite care after discharge from a hospital, specialty health care, substance abuse treatment).

7. Lack of services that allow for relapse. The nature of mental illness and substance abuse disorders is that individuals will relapse. Zero tolerance policies in some current treatment and housing programs reflect the lack of understanding of these disorders.

8. Lack of access to services that incorporate an understanding of dual diagnosis and co-occurring conditions. The multiple diagnoses of many homeless persons (involving physical, mental and addiction disorders) require sophisticated care that does not focus on one condition of an individual separately from other conditions.

9. Limited outreach and engagement between the service system and homeless persons. The service system is not always responsive to the needs of the homeless persons and the homeless persons are not always ready to receive services. Additionally, outreach efforts of the system are poorly coordinated.

10. The nature of certain illnesses keeps some persons from accessing or maintaining contact with services. So-called "treatment avoidance" is often symptomatic of addictions and mental illnesses, and is aggravated for many homeless persons by prior bad experiences within the treatment system.

11. Lack of knowledge regarding needs of homeless persons suffering from mental retardation or other developmental disabilities. There is little available data on the incidence rate of homeless persons suffering mental retardation or other developmental disabilities, though service providers frequently observe these conditions. Therefore little is known about this population and their service needs.

12. Criminalization of behavior related to a mental health or substance abuse disorder. Criminal sanctions including incarceration are ineffective responses that do not comprehend or help to resolve the underlying health problems.

13. Stigma. Homeless persons, persons with a mental illness and persons with a substance abuse disorder are often stereotyped, viewed inaccurately by the public, in print or other media. Stigma often leads to barriers in assuring the availability of and access to services, or unfair discrimination or practices.

14. Funding, funding, and funding. There is a need for additional funding to support the development or enhancement of needed services.

Strategic Framework: Health and Behavioral Health Care

Elements of an Effective and Responsive System

Key elements of an effective and responsive health and behavioral health care system that will help homeless persons get well and move out of homelessness include:

- 1. Mechanisms that facilitate a coordinated and integrated service delivery system.** Persons who are homeless have complex problems that require comprehensive services that are well coordinated.
- 2. Aggressive outreach.** Outreach is now considered the first and most important step in providing access for homeless individuals to needed mental health, substance abuse and social services, and to housing (Blueprint for Change, DHHS Pub. No. SMA-04-3870 2003).
- 3. Engagement** is essential to develop the trust, the rapport and the relationship needed to help individuals accept more long-term services, the ultimate goal of outreach efforts. (Interagency Council on the Homeless, 1991; McMurray-Avila, 1997).
- 4. Assertive Community Treatment.** ACT provides a full range of community-based integrated services to persons 24 hours per day, 7 days a week.
- 5. Treatment services** for persons with co-occurring disorders and multiple health conditions.
- 6. Prevention strategies.** Health services that address the known risk factors for homelessness.
- 7. Easy and quick access to detoxification services**
- 8. Service principles and values that respect consumer's voice** and right to self-determination and actively involve consumers in service planning and provision of service.
- 9. Low-demand approach.** The recognition that participation in treatment and receipt of services should not be required in order to gain access to housing.

- 10. Expedited assessment and eligibility determinations** for mainstream benefits, especially disability and health insurance benefits. Benefits assistance services include education, assessment, application assistance, documentation/records procurement, and advocacy.

Key Definitions

Outreach Services – An array of therapeutic services delivered directly to the individual outside of traditional service delivery locations, as well as connecting individuals to existing service providers. It typically focuses on those persons who are not aware of vital services or who are prevented by a variety of factors from accessing services.

Assertive Community Treatment – A service delivery model that provides comprehensive, community based treatment to individuals with serious and persistent mental illness. It is a multidisciplinary team of staff that provides crisis intervention, medication monitoring, case management, rehabilitation, substance abuse treatment and support to those who are the most seriously ill who require this intensive level of care. The team is accessible 24 hours a day, 7 days a week and delivers services in the community and not in the office. Case loads are small and usually do not exceed more than a ratio of 1:10. The ACT model has proven effective for certain populations including those individuals who are homeless and who have a serious mental illness.

Primary Health Care – The "medical home" for a patient, ideally providing continuity and integration of health care. All family physicians and most pediatricians and internists are in primary care. The aim of primary care is to provide the patient with a broad spectrum of care, both preventive and curative, over a period of time and to coordinate all of the care the patient receives.

Specialty Health Care – Refers to medical services provided by physicians upon referral by a primary care physician. Examples would include orthopedics, dermatology, cardiology, neurology, gastroenterology, gynecology, etc

Strategic Framework: Health and Behavioral Health Care

Recommendations

Each year, many individuals in Nashville are homeless and are in desperate need of health care, behavioral health care and social services. In order to achieve the overarching goal that untreated health conditions, illnesses and injuries will no longer cause or prolong homelessness in Nashville, the Health Work Group provides the following recommendations.

1. Establish new/expanded services.

Complement existing health care services by adding the following capabilities:

- Permanent supportive housing, with primary care, behavioral health care and case management services available on site
- Aggressive outreach to assess need, engage and re-engage homeless persons into systems of care; includes service-oriented outreach teams to intervene in cases of disruptive behavior
- Expedited enrollment procedures for SSI, SSDI, TennCare and other public benefits
- Single-agency responsibility for homeless persons with mental illnesses
- Assertive Community Treatment teams that provide on-going treatment and case management without time limitations
- 24/7 alcohol and drug detoxification, screening and assessment
- Increased residential substance abuse treatment for indigent and uninsured persons
- Respite Care setting(s) for recuperation of persons without homes after hospital discharge

2. Conduct a comprehensive assessment of health care system capacity and need,

to indicate additional areas for expansion or rescission. Assessment should include careful review of programs and service designs developed in other cities. The requirements of such a study exceeded the resources available to the Work Group.

3. Service system characteristics.

Assure that existing health and behavioral health services for homeless persons incorporate the following characteristics:

- Involvement of consumers in service planning and delivery of services
- Protection of confidential information about homeless consumers and respect of their right of self-determination
- Integration of treatment for co-occurring mental health and substance abuse disorders
- Incorporation of relapse tolerance into housing and service programs
- Provision of transportation to assure effective access to health and behavioral health services not available on site
- Evaluation of programs according to outcomes
- On-going community education regarding the needs of homeless persons and available resources
- Improved community partnerships to promote an effective service delivery system

Strategic Framework: Economic Stability

Nashville has a long history of planning around homelessness and has documented in numerous reports the need for improved access to public benefit programs, income resources, and improved job training and employment programs.

“Create a centrally-located job development and placement agency.”
- *Coping with Homelessness: A Plan for Nashville*, Nashville Coalition for the Homeless and the Center City Committee, 1987.

“Demonstrated that only a small percentage (of the homeless) were receiving mainstream benefits.”
- *Voice of the Homeless*, Metropolitan Health Department, 1998.

“Recognized need for ESL classes, vocational training and job counseling.”
- *Homeless Needs Assessment 2002: Nashville and Davidson County*, Metropolitan Health Department, 2002.

“Mainstream Services Strategies: Strengthen Partnerships with Mainstream Providers (such as SSI, SSDI, VR, TANF, FS, WIC, Veterans Benefits, TennCare, Child Support) and Simplify and Expedite Enrollment Processes.”
- *Housing and Services for People Experiencing Homelessness: A Plan by Providers*, Nashville, 2003.

These reports identify the following common themes:

- The on-going need for increased job training, readiness and placement for chronic homeless people who are willing and able to work.
- Obstacles exist that impede homeless people from fully participating in these

programs which can lead to unintended significant increases in other publicly funded services (particularly health care), and limit housing options.

In addition, the Downtown Partnership’s Ambassador Program monitors and tracks daily activity in the central downtown district to assess quality of life and other activities. Ambassadors interact with almost 600 homeless people on the streets each month, many of them chronically homeless. Based on this outreach, the Partnership has again confirmed the critical well-documented need for more effective partnerships to provide opportunities for the chronically homeless, particularly in the areas of income stabilization, supportive housing options, and results based job training and employment activities.

A fully realized economic stability strategy is necessary to maintain stable housing and establish and test personal accountability. Economic stability along with housing, is the critical precursor to any potential training and employment program. For those chronically homeless that may never be employed, full access to income maintenance, healthcare, and housing resources will allow them to better reach their highest level of independent housing, economic self-sufficiency, and social self-reliance.

Current Service System

Nashville currently offers a variety of low-income job training and employment activities for which homeless individuals are eligible. However, specific and effective outcome-based assessment, training, and employment services for the chronically homeless are basically non-existent.

Gaps in the Service System and Barriers to Care

Considerable barriers exist to successfully engage chronically homeless people in accessing and managing public benefit programs let alone job readiness or employment-related activities. Barriers include:

1. Low income service providers offering job training and employability programs have not sufficiently engaged the business community in effectively developing outcome-based activities for difficult to serve populations, especially the chronically homeless willing and able to work.
2. Local employers lack uniform and comprehensive information about available tax credit and incentive programs for training and hiring marginalized populations.
3. Stigma, discrimination, and misperceptions by the larger community about the chronically homeless will impact implementation strategies without a strong top-down, long-term commitment by local government, the private sector and faith-based community leadership.
4. Local homeless and specialized job training and employment-related activities are often population-specific and may include specific funder requirements or disincentives to working with a chronically homeless population.
5. Existing programs may target specific populations but are not always effectively coordinated across agencies.
6. Nashville homeless service providers have met short term success in implementing benefit access and employment-related demonstration activities over the last 15 years. However, many of

these were short-lived projects and never successfully integrated into effective long term programs.

7. There is no targeted state or federal homeless employability funding stream for traditional service providers to access.
8. Nashville does not have sufficient detailed demographics on the make-up of its chronically homeless population; this limits the community's ability to effectively prioritize new or targeted job training and employment services for this population.
9. Major public benefit and income resource programs (Social Security, SSI, Families First, Food Stamps, TennCare, etc.) do not place a priority on assisting homeless people to access needed services, but acknowledge they are among the more difficult of eligible groups to serve and consume above average work resources in the process.
10. Nashville lacks a well-defined integrated job training & employability assessment process for the chronic homeless population.
11. There is not a shared understanding of what "success" looks like for the chronic homeless person seeking the highest level of personal economic self-sufficiency.

Strategic Framework: Economic Stability

Best Practices

Many communities around the country have begun the re-design and management of job training and employment-related programs that serve homeless people. Key recommended economic stability practices from successful community approaches include:

- Results-driven or outcome focused expectations at both the individual and service agency level (to positively reinforce personal responsibility and agency program accountability.)
- Existence of a local Transition to Work model (beginning with an expectation to maintain stable housing; includes ongoing supports – job coaching, mentoring, problem-solving assistance.)
- Thorough training and employability assessments.
- Existence of formal Memoranda of Understanding (MOUs) with key local, state, and federal programs.
- Rapid linkage to benefits and re-housing/housing stability.
- “Safe Harbor” options to meet day to day survival needs.

Sample Initiative

The Project Match Pathway System is a long term incremental Welfare-to-Work program model that offers a highly structured path from service only pre-employment activities to unsubsidized employment. The system also includes an Incremental Ladder to Economic Independence with specific steps to independence in the areas of: Activities with Children; Volunteering; Employment; Education/Training; and Self-Improvement Activities. Project Match recognizes there are a variety of pathways to economic independence, but that ultimate success requires flexibility, choice and a wide variety of work preparation activities.

Project Match, Erikson Institute, 420 N Wabash Avenue, Chicago, IL 60611, (312)755-2250.

Sample Initiative

Chrysalis was founded in 1984 to create and locate employment opportunities to help homeless and other disadvantaged individuals become self-supporting. The program has received numerous awards and recognition for successfully bringing private sector business models to a difficult social service issue. Initially a homeless employment day center, Chrysalis went on to develop and operate a temporary employment agency and multiple businesses that serve as training and market wage employment for homeless individuals. Their approach is to create and offer employment programs that foster individual initiative and independence within an environment that is very similar to private sector work. The intent is to instill a positive work ethic and good work habits applicable to any employment setting. Chrysalis promotes itself as preparing a motivated low-income workforce, with strong supervisory oversight and post placement oversight. Chrysalis utilizes a “work first” philosophy that helps individuals maintain and upgrade employment after finding a job. Chrysalis acknowledges job retention as a primary problem and has instituted an enhanced case management system to improve retention.

516 South Main Street, Los Angeles, CA 90013 (310) 392-4117, Lesley Goldberg, VP of Development

Recommendations

1. Nashville will utilize an outcome based funding approach to be monitored at least annually for any continued homeless funding generated through Metro government. Calls for proposals will follow agreed upon criteria established by open committees comprised of both service providers and other interested parties such as the Chamber of Commerce and the Downtown Partnership. An inability to meet performance targets could lead to de-funding. All programs working with the chronically homeless would be encouraged to develop milestones and performance target measurement structures regardless of the funding source.

2. Nashville will develop a formal “Income Maintenance – Training – Employment Continuum.” The focus will be to meet the needs of the homeless individual with accountability, as they are ready and able to participate.

3. Nashville will develop formal Memorandums of Understanding with key public service providers. Key providers will include the local Social Security Office, the State Office of Disability Determination Services, the Department of Human Services, the TennCare Bureau, Tennessee Department of Labor and others to ensure full early access by homeless individuals to all publicly funded benefit and service programs.

4. Nashville will develop at least one results-based chronically homeless job readiness/ training/ employment pilot project. This project will involve the Chamber of Commerce, Metropolitan Development and Housing Agency, the Downtown Partnership, the Convention and Visitors Bureau, Metropolitan Transit Authority, Metro Action Commission, the Nashville Career Advancement Center, Metro

Social Services, Park Center, Matthew 25, Goodwill Industries, and others.

5. Nashville will aggressively seek new funding for job training and employment programs. This could include discretionary Workforce Development grants that target homeless individuals through the federal Department of Labor (Office of Disability Employment Policy, Employment and Training Administration), as well as state administered programs from the Department of Labor/Workforce Development, the Department of Human Services, and the Department of Mental Health.

6. Nashville should obtain the services of a full time homeless programs development director to maximize resource development for the chronically homeless. (A Development Director could also explore new or underutilized program options such as Americorp or partnering with Metro Action Commission to apply for discretionary CSBG funds.)

7. Nashville should establish a pilot project to facilitate access to basic local banking services for homeless individuals such as free basic checking accounts and debit cards as are provided to high school students.

8. Nashville will conduct an analysis of the public transportation barriers that prevent homeless individuals from participating in job training programs or maintaining employment. The analysis done by Metropolitan Transit Authority will include the participation of service providers, homeless individuals, low-income employment and training agencies, major employers of low-income individuals and other interested parties

Strategic Framework: Systems Coordination

An array of distinct components is necessary to construct an effective response to chronically homeless individuals. We must assure that the broad system of services and housing available to homeless individuals is as seamless and coordinated as possible. Among the many and often complex issues under the systems coordination umbrella, the Work Group divided into subcommittees to focus on three main topics:

Outreach

Nashville must have an engagement system that effectively encourages chronically homeless individuals to enter permanent housing and access appropriate services.

Webster Dictionary defines outreach “as an effort to build connections from one person or group to another”. It is these connections that offer street homeless individuals the opportunity to be linked with other segments of the social service system, and ultimately, an end to their homelessness.

Collect Accurate Data

Service providers must coordinate and communicate to assure no duplication and utilize limited resources effectively. A comprehensive homeless management information system (“HMIS”) will be a key component of this systems framework.

Coordinate Discharge Planning

We must work to prevent the discharge of persons exiting publicly funded institutions from immediately resulting in homelessness.

The definition of discharge planning taken from the Massachusetts Housing and Shelter Alliance is “the process to prepare a person in an institution for return or re-entry into the community and linkage of the individual to needed community services and supports.”

Sample Initiative

Via State General Funds, California operates programs in 24 counties and two cities that provide integrated services to persons who are mentally ill and homeless, at risk of homelessness, and or at imminent risk of being incarcerated. Known as the “**AB 2034**” programs (2034 is the number of the Assembly Bill that authorized the funding), they have demonstrated success in breaking the cycle of chronic homelessness for individuals with serious mental illnesses. The State gives broad discretion to the county contractors that administer the programs, but makes performance the basis for payment -- not services provided. Higher payments are given to counties that show the greatest reduction in homelessness, incarceration, etc. (National Alliance to End Homelessness)

http://www.dmh.cahwnet.gov/PGRE/Integrated_Services.asp

Strategic Framework: Systems Coordination- Outreach

Problems/Issues/Gaps

- Lack of geographical coordination and information sharing between outreach providers
- Current outreach system is ineffective at reducing street homeless
 - Not enough street outreach
 - Too much ineffective floating outreach
- Lack of formal training provided to outreach workers
- Constant cycling of chronically homeless in and out of criminal justice system

Recommendations

1. Create a Centralized Outreach Coordination Center (OCC) belonging to a single entity, (possibly Metro government) that should be designated, and charged to coordinate outreach efforts across various agencies in Nashville. With the full backing of the city, housing providers, mental health agencies, substance abuse agencies and the Metropolitan Police Department the OCC would be responsible for providing strategic direction of outreach efforts as well as defining objectives and goals annually for reducing street homelessness.

2. Create an Interdisciplinary Street Outreach Team by re-configuring/expanding existing outreach services into a “dream team” including a city-wide coordinator, social workers, a Nurse Practitioner, a Licensed Alcohol and Drug counselor, a mental health professional and a dedicated Metro Nashville police officer. The team would be housed at one location, preferably the OCC and be directly accountable to its hiring agency. The team would be flexible in terms of days/times out on the street.

3. Provide Formal Training for Outreach Workers that should be required of all outreach workers including specifics on local resources, building trust, how to engage clients, understanding community resources, and worker safety.

4. Develop a Community Court, where alternative sentencing is used to prevent the creation of a criminal record for many homeless individuals in Nashville, and to address the underlying causes that led them to homelessness. Community courts utilize a non-traditional approach to working with offenders, using sentencing alternatives and legal sanctions to promote rehabilitation and address the deeper issues of criminality.

Sample Initiative

At the **community court in Austin, TX**, when a defendant presents at the initial court hearing, it is first determined if they are a candidate for treatment. When treatment is deemed necessary, a referral is made to the court’s clinical evaluator for assessment and recommendations. When mental illness and/or substance abuse are identified as contributing factors to the defendant’s criminal behavior, the court then makes a referral to the resources that will best serve the defendant. The defendant’s participation in treatment then becomes part of their sentencing. For those not needing formal treatment, the judge can craft rehabilitative sentencing to include a range of social services such as counseling, work training, outpatient day treatment, etc. The referral to these social services is coordinated and followed-up by court-based social workers.

<http://www.ci.austin.tx.us/comcourt/overview.htm>

Strategic Framework: Systems Coordination - Data Collection

Nashville has a broad network of homeless service providers that offer services ranging from outreach to permanent supportive housing. Among the challenges faced by the city is how to collect comprehensive data on individuals who are homeless and served at many points in the system. To paint an accurate picture of the problem and evaluate efforts to address it, we must coordinate all of these services in a way that promotes and rewards data collection and information sharing within and between service providers.

A Homeless Management Information System (HMIS) provides a means of generating an unduplicated count of homeless individuals, as well as analyzing service use and the effectiveness of local systems at reducing homelessness. HUD has been directed by Congress to work with jurisdictions to gather homeless data across the country. The standard features:

- Provides an unduplicated count of persons served
- Tracks data on individuals who enter the homeless system, including demographics, where they were prior to entry, what services they access while in the system and how they exit the system
 - Tracks bed registry, incident management
 - Facilitates case management across agencies in a centralized manner through the use of case management notes
 - Provides reports and data on homelessness in Nashville, including the number of chronically homeless
 - Requires only one entry of initial data into the system so that both service providers and homeless individuals save time that is now wasted in intake processes at multiple agencies

Recommendations

- 1. Implement the Homeless Management Information System (HMIS) currently under development by the Metropolitan Health Department.** Nashville needs a centralized system to gather information on homeless services.
- 2. Mandate that All City-Funded Homeless Programs Participate in HMIS.** Currently, those agencies assisted by HUD's Continuum of Care homeless funding are top priority for beginning to participate in HMIS. The Systems Coordination Work Group recommends that Nashville-Davidson County broaden this mandate to include all city-funded programs that serve homeless individuals. Agencies that are privately funded and those that receive no government funding must also be urged to participate in HMIS, in order to glean optimal benefits.
- 3. Conduct Point-In-Time Count of Homeless Individuals No Less than Every 2 Years.** This will help the community monitor progress on outcomes related to reducing homelessness.

Strategic Framework: Systems Coordination - Coordinated Discharge Planning

Gaps and Barriers

- Internal Policies or Practices of Institutions Discharging Homeless
- Institutions may deny or delay treatment to chronically homeless
- No Institutional Follow-Up of Implementation of Discharge Plan
- Lack of Services for Homeless Without Diagnosed Disability
- No Services Available during the Weekend
- Lack of Available Housing

Recommendations

1. **Identify a comprehensive list of discharge related staff at institutions and facilities state-wide that serve a high number of individuals who are homeless and at risk of being homeless.** Begin involving them in a planning process by having them complete the discharge planning survey, and use the results to assess and analyze the extent of the problem.
2. **Educate and coordinate with key administrators and discharge personnel from hospitals, mental health, correctional, and residential treatment facilities in order to reduce rates of recidivism among the homeless population.** Develop training curricula and implement an on-going series of regional training workshops and technical assistance to institutions and facilities. Specific educational topics should include: a) homeless discharge planning protocols; b) benefits facilitation and acquisition; c) data collection and discharge review tools; d) community resources and referral process; e) cross-training and communication; f) service planning and linkage; and g) client advocacy.

3. **Establish criteria for exemplary discharge planning practices for individuals who are homeless and those who are at risk of being homeless**

4. **Assure pre-release assistance with enrollment and public assistance programs**

Sample Initiative

The Massachusetts Housing and Shelter Alliance (MHSA) developed **Discharge Planning Protocols in Massachusetts**, a set of strategies that centers on the prevention of homelessness, especially for those at risk of chronic homelessness. MHSA documents the connection between growing homelessness and discharge from public systems of care, to create resources, and to develop a comprehensive strategy of homeless prevention that assures successful discharge to the community. (Interagency Council on Homelessness)

<http://www.ich.gov/innovations/1/index.html>