1. Shelter Planning Task Force June 10 Agenda

   Documents: SHELTER PLANNING TASK FORCE JUNE 10 AGENDA.PDF

2. Best Practice Review

   Documents: BEST PRACTICE REVIEW.PDF

# Shelter Planning Task Force

June 10, 2015, 9 - 11 am
City Hall, State of Maine room (2nd floor)

## A G E N D A

1. Welcome
2. Best Practice presentation and discussion
3. Discuss possible scope/work plan revision
4. Shelter tour planning, wrap up and next meeting

Executive Department
Julie Sullivan, Acting Chief of Staff

**Shelter Planning Task Force**
**Best Practices Review**
**June 10, 2015**

**Summary:**

More than 50 articles and web sites were reviewed in order to understand the state of the art in emergency shelters. (Significantly, none of the programs examined included a municipally-run shelter.) Programs and studies consistently emphasized the same approach: moving away from emergency shelter and toward coordinated triage and assessment, emphasizing housing first/permanent supportive housing for the chronically homeless, and rapid re-housing for the more short-term homeless. While there is agreement, of course, as to the ongoing need for some amount of emergency shelter services, resources should be more heavily invested in housing and supportive services than in increasing shelter capacity.

The preponderance of data and best practices suggests that this Task Force may consider adjusting the scope of work to pick up where the prior Task Force to Prevent and End Homelessness left off, i.e., to focus on key elements of that plan coupled with the emphases in the national literature and best practice database. Thus, perhaps this Task Force focuses not specifically on emergency shelter planning, but on improving the current system in the areas of:

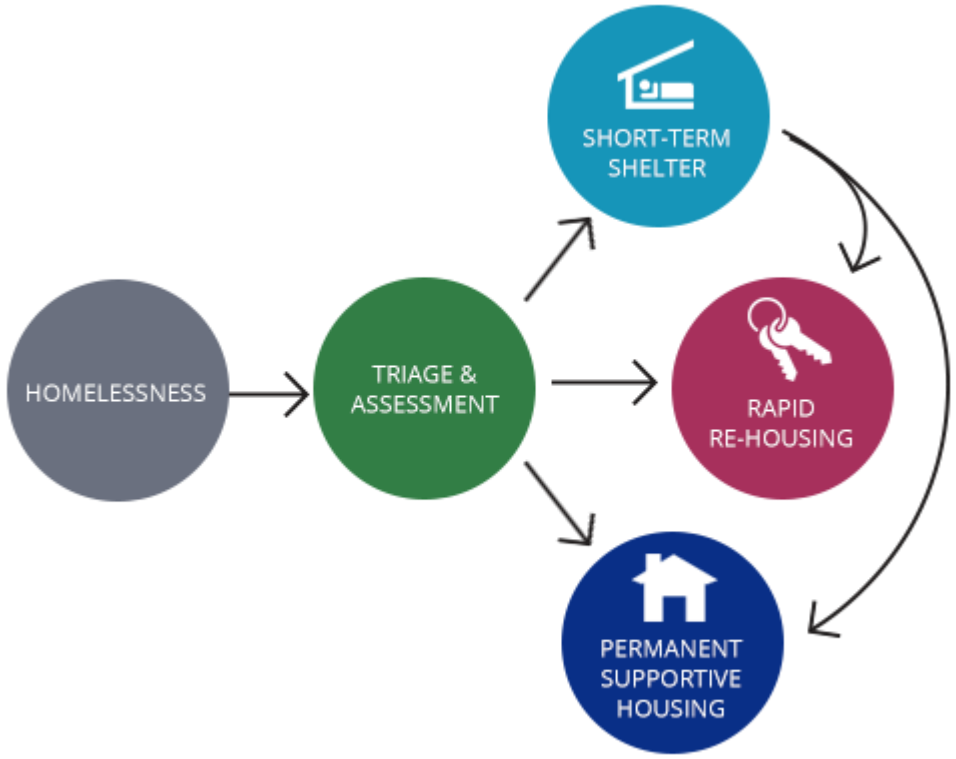
1. Coordinated triage/assessment
2. Housing and supportive services, and
3. Rapid re-housing/secondary homelessness prevention

The Emergency Shelter Assessment Committee (ESAC) has assumed the lead role in coordinating the current amplified effort to house the longest-term stayers from the Oxford Street Shelter. How is this working? Is there a better way to coordinate and ensure accountability? Is there a better way to allocate resources? Looking longer term, is there a more sustainable approach to housing the longest-term stayers? Should certain organizations specialize in specific functions – e.g., the City is responsible for housing placement, OA/Amistad provide supportive services, Preble Street and Milestone collaborate with the City on coordinated triage/assessment?

It would seem prudent to prioritize current system improvements over a new shelter at this time. The Task Force could reconstitute in 18-24 months to evaluate progress and determine whether a new shelter is called for then.

**Best practices:**

This graphic from the Massachusetts Housing & Shelter Alliance best captures the key components of best practice models from around the country:




Working in 2011-2012, the City's Task Force to Prevent and End Homelessness had a broad charge. The most relevant recommendations were:

1. Centralized intake process for triage and assessment
2. Increasing available Housing First buildings
3. Increasing case management services

Due to turnover at the City at multiple levels, implementation and evaluation of the recommendations has been less than ideal. It is unclear at this time what, if anything, has been done on these points, and thus could be a useful focus of discussion for the Shelter Planning Task Force.

The U.S. Housing and Urban Development (HUD) agency requires **coordinated assessment** systems (HUD Coordinated Entry Policy Brief, February 2015). Focusing on coordinated, versus centralized, seems a good point for the Task Force to consider, given the many points of access into the current system in Portland. https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf

Coordinated assessment can increase the efficiency in moving people from homelessness into successful housing placements by:

- Moving people through the system faster, by reducing the amount of time spent trying different programs/approaches before finding the right match
- Reducing new entries into homelessness by consistently offering prevention and diversion resources up front to keep people from becoming homeless
- Improving data collection and quality and providing accurate information as to what types of assistance consumers need

The National Alliance to End Homelessness has a coordinated assessment toolkit:
http://www.endhomelessness.org/library/entry/coordinated-assessment-toolkit

It is critical to have an objective process to prioritize housing first services.

http://sfpublicpress.org/news/2014-10/promise-of-supportive-housing-for-homeless-faces-reality-of-short-supply

MaineHousing recommends the use of VISPDAT.
http://100khomes.org/sites/default/files/SPDAT_Evidence_Brief%20(1).pdf

U.S. Interagency Council on Homelessness:
http://usich.gov/usich_resources/solutions/explore/coordinated_entry

***How is Portland coordinating triage and assessment?***

**Housing First** is a proven method of ending all types of homelessness and is the most effective approach to ending chronic homelessness. The U.S. Interagency Council on Homelessness has created a Housing First checklist that may be helpful in assisting this Task Force with improving current efforts:
http://usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf

The peer-reviewed journal *Prehospital Emergency Care* includes a paper examining the use of EMS services by supportive housing tenants before and after being housed. University of Washington researchers found an average reduction of 54% in the number of contacts with EMS in the two years after obtaining housing. Housing First is Associated with Reduced Use of Emergency Medical Services - Prehospital Emergency Care (Volume 18 | No.4, October-December 2014)

A study of housing retention among residents who were chronically homeless and affected by long-term severe alcohol problems found that clients were both interested in housing and able to retain it over the two-year study period. Residents had not actively sought out this housing, but were found and offered the housing opportunity by staff. Many of them reported that they did not believe they could have succeeded in abstinence-based housing, and continued alcohol use did not predict housing failure. Housing Retention in Single-Site Housing First for Chronically Homeless Individuals with Severe Alcohol Problems - American Journal of Public Health (Volume 103 | Issue S2, December 2013)

Research published in the American Journal of Public Health shows decreases in alcohol use and alcohol-related problems in a housing first program. The results provide a strong rebuttal to the "enabling" hypothesis, which held that providing alcohol-dependent people with housing where they were not prohibited from drinking would cause them to drink even more and experience more dire consequences as a result. Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories - American Journal of Public Health. (Volume 102 | Issue 3, March 2012)

A study put out by the Corporation for Supportive Housing and Enterprise Community Partners examines the costs of permanent supportive housing, examining 20 projects ranging in size from 24 to 96 units, from New York to Los Angeles. Permanent Supportive Housing: An Operating Cost Analysis - (September 2011)

The first-ever national study to examine Housing First programs looked at participants in three programs around the country. Participants had high levels of housing stability: 84% were in housing after 12 months. The findings demonstrate that Housing First programs are successfully housing people with serious mental illness and that intensive, ongoing services and housing subsidies are a critical component. HUD: The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness - (July 2007)

Housing stability among homeless individuals with serious mental illness participating in housing first programs - Journal of Community Psychology (Vol. 37 | Issue 3, March 3, 2009)

Pine Street Inn in Boston is working to expand housing for chronically homeless adults while simultaneously reducing demand for emergency shelter beds. Their goal is to change the present housing-to-shelter ratio from 50:50 to one that is weighted toward housing at 65:35. They are relying on private philanthropic support to fund this. http://www.pinestreetinn.org/campaign_why_housing

***What does Portland need to expand the Housing First approach?***

**Supportive services** are an integral part of ensuring consumers' success in housing. The U.S. Substance Abuse and Mental Health Services Administration describes most supportive services as delivered in multidisciplinary teams or a combination of team-based and referred services. For example, the case management model at Pine Street Inn, Boston, MA, includes a formal transition from intensive case management to less intensive support as consumers stabilize in housing. Formalizing this case management approach allowed staff to provide customized support to consumers during the critical time when they first transition from homelessness to housing. Pine Street Inn shared their greatest accomplishments as "Seeing people coming straight from the street who have been avoiding housing and services for decades coming in and accessing services and enjoying their neighbors in housing" indicating the effectiveness of this approach.

Services include: outreach and engagement; case management services; clinical services; income support; housing retention supports; development of independent living skills; supported employment; and peer support. Several specific services are cited as particularly helpful in stabilizing consumers in their homes. These include: º mental health and substance use treatment (e.g., increasing access to mental health and substance use treatment, crisis intervention, and relapse prevention for untreated individuals or intermittently treated prior to housing); º therapeutic communities (e.g., staff and peers working collectively with consumers); º advocacy (e.g., working with landlords to address disruptive tenant behaviors and prevent eviction); º benefits coordination (e.g., hiring benefits coordinators, training staff in Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) acquisition); and º life skills training (e.g., hiring staff to assist consumers in learning to budget money, maintain a clean home, and how to adjust to "living indoors").

http://homeless.samhsa.gov/ResourceFiles/4ehdqfnb.pdf

http://www.homelesshub.ca/performancemanagement

***What does Portland need to do to ensure sufficient supportive services?***

MaineHousing provided the following survey of **relevant models**, starting with a description of the Oxford Street Shelter to serve as a frame of reference.

This is a brief examination of a small sample of emergency homeless shelters from different regions throughout the country looking at the following areas: Scope of Services, Structure and Funding & Governance. If the committee members would like additional information, Maine Housing staff will provide the group with evidence of best practices and what is working in different communities around the country as well as here in Maine.

**Portland, ME – Oxford Street Shelter (OSS)**

**Structure:** A low barrier (folks under the influence can be admitted), co-ed emergency shelter for single adults. OSS is a municipally operated shelter. There is one main shelter site (154 max) with flexibility to open overflow shelters or "warming centers" as needed. Several other shelters operate in Portland that serves intoxicated individuals, teens, women, families and victims of domestic violence.

**Scope of Services:** Housing focused case management is offered to the shelter's longest term stayers and most vulnerable clients. The housing first model has been adopted by housing counselors at OSS. Additional housing services are offered through Maine Housing's Home to Stay program. Clinical services are available on site from a licensed clinical social worker.

**Funding and Governance:** OSS is funded primarily through two sources, Maine Housing money (bed night reimbursement and Home to Stay) and general assistance funds from the State of Maine. OSS has a very small "client fund" account for when donations come in. The client fund is used to procure small items for clients (toiletries, clothes, rental application fees). OSS is under the umbrella of the City's Department of Health and Human Services, Social Services Division. OSS staff report to the Social Services Division Administrator, HHS Department Head and Senior City leadership (City Manager, City

Council). OSS is also an active member of the Emergency Shelter Assessment Committee, Region One Homeless Council and the Statewide Homeless Council.

**Burlington, VT – Committee on Temporary Shelter (COTS)**

**Structure:** A high barrier (folks under the influence are not permitted) shelter system that serves both families and individuals at several sites in Burlington. Shelter for single adults is offered at the Waystation Shelter which has 36 beds. Shelter for families is offered at two sites, the Firehouse Shelter and the Main Street Shelter with capacity for 15 families. COTS require clients to save a portion of their income in order to access shelter services (70% singles, 40% families). During winter months, an overflow shelter is opened and operated by the local CAP agency. The winter overflow shelter is low barrier and people under the influence are welcome.

**Scope of Service:** COTS provides emergency shelter services, case management services which are focused on generalist case management (goal of 4-6 months to locate housing), homeless diversion services, transitional housing and permanent housing. Transitional housing is offered at two locations. One location has seven beds and the other offers 12 beds for formerly homeless veterans. Both programs require an ability to live independently. COTS offers permanent housing (the term permanent SUPPORTIVE housing is not used on the website) at two locations. 18 SRO's at one location and 28 units at the other. COTS uses a large portion of their resources for homeless prevention services. According to their website, COTS prevention programs have diverted over 2,000 households from homelessness. They provide assistance with rental arrears, mortgage arrears, security deposits and security deposit loans.

When COTS in Burlington reaches capacity, there is an overflow shelter that operates during winter months only (closes April 3). The overflow shelter is at a different location and has a twenty bed capacity (12 men, 8 women), but can also function as a "warming center" if needed (the capacity was stated to be "as many as we can fit"). The overflow shelter is operated in a building donated by Champlain College and operated by the Champlain Valley Office of Economic Opportunity. The shelter is open 7 nights a week from 6pm-7am and is staffed totally by volunteers. The State will also provide hotel rooms in some situations… I'm trying to find more info on this. This is the only overflow shelter I can find in Burlington and it seems to serve as the overflow shelter for all the shelters in Burlington. Here is a link with a story regarding the overflow:
http://helpinghousevt.org/category/warming-center/

**Pathways to Housing provides cutting edge housing first services in Burlington and other areas in Vermont, Maine Housing staff can provide more information if requested.*

**Funding and Governance:** COTS has a total revenue of $3,374,028 (FY 2014)

Individual and Business – 32%, $1,074,561

Federal Grants – 22%, $728,006

Foundations – 15%, $499,803

Rental Income - 10%, $344,341

State Grants – 6%, $208,075

VA – 7%, $237,883

United Way – 4%, $123,681

Other – 4%, $157,678

Expenses, $3,374,028

Adult Shelters – 16%, $546,533

Prevention – 12%, $384,302

Family Shelters – 24%, $789,007

Administration – 7%, $239,751

Development – 11%, $381,290

Housing Facilities – 15%, $469,678

Re-housing & Support Services – 15%, $454,029

COTS is governed by a board of directors. The executive director; and other departmental directors report to the board.

**Salt Lake City, UT – The Road Home**

**Structure:** The Road Home is the largest shelter in Utah. They offer shelter services for adult males, adult females and families. In FY 2014, the Road Home provided emergency shelter for over 7,000 individuals. The Road Home does not turn people away when they are in need for shelter services. During winter months, the Road Home opens an overflow family shelter in a nearby town.

**Scope of Service:** The Road Home has embraced the housing first model and is a large part of the groundbreaking work done in Utah. As the largest shelter in Utah, the Road Home was a key player in developing Utah's Ten Year Plan to End Chronic Homelessness, as well as the proclamation of reaching functional zero for chronic veterans. The Road Home targeted chronically homeless veterans (over 150 placements) with a group specifically targeting this population. The Road Home has seen an 18% increase in housing placements, and a 35% increase in rapid re-housing services, which they apply to their work with the chronically homeless. The Road Home also has funding from SAMSHA for street outreach to Salt Lake's most chronically homeless unsheltered individuals. The Road Home provides case management, housing counseling and permanent supportive housing services for homeless people in Salt Lake City. Permanent Supportive Housing is provided through Palmer Court, an

apartment complex owned by the Road Home and has the capacity to house 318 individuals and families.

**Funding and Governance:** $13,666,306 Revenue (FY 2014)

Private Contribution – 41.25%, $6,655,598

Federal Dollars – 26.04%, $3,558,246

Local Government – 11.11%, $1,518,905

State – 14.15%, 1,933,557

Expenses (FY 2014)

Supportive Shelter Services – 41.25%, $5,637,922

Deferred Revenue – 5.57%, $760,401

Rental/Deposit Assistance – 20.65%, $2,822,580

Administration – 5.13%, $700,980

Housing Services – 27.4%, $3,744,423

The Road Home has an executive director and board of directors as you would expect from a non-profit agency. The Road Home also plays an important role in Utah's Ten Year Plan to End Chronic Homelessness which requires collaboration with the State of Utah, City of Salt Lake, and other area agencies which comes along with performance measures and accountability to the community. **Utah's work with the chronically homeless has made national headlines and is seen as one of the prime examples of how to develop and execute a long term plan to address the issue of chronic homelessness in a community. Maine Housing staff will provide more information if the task force requests it.*

**Bangor, ME – Penobscot County Health Center (PCHC) Hope House**

**Structure:** Hope House is the largest homeless shelter in Bangor. Hope House serves male and female adults. Hope House operates 54 emergency shelter beds. Hope House is a low barrier shelter, and allows people to stay even if they are under the influence of drugs and/or alcohol. Meals are also provided on site. Hope House also provides 48 SRO transitional housing beds and a medical clinic on site. Hope House operates under the umbrella of PCHC, a provider of health services in Bangor.

**Scope of Service:** Hope House provides a wide variety of services. Transitional housing, health care, clinical services, case management and housing counseling are offered for shelter guests. Hope House is a proponent of the Shelter System Change initiative which has led to a revamping of the intake

process, including the Vulnerability Index Service Prioritization Decision Assessment Tool (VI-SPDAT) which is resulting in more rapid referrals to appropriate resources based on the intake assessment's results. Hope House has started a Long Term Stayer group in partnership with other community agencies that is targeting services to the most chronically homeless folks in Bangor; regardless of if they are in the shelter system or camping out. Due to focusing resources on the appropriate clients and rapid re-housing, the wait for Shelter Plus Care subsidies has gone from 180 days to 90 days.

**Funding and Governance:** Hope House is funded from several sources. They receive a small portion of funding from general assistance (GA) bed night reimbursement. The bulk of shelter funding is Maine Housing funds. Revenue is also generated from the 48 units of transitional housing units. The monthly rent for these units is $400 per month. 61% of the SRO units are self-pay, the remaining tenants use GA or other voucher based assistance to pay the rent. Housing navigation funds are provided through Maine Housing's Home to Stay program. Some costs are also covered from other sources within PCHC. Board of Directors and Executive Leadership (http://pchc.com/about-pchc/executive-and-clinical-leadership/) oversee 16 community health organization sites. The Hope House Health and Living Center, one of those sites (Hope House) has a shelter director, under guidance from the Chief Psychiatric Officer, and is trifurcated to: Shelter, Health Center, and Transitional Housing, each with supervisory leaders managing operations. Hope House is an active member of the Maine CoC, regional homeless council and statewide homeless council.

Hope House does have limited overflow during dangerously cold weather only. They used to have more capacity before they expanded their facility to include transitional housing SRO's and a new clinic. The Bangor City Council initially opposed the project, as a compromise PCHC agreed to only have the number of clients on the grounds equivalent to the number of beds available (54 shelter beds, 48 SRO's I think). When it is dangerously cold outside, they will put people in their lobby but they try to keep it very low key so as not to draw attention from the Council.

**Additional Comments:** While researching this project, Maine Housing staff discovered progressive work being done around the country. Communities such as Dayton, OH, West Virginia, Alameda, CA, Charlotte, NC and Rhode Island are all using cutting edge programming to end homelessness in their communities. Maine Housing staff is prepared to offer more detailed programmatic information if the committee finds it to be useful. Much of the progressive work being done at a community wide level and often not by stand alone, individual shelter providers. Coalitions to end homelessness, Continuums of Care and Government agencies are doing some exciting work streamlining services and making them more efficient.