1. Homelessness Task Force Report

   Documents: PORTLANDTASKFORCESTRATIGICPLANTOPREVENTENDHOME.PDF

Report of the Task Force to Develop a Strategic Plan to Prevent & End Homelessness in Portland

Revised November 16, 2012

Task Force Overview

At its November 21, 2011 meeting, the City Council of Portland passed an order establishing a Task Force to develop a strategic plan to prevent and end homelessness and appointing members to that Task Force.

The Task Force was charged with completing the following tasks:

1. Review and gain an understanding of the causal factors associated with homelessness, as well as the current community resources available to meet the unique needs of individuals experiencing homelessness;
2. Develop a multi-year strategic plan, including measureable objectives to reduce, prevent and end homelessness in the Greater Portland;
3. The strategic plan should focus on three areas; access to healthcare services, supportive and affordable housing, and prevention;
4. Convene a larger stakeholder group to include social service providers, advocates, consumers, community and business leaders, and public safety representatives to inform the work of the Task Force;
5. Develop a strategic plan to prevent and end homelessness that can be endorsed by the Portland City Council and one that can be evaluated over time and modified if needed.

The order also created and named individuals appointed as Tri-Chairs:

Jon Jennings, Business Community Leader
Suzanne McCormick, President & CEO, United Way of Greater Portland
Dory-Ann Waxman, Former City Councilor & Community Member

Over the next two months, the Tri-Chairs worked to identify and appoint Task Force members for each of the designated seats. Mayor Michael Brennan appointed Councilor John Anton as the City Council Representative.

Staff for the Task Force was identified from the City's Department of Health and Human Services Department, as well as homeless service providers. The United Way of Greater Portland provided partial support for the staff time dedicated to the Task Force. A full roster of Task Force members is included on Page 3 of this report.

The Task Force formally began its work on January 24, 2012 and subsequently met 8 times. The Task Force subdivided into four committees focused on the following aspects of homelessness and specific groups impacted by homelessness: 1) Retooling the emergency shelter system, 2) Access to physical and behavioral health, 3) Services to youth, families and veterans and 4) Supportive and affordable housing.

Task Force Membership

Member	Affiliation	Designation
Jon Jennings	Community Leader	Tri-Chair
Suzanne McCormick	United Way of Greater Portland	Tri-Chair
Dory Waxman	Former City Councilor	Tri-Chair
John Anton	Portland City Councilor	City Council Representative
Thomas Blackburn	Maine Construction Services	Community Member
Rabbi Carolyn Braun	Temple Beth El	Faith Organization
Dawn Doiron	Community Leader	Community Member
Kitty Garlid	Maine Medical Center	Healthcare Organization
Michael Gendreau	Mercy Hospital	Healthcare Organization
Thomas Chalmers McLaughlin	University of New England	Content Expert
Brian Petrovek	Portland Pirates & Portland Downtown District	Business Community Leader
Thomas Ptacek	Homeless Voices for Justice	Veteran & Consumer Representative
John Ryan	Wright-Ryan Construction	Housing Developer
Chief Michael Sauschuck	Portland Police Department	Public Safety
Karen Stein	UNUM	Business Community Leader
Mark Swann	Preble Street	Homeless Service Provider
Mike Tarpinian	The Opportunity Alliance	Homeless Service Provider
Dana Totman	Avesta	Content Expert

The Task Force was supported with content expertise from the following staff members:

Doug Gardner, Portland DHHS
Josh O'Brien, Portland DHHS
Pat McKenzie, The Opportunity Alliance
Jon Bradley, Preble Street

Summary of Recommended Actions

The Task Force is recommending the following action steps which will alleviate and begin to end homelessness in the City of Portland:

Retooling the Emergency Shelter System:
The Task Force recommends the creation of a centralized intake process through which all clients who are homeless would be assessed. Those appropriate for diversion to housing, other specialized shelters or other housing situations would be rapidly reassigned to these more appropriate options. Co-locating all service delivery partners within this centralized intake, will also increase the efficiency of the system and provide a higher level of service delivery and reassignment. Through this intake system, the overall emergency shelters in Portland will see a reduction in the number of clients who remain in the general shelter for more than 21 days. This will require reducing the current general shelter service and reconfiguring the shelter intake, assessment and referral process. Additional staff and change in the level and type of work done at the shelter will be necessary.

Rapid Rehousing:
The task force recommends a focus on providing appropriate permanent housing and support in the community for individuals, families and youth as quickly as possible. A range of supports and resources are required as each homeless household has unique needs. Meeting this goal will also require reconstructing three new housing first units consisting of 35 units each and appropriate supports for people who are chronically homeless. Housing first recognizes that stable housing is the first step for homeless individuals in recovery from substance abuse and/ or mental illness. This will require significant capital investment and funding for building maintenance costs and adequate staffing at three locations.

Increased Case Management:
The Task Force recommends case management services be expanded to people who are homeless and those case management delivery systems follow client needs, rather than reimbursable service delivery models. Clinically, Assertive Community Treatment-(ACT) services which are 24 hour/ 7 day a week delivery have been proven to be effective in national studies with clients who are chronically homeless. For those who have less severe issues, including co-occurring mental illness and substance abuse, case management based on the Rose, 1993, model has proven to be effective in increasing clients' self sufficiency and reducing recidivism rates. This will require hiring additional case management staff.

Report Monitoring:
The Task Force also recommends the development of a legacy group of Task Force members who can serve as a monitoring body to ensure the implementation plan moves forward in accordance with the proposed timeline.

Executive Summary

Our exploration of the issues and circumstances surrounding homelessness in Portland affirms that the problems are as complex and interrelated as are all issues that surround people who are struggling day to day with the challenges of living in poverty. Our work has examined the issues and causes of homelessness, the structural challenges of meeting the housing needs of those who are frequenting the emergency shelter system and the increasing challenges of providing appropriate level of stabilization for people with physical and behavioral health challenges.

Through an exploration of the data from city and social service providers who work directly with people who are homeless, as well as research on other programs, service delivery and recommendations from the national plan to end homelessness, we have developed a series of principles and strategies. These principles and strategies serve two important functions. First, they provide a framework which can relieve the overcrowding situation. Secondly, thoughtful adaptation of the longer term goals will reduce the reliance on longer term temporary shelter stays by quickly moving people into more appropriate housing. These longer term goals of increasing housing availability have proven effective in reducing the number of people who are chronically homeless.

Task Force members recognize that the issues of people being homeless and homelessness in Portland are complex and interrelated. The Task Force also recognizes that there are many myths associated with who is homeless as well as the circumstances surrounding how and why people are homeless in Portland. The Task Force recommends a coordinated series of public service announcements and public education initiative be developed to address several of the myths and stigma associated with people who are homeless and the circumstances surrounding how they became homeless, the daily struggles they face and other issues associated with the challenges of surviving in Portland without a permanent place to stay.

The Task Force recognizes this will require a significant investment on the part of many different organizations that are impacted by the challenges of homelessness within our community. Rough estimates of the costs associated with supporting our current system of housing, meeting people's basic needs and support is $6,748,021. This is based on an average annual cost of providing shelter and emergency services. This is based on an average annual per person cost of $25,086. This estimate is calculated from data associated with providing emergency services to people who are homeless, including shelter costs.

It is important to note that most of the funding sources for homeless services are prescribed for specific aspects of service delivery, e.g. funding which is earmarked for shelter cannot be used for case management. Case management funding may only be used with certain segments of the population who qualify. Additionally, these estimates do not include a large portion of the service delivery system which is funded through private donations, volunteer hours and other types of support. As suggested earlier, this also does not include many other organizations in Portland which interface and support the homeless service system including Milestone, Preble Street, Salvation Army and other organizations.

Even with all of this, the data from several studies in Portland is clear that providing additional housing options, further integration of flexible case management services and other flexible supports for individuals, youth and families reduces emergency room, mental health, case management and health care costs. Cost data suggests providing a combination of these three options can reduce emergency room costs by 63%, health care costs by 47%, mental health costs by 41% and case management costs by 22% - (cost studies, 2008, 2009, HPRP study 2011). The shift of costs and services also increases the clients' quality of life and increases efficiency in the level of services which are non emergency related. ***Appendix A*** provides a snapshot of the savings which can be observed through a greater focus on supportive housing and case management. Based on previous costs study analysis, it is estimated that the savings could be $5,086,723 over a 5 year period.

The Task Force also calculates that with the implementation of all of these initiatives, the emergency shelter system would see significant savings in shelter bed nights. Additionally, through full implementation, we estimate an annually cost savings to the emergency service system of $2,245,000.

The Task Force identified three key themes with specific principles and goals. These are further operationalized in the implementation plan and were derived from the work of the four committees of the Task Force. The themes are as follows:

Retooling of the Emergency Shelter System:

As suggested within this report, the current emergency shelter system is beyond capacity. Staff and local organizations continue to struggle with overflow strategies in order to meet the increasing need. Currently, a working group has been meeting within the city to develop a new approach. This retooling of the emergency shelter system will include the creation of a centralized intake process where all clients who are homeless would be assessed. Those appropriate for diversion to housing, other specialized shelters or other housing situations would be rapidly reassigned to these more appropriate options. This model is similar to other emergency shelter systems and is a recommended approach as defined by the United States Interagency Council on Homelessness, the national body created to address issues and best practices in working with people who are homeless. Co-locating all service delivery partners within this centralized intake process, will also increase the efficiency of the system and provide a higher level of service delivery and reassignment. Through this intake system, the overall emergency shelters in Portland will see a reduction in the number of clients who remain in the general shelter for more than 21 days.

Rapid Rehousing:

Portland Emergency Shelter data suggest most people who are homeless stay at the shelter for less than three weeks. Additionally, research on cost effectiveness of the Homeless Prevention, Rapid Rehousing Program-(HPRP) suggests that people who are diverted from the shelter or

who are placed into appropriate housing sooner, cost less to the overall system, have better outcomes on health and self sufficiency matrices, and score higher on quality of life indexes. Additionally, rapid rehousing has proven to be effective in reducing the rate of recidivism over time. Appropriate rapid rehousing has also worked to reduce the number of people who are chronically homeless through the use of permanent, supported housing units. Rapid rehousing has proven effective in past initiatives in Portland and is a recommendation of the Task Force to explore additional rapid rehousing initiatives.

Increased Case Management:

It can get very challenging for people with mental illness and those with substance abuse issues to navigate the complex health and human service delivery system. Additionally, eligibility requirements, requalification rituals and quick timelines often make it a struggle for someone who is homeless to keep track of deadlines, filing requirements and changing systems. In addition, untreated mental illness and significant struggles with substance use often cloud the process and a person's ability to meet basic needs in addition to advocating for themselves. A structured approach to providing both clinical case management which meets client needs, rather than dictated by eligibility requirements, as well as a case management navigator has proven to be effective in other assessments of service delivery models within Portland.

The Task Force recommends case management services be expanded to people who are homeless and those case management delivery systems follow client needs, rather than reimbursable service delivery models. Clinically, Assertive Community Treatment-(ACT) services which are 24 hour/ 7 day a week delivery have been proven to be effective in national studies with clients who are chronically homeless. For those who have less severe issues, case management based on Rose, 1993, model has proven to be effective in increasing clients self sufficiency and reducing recidivism rates. Studies of two different initiatives within Portland have confirmed these findings.

The Task Force understands that changing the current system to focus on these three themes is an ambitious undertaking and one which will require the expertise of many other stakeholders who are currently working closely with people who are homeless. If our goals, principles and strategies come together, the delivery of services and the support provided to people who are homeless will change in two significant ways. First, a central intake process will provide for quicker assessment, access to housing and supports for individuals to remain in housing. Secondly, separating specialized, temporary housing, will allow for individualized services to be provided in smaller housing units located in multiple locations throughout the greater Portland area.

Implementation Plan:

Retooling the Emergency Shelter System

Strategy	Action Items	Potential Funding Source	Timeline	Responsible Party
Develop a central intake and assessment process where rapid assignment to other temporary housing placements will occur. Individuals who arrive at an intake center would be assessed and placed in other temporary housing located in other parts of Portland and surrounding communities.	Phase 1, increase assessment and case management staff integrate Preble Street and Oxford Street Shelter roles and responsibilities-Phase 2-create a single point of entry and a general shelter in the same site. Phase 3-review of shelter sites for specialized implementation	Phase 1-State PATH funding Phase 2-City, CDBG, GA, MaineHousing, HUD, private sources, United Way. Phase 3- City, CDBG, GA, MaineHousing, HUD, private sources, United Way.	Phase 1-completed by February 2013. Phase 2-completed July 2013 Phase 3-ongoing	City of Portland Preble Street-(lead) Family Crisis Milestone Homeless Voices for Justice
Work with clients through a representative payee type model to assess individual assets which can be placed in escrow to support transition to stable housing.	Create a representative payee type program which would work with clients to assess individual assets which can be placed in escrow to support transition to stable housing.	City of Portland, DHHS pilot	Completed by July 2013	City of Portland-(lead) Preble Street Homeless Voices for Justice
Work in partnership with regional governments on creating a continuum of specialty housing to be located in the Greater Portland region.	Convening regional meetings	n/a	Ongoing	Mayors Coalition-(lead) City Council
Explore municipal zoning requirements so that all properties that satisfy conditional use regulations can be candidates for shelter usage.	Convene Mayoral summit to address the issues of zoning and location of additional temporary housing.	n/a	Completed by July 2013.	Mayors Coalition-(lead) City council

Develop several temporary housing units which serve the needs of people who present at the intake center. Temporary housing units may include respite housing for those discharged from local hospitals, housing for veterans, short term housing for people with substance abuse issues, housing for people with mental illness, housing for families, etc.	Convene a group of stakeholders to explore the opportunity to create additional temporary shelter alternatives.	DHHS, HUD, MaineHousing, private funding, affordable care act, accountable care organizations	Convene first meeting by November 2012. Develop first new site by December 2013.	ESAC-(lead) Preble Street City of Portland Maine Medical Center Family Crisis Center Avesta Milestone Mercy Hospital Opportunity Alliance

Rapid Rehousing

Strategy	**Action Items**	**Potential Funding Source**	**Timeline**	**Responsible Party**
Create three new housing, 35 housing first units and appropriate supports for people who are homeless within the Greater Portland Region.	Develop, locate and site 3 projects.	HUD, DHHS, City of Portland,	Phase 1- first building complete July 2015, final building completed July 2018.	Avesta Housing-(lead) City of Portland Preble Street Portland Housing Authority Shalom
Enlarge diversion and prevention opportunities such as short term rental vouchers, assistance with back rent and security deposits and legal services for people who have been homeless for 14 days or less and are in the emergency shelter system.	Develop flexible funding source. Implement wrap around funding for eligible clients;	HUD using the HPRP model, HUD VASH,	Pilot of funding and program implementation by December 2012, full implementation with July 2013.	Preble street Veterans Assistance Shalom Portland Housing Opportunity Alliance DHHS

Work in partnership with landlords to increase access to housing stock which will increase available rental opportunities for people who are homeless. Create/expand resources for landlords to work through issues with tenants.	Convene working group to develop housing liaison system for working with local landlords	General assistance, MaineHousing, DHHS, City of Portland, HUD, SSVF for veterans	Ongoing	City of Portland-(lead) Portland Housing Authority Preble Street Shalom

Increased Case Management

Strategy	**Action Items**	**Potential Funding Source**	**Timeline**	**Responsible Party**
Utilize flexible funding mechanisms to support the delivery of substance abuse and mental health services for clients who are homeless through an ACT that meets chronic homeless fidelity standards.	Create services funded for non MaineCare clients but efficient link and follow up by substance abuse and mental health providers.	DHHS, Mercy, Maine Medical Center	July, 2013.	City Council-(lead) Preble Street Opportunity Alliance Maine Medical Center Mercy
Implement a medical home model of respite and treatment for people who are discharged from the hospital.	Convene a summit of leaders in the health care field in Portland to explore the issue of integrating care to people who are homeless and suffering with health related issues	n/a	November 2012	United Way of Greater Portland-(lead)

Strategy	Action Items	Potential Funding Source	Timeline	Responsible Party
Implement a medical home model of respite and treatment for people who are discharged from the hospital.	Develop a working group to create a medical home model of respite care will cost for clients transitioning from the hospital	DHHS, Affordable Care Act, hospitals and private funding.	July 2013	United Way Portland (lead) City of Portland Opportunity Alliance Maine Medical Mercy Hospital
Collaboration and planning between community provider, schools, and DHHS. Family mediation, case management is available in community (neighborhoods)	Create a Task Force to address issues relating to schools and neighborhoods.	n/a	December 2012	Opportunity Alliance-(lead) Preble Street
Replicate HOME Team and Preble Youth Outreach type model for people who are suffering from behavioral health issues.	Maintain and build on existing teams.	DHHS, CDBG, MaineCare,	ongoing	Preble Street/Milestone-(lead)
Increase work, training/education and treatment options for homeless youth including flexible shelter options.	Create community support teams to work with homeless youth.	DHHS, MaineCare, CDBG	July 2013	Preble Street-(lead) City of Portland
Increase work, training/education and treatment options for homeless families including flexible shelter options.	Create community support teams to work with families who are homeless.	DHHS, MaineCare, CDBG	July 2013	Preble Street-(lead) City of Portland
Increase work, training/education and treatment options for veterans who are homeless including flexible shelter options.	Enhance community support teams to work with veterans who are homeless	Veterans Administration, DHHS, MaineCare, Department of Defense	July 2013	Veterans Administration-(lead)

Full Report

Introduction:

The emergency shelter capacity for people who are homeless in Portland has reached a point where the current system of overflow, moving of people during the night and overall capacity is unsustainable. According to data from Preble Street and the City of Portland, shelter capacity at the women's shelter, teen shelter and men's shelter has been over capacity since June 2011. According to Portland Emergency Shelter Assessment Committee, in July 2012, on any given night in Portland, there are 444 people seeking shelter. The data suggests that 71 percent of people who are homeless are homeless for 30 days or less. Factors such as mental illness, substance abuse, and lack of employment and job training all contribute to people being homeless.

These factors are intertwined with the larger issue of poverty and affordable housing not just in Portland but nationally. A 2009 U.S. Conference of Mayors report cites lack of affordable housing is the number one reason first time homeless people report when arriving at the shelter. This lack of affordable housing also places a number of people at risk of being homeless. Rental subsidies play an important role in a person or families ability to remain stably housed but the need for subsides far outpaced the available resource. Data from the 2010 HPRP report suggested less than 30 percent of individuals who requested assistance had received a subsidy in the past from a federal, state or local funding source.

Homelessness in Portland:

As suggested earlier, the issue of homelessness and the factors which lead to people being homeless are complex. Data from the City of Portland and Preble Street suggest the average age of a person at the shelter is 40. At Oxford Street Shelter, 49 percent of clients at the shelter were over the age of 41. At Florence house, 66 percent of the women reported being victims of abuse and 54 percent reported being victims of domestic violence.

For both men and women who are homeless in Portland, the challenges of mental illness and substance abuse are significant. The data suggests nearly 60 percent reported mental illness and 38 percent reported struggling with substance abuse. Additionally, nearly 72 percent of those who reported mental illness also reported a co occurring disorder of substance abuse. The correlation between co occurring disorders and homelessness is well supported in the research literature, (Arehart-Treichel, 2004). Untreated co-occurring disorders interfere with a person's ability to secure and maintain employment and long term, stable housing. Additionally, research suggests navigating the complex social service and benefit system is often unrealistic for a person who is suffering from a co-occurring disorder, (Burt, 2003, Arehart-Treichel, 2004).

Substance abuse and the challenges associated with addictions are as complex as the issue of homelessness. According to HPRP data, nearly 70 percent of clients, who are chronically homeless, also report struggling with addictions. Housing first models (Roman, 2012) suggests

permanent, supportive housing can impact the frequency and overall abuse of substances over time.

Moreover, recent research on housing first models suggest the insecurity of being homeless, including issues of isolation, danger and vulnerability can actually serve as confounding factors in a person's mental illness and ability to function, (Witte, 2006).

Another important factor relating to homelessness in Portland is the current capacity of the shelters. Data from 2011 suggested the overflow plan was used 256 nights, or 70 percent of the time. While the data suggests the number of chronic homeless has dropped from 36 percent in 2007 to 29 percent in 2011, the number of intakes at the shelters has continued to increase. The Task Force has explored this issue through the data and there appear to be many factors contributing to the increase. As mentioned before, these include lack of affordable housing options, changes in funding for different programs and services, limited employment opportunities which provide a sustainable, living wage and changes in the allocation of MaineCare benefits. All play a role in the increase of homelessness in Portland.

One issue which continually emerges relating to homelessness in Portland is the issue of residency in Portland. The Task Force explored the issue of residency and its impact on capacity. Data from the census bureau suggests the actual population of Portland has decreased over the past 20 years. Additional data from the Department of Health and Human Services suggests more people who were receiving benefits in Maine have left the State than have returned. Additionally, data from several comparable New England Communities, with similar demographics, suggest residency requirements do not reduce the number of people who are homeless and actually can increase issues relating to capacity.

Best Practices and Solutions that Work - *Retooling the Emergency Shelter System:*

The 2010, United States Interagency Council on Homelessness, 10 year plan suggests communities consider retooling the crisis response system which includes shelter and the delivery of social services to people who are homeless. The plan suggests part of the retooling may include the integration of service delivery models and sectors within the same organization. Portland has a long history of collaboration and collocating of services for people who are homeless including, meals, casework services, drop-in centers, community policing, health care and workforce development. For youth, Preble Street, Day One, Portland Public Schools have a long and demonstrated history of success at working in tandem with youth on issues of homelessness, mental illness and substance abuse, education and workforce development. Several of the subcommittee's work has been focused on exploring alternatives with the goal of creating a system whereby people who are homeless can still have a place to stay, but also a process of quicker, more responsible referral and assessment to other, longer term solutions. Other cities in the Northeast have developed a centralized intake process which serves as the clearinghouse for all people in need of shelter.

The clearinghouse concept can address two important issues, chronic homelessness and episodic homelessness. The data suggests, 29 percent, of people who are homeless are chronically

homeless. People who are included in this category often have multiple needs that need to be supported in order for them to find, secure and remain in stable housing. These needs can include issues of domestic violence, veterans who may be struggling to integrate back into the community, people who have mental illness which prevents them from finding stable, supported housing and people who have severe medical needs. The data clearly suggests a majority of people who are in need of emergency shelter; require shelter for less than 30 days. This accounts for 71 percent of the total shelter population. These episodic experiences with homelessness require a rapid response to move them from the shelter to stable housing. Additionally, the number of veterans who are experiencing homelessness has been increasing in recent years. Many federal and State programs have been developed to address homeless veterans.

An effective clearinghouse approach will include several key concepts from the successful Housing Prevention and Rapid Rehousing program-(HPRP). HPRP is based on the premise that a quick assessment, appropriate and relevant case management, and a customized placement and support plan increases the likelihood of stable housing. Additionally, the HPRP model also suggests increases in individuals' self sufficiency once placed in specialized housing.

The clearinghouse approach also affords the opportunity to locate smaller, temporary housing units, in different parts of Portland and surrounding communities. This approach builds on strong collaborative work which Preble Street and the City of Portland have done in addressing the increased demand versus limited capacity in the shelter continuum.

Best Practices and Solutions that Work -*Housing First/Rapid Rehousing:*

According to the Resource Development Institute, 2011 report, "Rapid Re-Housing" means that the household gets help to obtain permanent housing as quickly as possible. There is no universal deadline or time limit that defines "rapid." Households vary and housing markets in Portland and the Greater Portland area vary. It may take days or weeks to find a vacancy in housing for individual or family they can afford with a landlord who will accept their rental history. The important point is that permanent housing is the preeminent goal. Households are not required to wait in temporary housing while they attend classes, acquire skills or otherwise demonstrate a given level of "housing readiness." They move directly into permanent housing. If there are skills and information they must learn to sustain their housing, those things are learned when they are in their own housing.

As suggested earlier, this rapid rehousing approach has been proven to be effective with both people who are situationally homeless as well as those who are chronically homeless, (Witte, 2009). Rapid rehousing has also demonstrated to be effective in stabilizing people who suffer from mental illness and substance abuse. The paradigm of a housing first system is simply that providing stable and permanent housing is the first priority for people in crisis. In housing first, individuals struggling with mental illness and/or substance abuse are housed without service or treatment requirements. Outcomes locally and nationally show success in stabilization as well as acceptance of services and decreases in substance abuse and mental health crises. The foundation of a re-imagined system is the conclusion that housing stability is a critical first step on the road to wellness. Physical health, mental health, and other supportive services are

provided after individuals are housed, enabling these individuals to better address these challenges, (Draine, Salzer, Culhane, Hadley, 2002). If people do not have to worry about whether they have a safe place to sleep, and enough food to eat, they are more likely and able to focus on the other necessary steps they need to take to stabilize the other complicating factors in their lives, (Chalmers McLaughlin 2012, Majtabai, 2005).

Best Practices and Solutions that Work –*Increased Case Management:*

For people who are suffering from homelessness, case management is an important factor in helping them transition back to and maintaining stable housing. In the context of the HPRP program, case management in *Engagement and Stabilization* as well as the *Diversion and Prevention* was defined as the case manager serving in the role of a system navigator who provides community resource connections and links and brokers relationships with other service providers. The key distinction in these instances is the expectation that participants who work with the case manager are themselves expected to follow through and to participate fully in their own stability. As such, the participants play a vital role in determining the goals to be accomplished in developing clear objectives to reach those goals, (2012, HPRP report). Davis, 1998, identifies seven important components to effective case management with people who are homeless:

1. Conducting assertive, community-based outreach;
2. Nurturing trusting, caring relationships with clients;
3. Respecting client autonomy;
4. Prioritizing client self-determined needs;
5. Providing clients with active assistance to obtain needed resources;
6. Maintaining small case loads; and
7. Implementing Assertive Community Treatment approaches.

Other researchers such as Rose, 1992, and Saleeby, 1997, suggest the most important aspect of case management is the connection between the client and the worker, as well as the need for the worker to understand the role of client self determination within the context of the service delivery structure. The essence of this approach to case management is that case workers meet the clients where they are. This could be in the shelter, at the drop in center, soup kitchen, on the street. Case managers are embedded in these locations where clients congregate. As such, case management from this model is street based, rather than office based or on call.

Committee Goals, Principles and Strategies:

Through the work of the four Committees, the Task Force identified the following goals, principles and strategies for preventing and ending homelessness in Portland. These goals, principles and strategies are divided into four key areas: 1) Retooling the emergency shelter system, 2) Access to physical and behavioral health, 3) Services to youth, families and veterans, and 4) Supportive and affordable housing. .

After examining several different Task Force models used to create a framework for addressing homelessness in other cities and at the national level, the Task Force chose a system of organization based on goals, principles and strategies. As suggested by our overview here, these three components are linked to issues which are presented within the data, as well as aligned with national priorities established by the Interagency Council on ending homelessness and embedded within the academic and professional literature.

The goals outlined are linked directly to the overall findings of our Committees/work groups and provide the initial frameworks, or guidelines for the further detail. Principles provide the further detail to the goal by offering some definition of the initial action steps which lead to the strategies. Strategies are the specific activities which operationalize the terms set forth in the principles.

1. Retooling the Emergency Shelter System:

Short term goal A: Alleviate overcrowding in Portland's emergency shelter system

Principle 1: Coordinate Portland's emergency shelter services to a centralized intake and assessment model.

> Strategy a: Work in partnership with Preble Street, City of Portland shelter services, Milestone and others on integrating a centralized intake, engagement and rapid assessment protocol.

Principle 2: Create a centralized rapid assessment and referral mechanism which serves all of the Portland emergency shelter system, and coordinate with existing services offered.

> Strategy a: Develop a central intake and assessment process/center where rapid assignment to other temporary housing placements will occur. Individuals who arrive at the intake center would be assessed and placed in other temporary housing located in other parts of Portland and surrounding communities.
>
> Strategy b: Work with clients through a representative payee type model to assess individual assets which can be placed in escrow to support transition to stable housing.
>
> Strategy c: Work with clients on employment opportunities and workforce development in order to achieve greater economic security.

Long term goal A: Regionalize the solution to homelessness in Greater Portland

Principle 1: Encourage other neighborhoods and communities in Greater Portland to support the creation of temporary housing campuses for referral from the intake center/process.

Strategy a: Work in partnership with regional governments on creating a continuum of specialty housing to be located in the Greater Portland region.

Strategy b: Explore municipal zoning requirements so that all properties that satisfy conditional use regulations can be candidates for shelter usage.

Strategy c: Explore other vacant buildings and municipal properties that can be adaptively reused for temporary shelter.

Principle 2: Enlarge temporary housing units in Greater Portland to serve as suitable housing for those who are referred from the intake center.

Strategy a: Develop several temporary housing units which serve the needs of people who present at the intake center. Temporary housing units may include respite housing for those discharged from local hospitals, housing for veterans, short term housing for people with substance abuse issues, housing for people with mental illness, housing for families, etc.

Strategy a: Explore Portland's zoning requirements so that all neighborhoods are equal candidates for emergency shelters, dispersed service locations or specialized care housing as a conditional use.

2. Access to Physical and Behavioral Health Services:

Short term goal A: Coordinate behavioral and primary care treatment for people in the shelter system.

Principle 1: Increase the availability of substance abuse and mental health services for clients who are homeless and do not have the ability to pay the full cost of the service or lack insurance.

Strategy a: Create flexible funding mechanisms to support the delivery of substance abuse and mental health services for clients who are homeless.

Principle 2: Develop medically appropriate housing and respite care services for people who are discharged from the hospital and are in need of medical monitoring.

Strategy b: Implement a medical home model of respite and treatment for people who are discharged from the hospital.

Long term goal A: Increase housing opportunities for people who are homeless and are struggling with addiction.

Principle 1: Enlarge non-medical supportive transitional housing opportunities, case management and health service delivery systems.

Strategy a: Replicate HOME Team and Preble Youth Outreach type model for people who are suffering from behavioral health issues.

Strategy b: Replicate HPRP type model of case management and flexible rental funding for people who are homeless and suffering with behavioral issues.

Principle 2: Expand medically appropriate treatment facilities for people who are homeless and are struggling with physical or behavioral health issues.

Strategy a: Increase capacity in residential treatment facilities to accept people who are homeless with physical and behavioral needs.

Long term goal B: Increase employment opportunities for people who are homeless and are struggling with addiction and mental illness.

Principle 1: Create supportive work force development programs which serve people who are homeless and have struggles with addiction and mental health disabilities.

Strategy a: Expand appropriate employment opportunities for people with behavioral disabilities.

3a. Youth and Families:

Short term goal A: To intervene early with runaway youth/youth at imminent risk of leaving home.

Principle 1: Provide earlier, targeted intervention and better options decrease number of unaccompanied youth seeking shelter and decrease the length of time out of home or out of a safe place.

Strategy a: Ensure collaboration and planning between community provider, schools, and DHHS. Family mediation, case management is available in Portland neighborhoods.

Strategy b: Create housing options for youth leaving corrections and foster care (needs assessment of need and development of models).

Strategy c: Develop/maintain specific substance abuse and mental health interventions for families.

Short Term goal B: Provide a continuum of care for unaccompanied youth who cannot return home.

Principle 1: Decrease the time youth spend in homelessness by increasing housing, support, and treatment options.

Strategy a: Increase shelter options for homeless youth; maintain outreach, drop-in, health, mental health, and substance abuse in harm reduction model.

Strategy b: Increase specific housing options to include transitional and permanent supportive housing models. (Explore housing first models emerging for youth)

Strategy c: Increase work, training, and education options and models which target homeless youth.

Strategy d: Implement and maintain community support models that meet the needs of homeless youth with multiple challenges and co-occurring mental health and substance abuse.

Long term goal A: Prevent families from falling into homelessness.

Principle 1: Increase prevention with families utilizing the "but for" definition.

Strategy a: Increase availability of housing support and case management for families at risk including legal services.

Strategy b: Maintain a client fund that can assist with immediate financial issues.

Strategy c: Provide financial counseling to families at risk of homelessness

Strategy d: Increase work and income options for families (including looking at models for training and employment).

Strategy e: Increase subsidies available for low income families.

Strategy f: Ensure that mental health and substance abuse treatment are quickly available when needed.

3b. Veterans:

Short term goal A: Develop shelter, transitional housing, and/or permanent housing programming options specifically for veterans

Principle 1: Veterans have specific issues and entitlements and a veteran's shelter can alleviate shelter crowding.

> Strategy a: Work in partnership with the VA, community providers, and housing developers to create emergency shelter and transitional housing options in Portland (exploring VA funding for transition in Place).

Principle 2: Increased permanent housing options for veterans

> Strategy a: Advocate for and obtain additional VASH vouchers for Portland.
>
> Strategy b: Maximize use of the Support Services for Veteran Family program to house homeless households and to prevent households from becoming homeless. (Support continued funding past year two).
>
> Strategy c: Explore and possibly implement permanent housing for veterans through a site or the development of site based vouchers in existing units.

Short Term goal B: Ensure that veterans access all entitlements from the VA and other public programs.

Principal 1: Outreach at shelters is essential to connecting veterans with VA entitlements

> Strategy: Place a full-time outreach worker from the VA at Oxford Street Shelter to assist with connecting homeless vets to VA and to verify status and entitlements.

Principle 2: All veterans should access needed health and behavioral health services.

> Strategy a: Work with the VA Community Based Outreach Center, Togus Medical Center, and health providers in the community to create barrier free access to health care.

Short term goal C: Make sure veterans with needs for community support receive the appropriate level of case management as well as employment, mental health, substance abuse, and social supports.

Principle 1: All veterans should be provided case management if needed at an appropriate level to support stability in the community.

> Strategy a: Support case management through VASH, SSVF, and other VA options and provide additional case management and outreach through community programs as needed.

4. Supportive and Affordable Housing:

Short term goal A: Reduce the number of admissions to the Portland emergency shelter system.

Principle 1: Alleviate the number of first time admissions to the emergency shelter system in Portland.

> Strategy a: Enlarge diversion and prevention opportunities such as short term rental vouchers, access to legal services, assistance with back rent and security deposits for people who have been homeless for 14 days or less and are in the emergency shelter system.

Principle 2 Work in partnership with local landlords to stabilize individuals and families who are 14 days from eviction and at risk of entry into the emergency shelter system.

> Strategy a: Strengthen the proactive system of catching and diverting individuals and families from the emergency shelter system.

Principle 3: Reduce the number of direct referrals from hospitals and correctional facilities to the Portland Emergency Shelter system.

> Strategy a: Integrate into the hospital/jail referral and discharge system appropriate housing placements and services for patients or inmates where they have natural supports.

Long Term Goal A: Reduce the number of long term/chronically homeless in Portland.

Principle 1: Enlarge the number of supportive housing units available in Portland for people who are long term homeless.

> Strategy a: Create new housing first units and appropriate supports for people who are homeless-(acute cases). Work with regulators and organizations to advocate for funding for development costs.

> Strategy b: Work in partnership with landlords to increase access to housing stock which will increase available rental opportunities for people who are homeless. Create/expand resources for landlords to work through issues with tenants– (broader approach).

Principle 2: Ensure necessary level of support which will allow people to remain housed.

> Strategy a: Leverage Federal, State and local funding sources to fund supports for people to secure and remain in their homes.

Cost Savings of Full Implementation:

The Task Force recognizes that implementation of all of the initiatives within this plan are both ambitious and expensive. However, the data from other cost effectiveness evaluations of many of the initiatives outlined here will provide an overall system savings.

The number of chronically homeless individuals, estimated to be 100 clients, would represent at bed night savings of 36,500. Cost study data suggests these 100 clients will also saving the emergency shelter system, to include emergency room visits, ambulance calls, jail nights, mental health crisis admissions and emergency social service delivery systems nearly $1,300,000 annually. Shelter night savings would also be realized for an estimated 167 clients who would be rapidly rehoused, saving approximately 4,000 bed nights. Changes in case management and mental health and substance abuse service delivery methods are estimated to reduce emergency room costs and inpatient psychiatric admissions by nearly $945,000 over a 12 month period. All told, total emergency system cost savings is estimated at $2,245,000 annually.

References

Arehart-Treichel, J.,(2004), Homelessness Does Not Lead to Increased Substance Abuse., *Psychiatric News*, 39(12),9-11.

Burt, M., Aron, L. Douglas, T., Valente, J. Lee, E & Iwen, B.(1999). Homelessness: Programs and the people they serve. 1996 National Survey of Homeless Assistance Providers and Clients

Burt, M. and Cohen, B.(2002), Differences among Homeless Single Women, Women with Children and Single Men, *Social Problems*, 36(5), 508-524.

Chalmers McLaughlin 2012, Homeless prevention, rapid rehousing evaluation for the City of Portland, available: www.portlandmaine.gov

Draine, J., Salzer, M., Culhane, D. & Hadley, T. (2002). Role of Social Disadvantage in Crime, Joblessness, and Homelessness Among Persons With Serious Mental Illness. *Psychiatric Services*, 53(5), 565-573.

Fangmeier, R. (1990). Doubled-Up Homeless Study. Practice and Research. Retrieved http://www.columbia.edu/cu/csswp/research/complete.double.htm.

Folsom, D., et al. (2005). Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients with Serious Mental Illness in a Large Public Mental Health System. *Am J Psychiatry*, 162(2), 370-376.

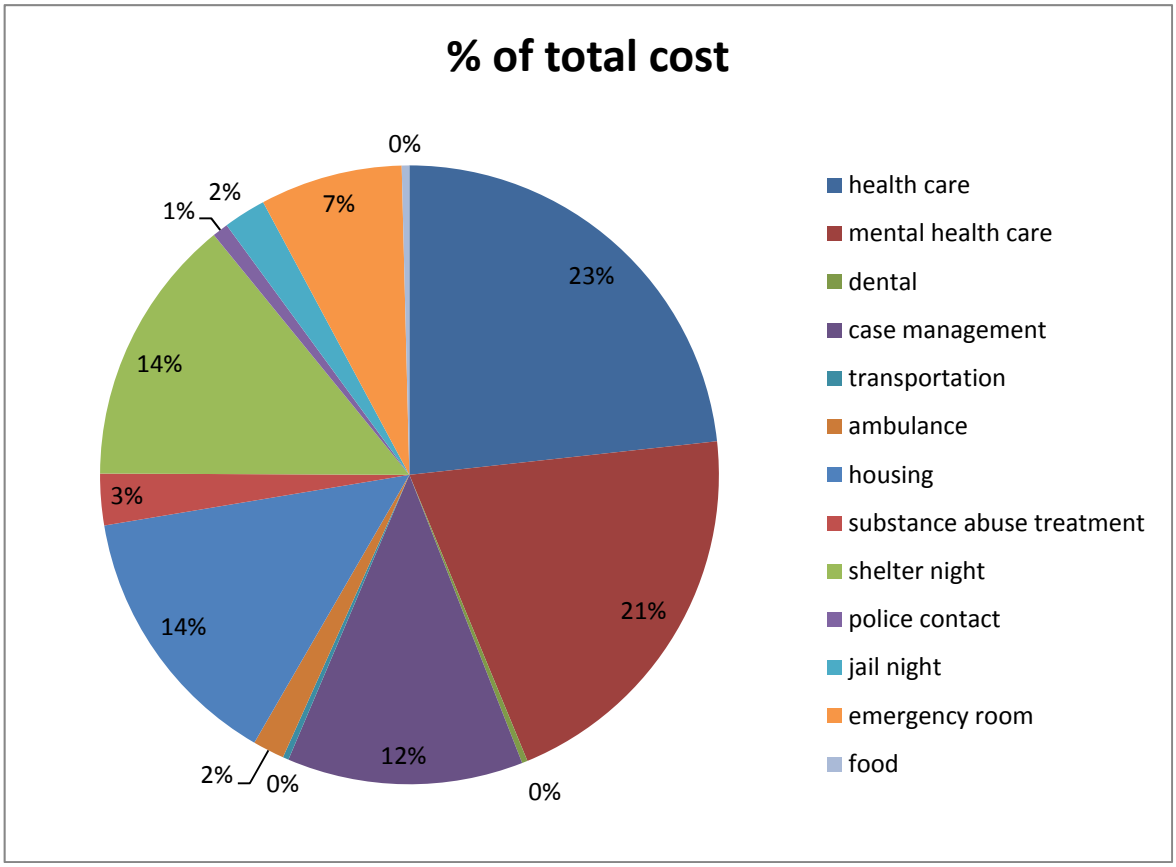
Mojtabai, R. (2005). Perceived Reasons for Loss of Housing and Continued Homelessness Among Homeless Persons With Mental Illness. *Psychiatric Services*, 56(2), 172-184.

Moore, J. (2005). Unaccompanied and Homeless Youth Review of Literature (1995-2005). National Center for Homeless Education. Retrieved http://www.serve.org/nche/products_list.php#uy_lit_review.

Morse, G, 1998, *A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research*, retrieved: http://aspe.hhs.gov/homeless/symposium/7-Casemgmt.htm

U.S. Interagency Council on Homelessness, (June 2010). Opening Doors: *Federal Strategic Plan to Prevent and End Homelessness.* Washington, DC.

Appendix A: Total cost of supporting 99 people who are homeless over a 12 month period in Portland.



Data represented here is for the 99 clients who were homeless in Portland 1 year in 2009. The total cost of providing the emergency service structure to these 99 individuals was $2,776,409.36 over the 12 month period. That is $28,044.59 per person per year. The costs reflected above are the percent of the total cost for providing the emergency structure.