# RESEARCH REPORT

## APPLICABILITY OF A CONTINUUM OF CARE MODEL TO ADDRESS HOMELESSNESS

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06/2001

Canada Mortgage and Housing Corporation

# Applicability of a Continuum of Care Model to Address Homelessness

## F I N A L  R E P O R T

## March 2002

**Prepared by:**

**Social Data Research Ltd.**

**Canada Mortgage and Housing Corporation**
Applicability of a Continuum of Care Model
**F I N A L  R E P O R T**

## Executive Summary

This report presents the results of a study that examined the Continuum of Care (CoC) model of addressing homelessness in the United States (US). The model requires communities to develop coordinated action plans in order to receive funding by the US Department of Housing and Urban Development (HUD) for local homelessness initiatives. Four sites were studied to explore the model's benefits, limitations, similarities and differences. The selected sites for the case studies were:

1. Broward County, Florida
2. King County, Seattle, Washington
3. City of Memphis, Tennessee
4. Philadelphia, Pennsylvania

The case studies were conducted using secondary data collection methods including interviews, document reviews and self-administered questionnaires. It was not within the scope of this research to conduct site visits. The final phase of the research involved a survey of Canadian stakeholders to examine the applicability of the CoC homelessness model for Canada based on the findings of the case studies and their knowledge of the Canadian environment. It should be noted that an examination of the homelessness policy framework in Canada was not part of the research.

The majority of stakeholders working at the local program level were of the opinion that the American CoC model had much to offer. These respondents, however, felt strongly about the importance of building on what is already in place in Canada. They were in favour of incorporating the best features of the American CoC into existing Canadian best practices, rather than simply replacing existing programs. They also noted the necessity of applying Canadian values, policies and legislation to the CoC model if it were to be implemented in Canada.

Stakeholders' comments highlighted the following general advice about the implementation of a CoC model in Canada:

- Encourage all levels of government to work toward the same goal through a common housing and homelessness strategy.
- Make sure the approach is not too "top down" and allows for local differences.
- Ensure that the application process is not too onerous for agencies.
- Support the planning process at the local level through the provision of resources and necessary technical expertise.
- Conduct follow up research and evaluation to determine and share best practices.
- Acknowledge the need for a supply of permanent affordable housing as the long-term solution to homelessness.

**Prepared by Social Data Research Ltd.**
**130 Slater Street, Suite, 750, Ottawa, ON, K1P 6E2**
**Tel: 613-594-9589; Fax: 613-594-8705; www.sdrsurvey.com**

**Société canadienne d'hypothèques et de logement**
Applicabilité du modèle du continuum de services
**R a p p o r t  d é f i n i t i f**

## Résumé

Ce rapport présente les résultats d'une étude portant sur le modèle du continuum de services qui a cours aux États-Unis pour s'attaquer au problème des sans-abri. Le modèle exige que les collectivités élaborent des plans d'action coordonnés pour être admissibles à l'aide financière du Department of Housing and Urban Development (HUD) des É.-U. pour les initiatives locales visant les sans-abri. Quatre cas ont été étudiés pour déterminer les avantages, les limites, les ressemblances et les différences du modèle :

1. Broward County, Floride
2. King County, Seattle, Washington
3. Ville de Memphis, Tennessee
4. Philadelphie, Pennsylvanie

Les chercheurs ont mené les études de cas à l'aide de méthodes de collecte de données secondaires comme les entrevues, les études documentaires et les autoquestionnaires. Toutefois, ils n'ont pas effectué de visites sur le terrain. L'étape finale de la recherche consistait à demander aux intervenants du Canada d'évaluer l'applicabilité du modèle du continuum de services au contexte canadien en fonction de leurs connaissances du contexte canadien et des constatations issues des études de cas. Il est à noter qu'un examen de la politique-cadre en vigueur au Canada à l'égard du phénomène des sans-abri était exclu des travaux de recherche.

La plupart des intervenants oeuvrant sur le terrain sont d'avis que le modèle américain du continuum de services comporte beaucoup d'avantages. Les répondants croient fermement qu'il importe de construire sur les bases de ce qui existe déjà au Canada. Ils favorisent l'intégration des meilleures caractéristiques du modèle américain aux pratiques exemplaires canadiennes, au lieu de carrément remplacer les programmes existants. Ils insistent aussi sur le fait qu'il faudra appliquer au modèle du continuum de services les valeurs, les orientations et le cadre législatif propres au Canada, si le modèle est implanté au pays.

Les intervenants soulignent l'importance de certaines pratiques relativement à la mise en œuvre du modèle du continuum de services dans un contexte canadien :

- Encourager tous les ordres de gouvernement et les municipalités à travailler à l'atteinte d'un objectif commun par le truchement d'une stratégie commune en matière de logement et de sans-abri.
- Mettre en place une approche peu centralisatrice qui admet les différences locales.
- S'assurer que le processus de demande n'est pas trop lourd pour les organismes.

**Rédigé par Social Data Research Ltd.**
**130, rue Slater, bureau 750, Ottawa (ON)  K1P 6E2**
**Tél. : (613) 594-9589, Téléc. : (613) 594-8705, adresse Web : www.sdrsurvey.com**

- Soutenir le processus de planification à l'échelon local en prêtant les ressources et l'expertise technique nécessaires.
- Mener des études et des évaluations de suivi afin de déterminer les pratiques exemplaires et de les faire connaître.
- Admettre qu'un stock permanent de logements abordables constitue la solution à long terme au problème des sans-abri.

**Rédigé par Social Data Research Ltd.**
**130, rue Slater, bureau 750, Ottawa (ON)  K1P 6E2**
**Tél. : (613) 594-9589, Téléc. : (613) 594-8705, adresse Web : www.sdrsurvey.com**

National Office
700 Montreal Road
Ottawa ON K1A 0P7
Telephone: (613) 748-2000

Bureau national
700 chemin de Montréal
Ottawa ON K1A 0P7
Téléphone : (613) 748-2000

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**EXHIBITS:**

## Introduction

This report presents the results of a study that examined the Continuum of Care (CoC) model of addressing homelessness in the United States (US). The model requires communities to develop coordinated action plans in order to receive funding by the US Department of Housing and Urban Development (HUD) for local homelessness initiatives. Four sites were studied to explore the model's benefits, limitations, similarities and differences. Canadian policy makers and program leaders who specialize in homeless issues were then presented with the case study findings and asked to assess the model's applicability to Canada. It should be noted that the informants were not asked to review the CoC program, just the case studies and the draft overview document.

The case study sites were chosen after careful consideration of a number of selection criteria including:

- existence of the fundamental components of a CoC system
- availability of outcome-related information and willingness to participate
- different geographic climates
- different sizes of communities
- different types of homeless clients
- different management systems
- recommendations from HUD based on evaluation scores

The selected sites for the case studies were:

1. Broward County, Florida, comprised of southern suburban cities
2. King County, Seattle, Washington, a north-western city including rural communities
3. City of Memphis, Tennessee, a southern city
4. Philadelphia, Pennsylvania, a north-eastern city

All four sites selected for the case studies are flagship CoCs. Two sites were top-scoring national HUD applicants, two had received HUD's best practice awards, and one site was the first site in the US to produce a blue print to end homelessness with buy-in from politicians. Three of the sites have similar populations of about 1.5 million people while Memphis has a population of 650,000. The number of homeless persons at any one point in time ranges from 6000 to 10,000 across all four sites.

## Methodology

This study was conducted in three phases. A detailed methodology report submitted under separate cover during phase one outlined the process for final site selection, identification of key informants at each site, the framework used for the data collection and the final data collection instruments. The case studies were conducted in phase two using secondary data collection methods including interviews, document reviews and self-administered questionnaires. It was not within the scope of this research to conduct site visits. The final phase of the research involved a survey of Canadian stakeholders to examine the applicability of the CoC homelessness model for Canada based on the findings of the case studies and their knowledge of the Canadian environment.

Case studies

Using an interview guide, in depth telephone interviews were conducted with leaders[1] at each CoC site identified for the consultants by HUD and confirmed during phase one of the study[2]. In addition to the interviews, these key informants completed detailed questionnaires and submitted extensive documentation including their HUD funding application, any available evaluations, needs assessments, and gap analysis reports. Information was also obtained directly from HUD regarding the CoC application process and selection criteria and from a scan of selected relevant literature.

The descriptions of the individual CoCs at each site are presented in Appendix A.

The stakeholder survey

To examine the implications of the case study results for Canada a stakeholder survey was conducted of identified individuals working in the area of homelessness at the local and provincial level across Canada. The individuals surveyed were selected using a three-tiered process. First, national and regional CMHC officers across Canada were contacted for provincial and local referrals in their jurisdiction. Second, provincial policy and program leaders in homelessness identified by CMHC were contacted to obtain their commitment to participate in the survey as well as their recommendations for local leaders in their province. Finally, local stakeholders were contacted. Through this process 17 stakeholders representing each of Canada's regions were identified and agreed to participate in the survey – 8 working at the provincial or territorial policy level and 9 engaged at the municipal level in program planning and delivery. (See Appendix B for a list of the contributors)

Each participant in the stakeholder survey was asked to respond to a series of questions about the results of the research. To assist them in the process, participants

[1] Site leaders were: Steve Werthman, Administrator, Homeless Initiative Partnership, Broward County Florida; Patricia Morgan, Executive Director, Partners for Homelessness, City of Memphis/Shelby County, Tennessee; Dainette Mintz, Director, Special Needs Housing, City of Philadelphia; Cynthia Ricks-Maccotan, Administrator, King County Department of Community & Human Services, Seattle.

[2] A screening survey in the first phase of the study confirmed the most appropriate key informants at each site.

were sent the draft report outlining the integrated results and the individual case descriptions of the American sites. The stakeholder survey was conducted by telephone and Email.

## A brief description of the HUD CoC Model

Over the course of the last seven years, HUD has initiated and institutionalized policies to address the critical problem of homelessness in the United States. HUD's approach to breaking the cycle of homelessness is known as the Continuum of Care (CoC). Simply stated, a CoC is a coordinated network of public and private homeless assistance providers serving a geographic area. HUD defines a local CoC plan as "a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximize self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness". [3]

Previous to the CoC model all homeless organizations in the United States competed against each other for funding. Under the CoC model each community is awarded funding to allocate to their local service providers. Local planning bodies decide which agencies in their jurisdictions should be funded and the amount of funding each should receive based on demonstrated needs in the community.

Local agencies serving the homeless must co-operate to submit a single consolidated application to compete for Homeless Assistance Grants at the federal level. In a 1995 review of the homeless programs administered by HUD[4], the report to Congress concluded that "a consolidated approach to homeless assistance that improves coordination and eliminates fragmentation simply makes sense".

The CoC officially dates back to September 1996 when HUD announced some $675 million (US) in available grants to address the housing and service needs of 300,000 homeless people. HUD's long-term goal is to more than double the cumulative population moved to permanent housing to 660,000 by the end of 2006. [5] By the year 2000, HUD had funded 360 CoC programs across the United States. The total funding awarded was $900 million (US) for an average award of $2.5 million (US) per site. [6]

[3] Source: HUD's Trainer Guide to Continuum of Care planning and implementation.
[4] Review of Stewart B. McKinney Homeless Programs Administered by HUD: Report to Congress. Prepared for the US Department of Housing and Urban Development by the Office of Policy Development and Research, January, 1995.
[5] US Department of Housing and Urban Development FY2000-FY2006 Strategic Plan, September, 2000
[6] Interview with Paul Dornan, CoC Program Officer, HUD

The CoC application process

Within HUD, there are essentially two funding processes for homeless initiatives: (1) formula based non-competitive funding; and (2) competitive funding under the CoC process. The funding application for the CoC Homelessness Initiative begins when HUD publishes a Notice of Funding Availability (NOFA) in the Federal Register. Applicants must submit specific information about each proposed project along with their CoC application. The process typically takes about six months from the time the application is initiated to the time successful candidates receive their funding. The funding cycle is three years with annual renewals within that period.

Through the competitive process, the CoC model encourages local service providers to combine their efforts and to explain and rank their community's needs. To receive CoC funding, local providers must successfully demonstrate a coordinated effort to provide homeless individuals and families with a full range of services. When insufficient funds remain to fund all projects having the same HUD score, priority is given to permanent supportive housing projects. This is consistent with legislation passed by Congress in 1999 mandating that 30% of HUD funds awarded annually to CoCs are designated for permanent supportive housing.[7]

In terms of scoring applications, HUD awards additional points to those communities whose applications incorporate "mainstream" resources and who demonstrate leveraging of funds to generate other public or private resources. Highest points are achieved by those sites that demonstrate the coordination and integration of homeless programs with mainstream health, social services and employment programs for which homeless populations may be eligible. These include Medicaid, Temporary Assistance for Needy Families, Food Stamps, and services funded through the Mental Health and Substance Abuse Block Grant, Workforce Investment Act and the Welfare-to-Work grant program.

In addition to the CoC funding, HUD works to prevent homelessness through a number of housing assistance and housing development programs, which aid low-income families. These include rental subsidies, voucher programs and low-income housing tax credits. At the federal level, HUD is one of several agencies charged with supporting the services and care provided at the local level to deal with the problem of homelessness. Other federal partners include the Department of Health and Human Services, the Department of Education, the Department of Labour and the Department of Agriculture.

[7] Permanent housing – considered a key element of the strategy for reducing homelessness – is supported through HUD's Supportive Housing program (SHP), Shelter plus Care (S+C) and Single Room Occupancy (SRO) programs. Other HUD non-competitive programs which address homelessness in the Continuum include the Emergency Shelter Grant Program, and the Title V program where HUD collects and publishes information about surplus federal properties that can be used to help homeless persons.

Who are the homeless?

HUD defines homeless individuals and families as those who are sleeping in places not meant for human habitation (such as cars, parks, sidewalks, and abandoned buildings) or those who are sleeping in an emergency shelter as a primary nighttime residence. Persons may also be considered homeless if they:

- are living in transitional or supportive housing for homeless persons but originally come from streets or emergency shelters;
- ordinarily sleep in transitional or supportive housing for homeless persons but are spending a short time (30 consecutive days or less) in a hospital or other institution;
- are being evicted within a week from private dwelling units and no subsequent residences have been identified and they lack resources and supportive networks needed to obtain access to housing; or
- are being discharged within a week from institutions in which they have been residents for more than 30 consecutive days and no subsequent residences have been identified and they lack the resources and support networks needed to obtain access to housing.

Fundamental components of HUD's CoC model

The fundamental components of HUD's Continuum of Care model[8] are:

1. Outreach, intake, assessment and referral services to (1) identify an individual's or family's service and housing needs, and (2) link them to appropriate housing and/or service resources;
2. Emergency shelters with appropriate supportive services to help ensure that homeless individuals and families receive adequate emergency shelter and referral to necessary service providers or housing finders;
3. Transitional housing with appropriate supportive services to help people develop the skills necessary for permanent housing and independent living; and
4. Permanent supportive housing which is long-term, community-based housing that has services for homeless people with disabilities and enables special needs populations to live as independently as possible in a permanent setting

According to HUD [9], first and foremost, an effective CoC system is coordinated. To be successful in the funding competition, local communities must demonstrate that all four fundamental components presented above are present in their system. They must also demonstrate that there are linkages and referral mechanisms among these components to facilitate the movement of individuals and families toward permanent housing and self-sufficiency. A CoC system should also include a focus on homelessness prevention.

[8] Best Practices 2000: Focus on Continuum of Care, US Department of Housing and Urban Development, March 2000, Issue no. 2

[9] Best Practices 2000: Focus on Continuum of Care, US Department of Housing and Urban Development, March 2000, Issue no. 2

An outcome-focused evaluation of HUD's CoC program was being conducted by an independent consulting firm in the United States at the time of this study.

## A summary of what the case studies revealed about the HUD CoC model

- All sites had a well established planning process in place which included:
  - city or county commitment of resources for a full-time manager and one or more staff members
  - a coalition of service providers who undertake selected responsibilities such as shelter and street counts and who participate regularly in the planning process
  - an open community advisory committee with broad stakeholder representation including public and private sector partners who meet at strategic times to advise on policy
- All sites included some variation of the four CoC components
- There were local differences in the implementation of the components depending on:
  - The nature of the progress made by the community to address homelessness prior to the introduction of the CoC
  - The relative strength of individuals involved in planning process
  - The sub-populations of homeless persons being served
  - The ability to partner with non-traditional stakeholders such as business and politicians
- The sub-populations of homeless being served were similar at all sites but priorities differ in terms of numbers being served and types of services offered – the dually diagnosed (people with mental illness and drug and/or alcohol addictions) or the seriously mentally ill are a high priority for everyone
- There are specialized service systems within the CoC for sub-populations such as families with children, those with HIV/AIDS, veterans, persons with mental illness.
- In most sites the general population of homeless is served by an agency such as the Salvation Army
- There has been an uneven progress towards the monitoring of performance outcomes – only one site had clearly defined indicators at the time of the study
- Computerized client tracking systems are still emerging and continue to be a challenge at all sites – all sites are working on the implementation of a system-wide client and resource based database [10]

[10] Up to now HUD did not require that sites develop an automated information and data collection system. However, Congress has recently mandated that all communities have a homeless management information system (HMIS) operational within a given time period (three years has been proposed). HUD is in the process of establishing some common definitions and standards and will be providing sites with technical assistance to assist with setting up the HMIS including the assessment of available software in the marketplace. (Information provided by HUD key informant)

# INTEGRATED RESULTS OF CASE STUDIES

## Lessons learned across four sites

Key informants at each of the four American sites were asked to provide their observations about what has worked well and what has been a challenge in the planning and implementation of the CoC model in their community. This section presents the cumulative lessons learned across the four American sites based on these observations.

### Observations related to the planning and implementation process

What has worked well

According to key informants:

- There is general agreement that the CoC planning process has been successful in bringing a large array of different stakeholders and local service providers to the same planning table for the first time.
- The model has helped organizations (both public and private) who weren't working together see the advantage of doing so to achieve common goals.
- The planning process has increased the overall awareness of agencies about each other and the services they provide.
- The HUD application process itself is rewarding and has encouraged agencies to coordinate their services.
- There is general agreement that the competitive process has resulted in higher quality projects. In addition to HUD requirements, at least one site offered "bonus" points for leveraging of other resources and for coordination with other programs.
- Some additional criteria have been introduced to the selection process over time. At several sites cost effectiveness of program is now a requirement. As a result of the extra attention placed on cost-effectiveness and increasing use of mainstream resources, two agencies (in Memphis) reduced the amount of their request to HUD.
- At one site (Seattle-King County), the funding committee visited proponent agencies in the community, producing a rating that became part of an agency's overall score. This was a way of ensuring that agencies could deliver what they said they would. It also improved the overall quality of programs.
- The HUD process has facilitated ongoing partnerships. Funding is the main incentive for stakeholders to work together.
- The fact that the CoC is a national initiative has helped to crystallize programs at the local level. Existing coalitions have been strengthened as a result of the CoC.

- The leveraging criteria for funding has encouraged coordination with mainstream health and social service provider organizations.
- The number of homeless and those in "tent cities" has decreased. Permanent housing and transitional housing for special needs populations has increased.

Aspects related to the planning & implementation that continue to be a challenge

According to key informants:

- It is hard to get "non-traditional" stakeholders (e.g., businesses, suburban cities) to participate on a regular basis.
- There are still "turf wars" among some agencies, particularly those who have been used to acting independently.
- Obtaining contractual and partnership agreements among agencies is a long process. Finding common ground among many diverse agencies has taken longer than anticipated.
- The jurisdictions are large and can include many smaller communities. It is often difficult to find an approach that satisfies everyone
- The NIMBY mentality is still fairly wide spread. Local neighbourhood groups often challenge new projects for the homeless in their area.
- Agencies need to understand that they are part of a larger system and do not need to solve all the problems on their own.
- Implementing an automated information & ongoing data collection system has been a challenge at all sites – some are still not up and running.
- Lack of reliable data on the homeless continues to be an issue. Some individual agencies have data but it is generally not system-wide.
- Balancing available funding between renewal projects and first time programs is a constant challenge. The priority is often to renew funding for effective existing projects.
- Sometimes it is difficult to get mainstream health and social service agencies to change the way they do things.
- Some agencies have not been able to meet their commitment in terms of program delivery either because goals were not realistic or because of lack of experience.
- Some agencies have had difficulties leveraging their estimated share of funds. It's difficult to know in advance what funding might be available in the future.

Lessons learned about planning and implementation

According to key informants:

- It is important to involve all levels of government in the planning and implementation process to minimize gaps and utilize the whole social service system.
- It is important to have representation from recipients of services in the various

subgroups of the target population to design effective programs that meet the needs of clients.

- It is important to involve different funders (private sector, foundations etc.) around the table so that they understand how and why their money is spent.
- Front line agency staff as well as management should be involved in the planning and implementation process since their perspectives are often different.
- Grassroots agencies are often helpful in identifying local needs and should be involved in the process.
- Involving neighbourhood associations up-front and getting their buy-in helps to minimize the NIMBY factor.
- Support from local politicians and senior city officials is critical in overcoming NIMBY issues. They can help to negotiate various potential roadblocks such as zoning and planning regulations.
- The CoC cannot be successful without strong support from mainstream services. In particular mental health and substance abuse treatment centres, income support, and decent safe housing must be available.
- It is important to establish realistic target dates given the lengthy period of time required to secure agreement from key stakeholders and move projects through governmental processes.
- Continuous marketing of the CoC's activities and successes to partner agencies, the corporate sector and the public at large through oral and written presentations will increase buy-in and overall awareness of the system.
- Multiple modes of ongoing effective communication among partners include telephone, e-mail, newsletters, cross-board appointments, and regular meetings. It is important to distribute fact-based information as much as possible to all partners and to have a feedback mechanism following each presentation.
- Offering small stipends and bus passes to client representatives will facilitate their involvement. It is important to have food and refreshments available at meetings.
- It is important to get written commitment from each partner agency in terms of their services and leveraged funding.
- It is necessary to build in ongoing technical assistance to less experienced organizations to complete the grant application. At one site, experienced organizations are paired with less experienced agencies. Another site offers training workshops to assist agencies with the process. A third site offers direct technical assistance.
- It is important to track the operating costs associated with each component as some components may be more expensive to implement than others – for example, at two sites emergency shelters cost more to operate than transitional and permanent housing

### Extent to which sites are meeting their short and longer term goals

Each of the sites articulated their own short and longer term goals. For the most part, short term goals related to the provision of emergency housing to those in immediate

need. Longer term goals were related more to finding ways to prevent homelessness and to integrate people back into society.

According to key informants:

- None of the sites have completed formal outcome evaluations. Only one site has performance outcome indicators and data processes in place to do this.
- However, key informants agree that most programs are meeting their short term goals and are on track to meeting their longer term goals, although the journey is taking longer than anticipated. Part of the reason is that the HUD application process itself is lengthy and daunting, taking an average of six months to complete.
- One of the short term goals was to bring agencies together in a coordinated way and this has been achieved.
- To a varying degree, all sites have introduced more transitional housing and supportive housing into the system, however, the lack of affordable permanent housing is cited as one of the biggest challenges in meeting the longer term goal of reducing homelessness.
- Support services are seen as critical to meeting longer term goals, however, it is difficult to sustain ongoing service funding through HUD. The trend at some sites now is to encourage as much housing as possible through the CoC and arrange support services through partnerships with mainstream agencies.
- A Mayor's Task Force on Homelessness at one site has been extremely helpful in meeting the longer term goal of breaking the cycle of homelessness by focusing more attention on prevention and increasing access to mainstream services.

### Lessons learned about fundamental components of CoC

The following summarizes the lessons learned for each of the components of the CoC, including prevention, and what aspects continue to be a challenge according to key informants.

### A. Prevention services

Lessons learned according to key informants:

- Prevention programs need to be well coordinated with shelters, transitional housing and permanent supportive housing in order to make appropriate referrals for at risk individuals and families who are not eligible for rent and utility assistance.

- Emergency assistance programs serve the working poor in emergency situations fairly well. The programs are not as effective for households that would likely become homeless due to long-term health problems or chronic unemployment. For this population more emergency housing is needed where no deposit is required and individuals/families can pay by the week or month at a reasonable cost until they are working full-time again or their disability payments start.
- The need for a strong prevention strategy is paramount. But long term, intensive services needed to prevent homelessness for those with multiple problems are and should continue to be the responsibility of mainstream programs. The Federal government has recognized this and has recently invited State governments to apply for grant funds to coordinate statewide groups to develop and present recommendations for much needed policy changes.

Challenges according to key informants:

- It is difficult to track successful outcomes for prevention programs. How do you define success? Providing legal aid, for example to resolve a tenancy issue may not result in a positive outcome but that does not mean the aid should not have been given in the first place.

## B. Outreach/Assessment

Outreach services might include street outreach to homeless youth or single adults, or it might include special mobile health care or mental health care workers.

Lessons learned according to key informants:

- Sites have found that specialized outreach teams serve people who can be located and are amenable to treatment and services quite well. This approach is not as effective in assisting those clients who are too sick (psychotic or addicted) to accept help.
- Communities might be well-advised to establish free-standing outreach programs as outreach is often not a top priority for agencies that are already struggling to meet the needs of their existing clients.
- It is very important to involve officials responsible for administering the justice system to divert homeless individuals who have come into conflict with the law from jail, and to institute discharge policies that ensure housing is available for those being released.
- Rather than only using support workers, it is effective to use a multi-disciplinary outreach team that includes a law enforcement official as well as a homeless person and community support worker.

Challenges according to key informants:

- An outstanding challenge is the fragmented, dysfunctional mental health system. To be really effective, outreach must be matched with adequate services,

emergency shelter, transitional housing and permanent supportive housing. These resources are very limited for persons with severe mental illness.
- Continued development of supportive housing for persons with chronic drug and alcohol dependencies is a challenge.

## C. Emergency shelter

The emergency shelter grant program under HUD is designed to help improve the quality of existing emergency shelters for the homeless, to make available additional shelters, to meet the costs of operating shelters, to provide essential support services to homeless individuals, and to help prevent homelessness. For example, at one site, emergency shelter can last up to 60 days and provide a full array of services depending on the needs of the client.

Lessons learned according to key informants:

- Although emergency shelters with attached services are more costly, the cost benefit is there in the long run particularly if this increases the chances that clients will stay off the streets and re-integrate into society.
- It is more costly to run shelters that accommodate persons with special needs such as the developmentally handicapped, physically handicapped, veterans, persons with pets, (in San Francisco, they have a shelter just for pets), and married couples (who typically are not accommodated in one room because of safety issues related to domestic violence).
- Emergency shelters for families are also more costly because of the added safety and security services needed for children.
- Emergency shelters work best for higher functioning individuals and families. Those with special needs such as severe persistent mental illness or chronic public inebriates are often better served in “low demand” shelters (where persons are allowed to continue to use substances, but perhaps at a reduced level) or “tiered incentive” models (where sobriety is rewarded with extra benefits such as a private room with a TV).
- Another successful model is a structured program involving principles of “Reality Therapy” (taking responsibility for consequences of one’s own behaviour).

Challenges according to key informants:

- Emergency shelter for adults unaccompanied by children often becomes long-term housing of last resort for many unless there is a clear focus on assessment and triage to treatment, transitional housing or permanent supportive housing.
- Shelters that are serving a variety of sub-populations need to be flexible in their approach. One size does not fit all.
- All sites have found it challenging to provide support services. One approach is to foster a collaborative arrangement between existing support service providers and shelters (either through sub-contracts or commitments of in-kind services) as opposed to establishing duplicate “in-house” services at the shelters. The

advantage of this for the clients is that when they leave the shelter they are still connected to the system through the support services.

## D. Transitional housing

Transitional housing is a type of supportive housing used to facilitate the movement of homeless individuals and families to permanent housing. Basically, it is housing in which homeless persons live for up to 24 months and receive supportive services that enable them to live more independently. The supportive services may be provided by the organization managing the housing or coordinated by them and provided by other public or private agencies.

Lessons learned according to key informants:

- This component has been found to serve families with children very well. Also recovering substance abusers are typically well served in terms of availability and quality of programs. Beds are more limited for homeless individuals with severe and persistent mental illness.
- At one site there has been a proliferation of transitional shelters far in excess of either emergency shelters or permanent housing because many are independently funded and are not part of the integrated CoC plan. This demonstrates the need to establish and maintain linkages between the components of the system using inter-agency agreements.
- At one site, transitional housing is available for persons with HIV/AIDS but the program is only effective when clients are willing to address underlying addiction issues. Experienced providers understand that unless substance abuse and mental illness are addressed as the primary issues creating and perpetuating homelessness for affected individuals they are only "managing" homelessness. (In a recent study of homeless families with children at one site, 37% of the single mothers self-reported substance abuse problems.)

Challenges, according to key informants:

- The main challenges include a fragmented, under-funded and dysfunctional mental health system, and ineffective involuntary commitment laws.

## E. Permanent supportive housing

Permanent supportive housing is long term, community-based housing with support services for persons with disabilities. This type of housing enables special needs populations to live as independently as possible in the community. The supportive services may be provided by the organization managing the housing or coordinated by the housing agency and provided by other public or private service agencies. Housing can be provided in one structure or several structures at one site or in multiple structures at scattered sites. It can involve the rehabilitation of existing rental housing into affordable housing units for homeless families or the use of tenant-based rental

assistance to lease one bedroom units in scattered sites for homeless individuals. Tenants in these rental units are typically linked to a case management service. In general there is a severe shortage of affordable permanent housing and permanent supportive housing in the United States. (Mainstream subsidized housing has been seen by some not to effectively serve the various sub-populations of the homeless, in particular those with special needs.) At all sites this component is still a new and growing part of the continuum, one that most sites would like to be able to increase in the future

Lessons learned according to key informants:

- The most effective approach is for agencies that serve the homeless to seek out organizations that develop affordable housing and coordinate efforts with these groups.
- It is important to look beyond agencies that serve the homeless to develop permanent supportive housing for persons with severe and persistent mental illness. There is a need to seek out local, state and federal funding sources, foundations, profit and not-for-profit developers, and coordinate efforts with these sources. There is a need to be proactive and aggressive about securing funds and services from mainstream programs that should be paying for these services.
- For example, in Memphis, the Director of Housing Planning and development for Tennessee's Department of Mental Health and Developmental Disabilities has been very successful in establishing the" Creating Homes Initiative", which focuses specifically on the development of permanent supportive housing options for the mentally ill. The initiative has leveraged significant private resources.
- Local agencies can easily become too dependent on a single source of funding such as HUD to operate programs rather than seeking and incorporating support services from other mainstream providers. Incentives and leveraging requirements can encourage maximum use of other resources.

Challenges according to key informants:

- All sites are challenged to help ensure that people do not fall through the social safety net in the first place. It would help if social assistance administrators could be more flexible in their approach with those at risk of homelessness.
- The cost of housing continues to rise as wages for very low-income persons remain stagnant or increases only marginally.
- Households that do not secure subsidized housing find it extremely difficult to pay rent with limited incomes. It can be even more difficult when that household must also pay for childcare.
- Higher functioning persons find it somewhat easier if they have completed transitional programs that provide life skills training, budgeting and credit counselling.

- According to one site (Memphis), only the sub-group of individuals with HIV/AIDS is served with permanent supportive housing. Persons with severe mental illness have not been served well, but much development is being conducted for this population. Presently Memphis has no permanent supportive housing for persons in recovery from chronic substance abuse.

**How well does the model reach its intended target population?**

Which groups are best served and why?

- Outcomes for families with children are reported to be very good at all sites, particularly when the primary care giver completes the more well established transitional housing programs.
- Tremendous efforts are being made at all sites to reach the chronically homeless through specialized outreach teams. All sites report some strides are being made.
- Generally, most sites also report an array of treatment/recovery/transitional housing programs for persons with chemical dependencies, including units for families in which the primary caregiver is in recovery.

Which groups are most challenging and why?

- All sites report that the most difficult sub-groups to serve are those persons with long-term alcohol and drug dependencies, and persons with a combination of severe mental illness and substance abuse .
- Perhaps the most challenging are persons with substance abuse and mental health issues who require aggressive outreach and an assurance of permanent supportive housing before they will accept services .
- Many homeless chronic substance abusers have relapsed numerous times, and have simply given up hope of recovery.
- Persons with severe mental illness, if psychotic, are often not in touch with reality enough to make competent decisions. The law often does not allow for commitment of persons who are not “a danger to themselves or others.” Others fear hospitalization, the side effects of medications, and are treatment resistant.
- It is extremely expensive to provide adequate services and housing for these sub-populations and often very difficult to access funding from mainstream sources to assist them.

Agreements on behaviour

Some agencies have contractual agreements with clients regarding expected behaviour changes. These behaviour changes could include, for example, abstaining from alcohol or drug use while in care. However, agencies often independently set their own standards regarding expected client behaviour. This precludes a systematic approach

with a range of expectations to suit various client needs, from harm reduction to abstinence.

Lessons learned according to key informants:

- Contractual agreements have been found to be critical to clients' progress in many instances. One provider (in Memphis) called it the "two oar" philosophy, i.e., the provider and the client are both in the same boat and each has an oar, but if only one person is rowing, "all we do is go around in circles." On the other hand, those individuals who are not willing or able to commit to or follow through on contractual arrangements remain chronically homeless, cycling through the streets, shelters, jails and hospitals.
- Some agencies successfully practice "zero-tolerance" for substance abuse. Such shelters admit people who are active alcoholics or addicts, however clients are not allowed to bring alcohol or drugs into the facility nor are they admitted if they are obviously inebriated or high. This approach is intended to prevent others in the program from relapsing.
- Some shelters have "a second chance" policy for infractions
- Clients may be asked to leave a facility if they use or sell drugs or alcohol on the premises, fight, bring weapons into the facility, or fail to follow through on individual development or treatment plans as agreed.
- At one site, a standard approach for involuntary discharge is being introduced for all shelters in the system. It uses a "progressive counselling" approach so that minor offences do not result in termination of shelter. There will also be clear guidelines on grievance policies and an appeal process for clients.

**How seamless is the model?**

One of the main strengths of the CoC model is the potential for a client's seamless progression through services in the system as they are needed. Nevertheless, key informants did identify some of the challenges present in the model.

Challenges according to key informants:

- All sites agreed that most people (particularly families with children) could progress fairly well through the continuum, depending on the availability of beds. However, clients with multiple needs, particularly mental health issues, may not be able or willing to take advantage of offered support opportunities. More costly one-on-one outreach approaches with continual follow-up are needed in these cases.
- The critical lack of decent, safe, permanent housing and permanent supportive housing presents a bottleneck, and contributes significantly to recidivism.
- According to one site, there are in reality several continuums within the overall continuum. There is a continuum for families with children, a continuum for individuals with substance abuse problems, a continuum for persons with mental illness and a continuum for persons with HIV/AIDS. There is also a continuum

for veterans. Single persons without children move through the various continuums depending on their primary disability.

- To prevent bottlenecks, clients need to be able to access the service system from whatever point they make contact. For example, if an individual requests services from an agency, is eligible, and the agency has a bed, the person is admitted. However, if the service is not appropriate, the individual should be referred to other, more suitable resources

Factors which facilitate or hinder the process

Factors which facilitate the process according to key informants:

- HUD's policies are very helpful in encouraging providers to look at the overall system needs as opposed to simply focusing on individual program needs. Any programs funded by the Federal government are required to coordinate with other programs and diversify funding.

- HUD's requirements provide an excellent basis for collecting and analysing data and qualitative information which is critical for creating a comprehensive system of services and housing. Congressional action in requiring that 30% of HUD's CoC funds be used for permanent supportive housing, and HUD's bonus of up to $500,000 to localities that list a new permanent supportive housing project as the community's first priority have been very helpful in encouraging communities to focus on long-term solutions.

- It is helpful for leaders in the field to continually stress the importance of linkages. At one site, all County contracts have stipulations which require agencies in each phase of the CoC to accept specific numbers of clients from specific other agencies in the CoC.

Factors which hinder the process according to key informants:

- Some case workers and agencies can get bogged down in the crisis of the moment as opposed to exploring opportunities for collaboration outside their agency.

- Some privately funded, faith-based programs are focused on meeting the spiritual needs of homeless people first and tend to be more isolated from programs funded by the Federal government. It would be helpful if these operators were more willing to refer clients to other support programs.

- Funding continues to be an issue, including difficulty in maximizing use of mainstream programs such as Food Stamps, Temporary Assistance for Needy Families (TANF), Alcohol, Drug, and Mental Health Block Grant funds, and Workforce Investment Act resources. While some states are apparently being

very creative and flexible in coordinating these services with programs for homeless people, other states are just beginning to move in that direction.

- In some cases, zoning issues and the NIMBY factor still hinder the development of supportive housing. There is a constant need to educate politicians and planning commissioners about the model

### Lessons learned about identifying gaps and priorities

HUD funding requires that needs and gaps be substantiated at the local level. The data collection process has been challenging for some sites.

Lessons learned according to key informants:

- Point-in-time "snapshot" data is extremely important. An annual street and shelter survey can identify unmet needs. When a shelter count is compared to the inventory of available beds, it can identify programs that are not operating at full capacity. This could indicate the need for better coordination or the need to revise the program.
- It is also very important to collect longitudinal data on homeless individuals, since homelessness is cyclical. For effective planning, both point-in-time service data and individual longitudinal data must be considered
- It is very important to develop an accurate inventory and needs assessment to help ensure development of services and housing options for all sub-groups. Communities need to be very specific when identifying needs and assigning priorities for different components in order to ensure that new programs meet the needs of under-served individuals or families.
- While HUD has categories for each component and sub-group, communities need to go beyond those broad categories to more definitively address sub-groups within sub-groups. For example, a community may have adequate emergency shelter for mothers accompanied by children, but there may be a significant need for emergency shelter for fathers with children, two-parent families, or families with older children.

### Factors that facilitate the leveraging of resources and integration with mainstream services

According to key informants, factors which facilitate the process of leveraging include:

- An early start on securing commitments for resources and making maximum use of mainstream resources such as food stamps, client income, welfare benefits, health care, mental health services etc.
- HUD's award of bonus points for the amount of money leveraged from mainstream agencies

- the HUD application requirement for written agreements from main stream providers outlining their dollar commitments
- the provision of information and technical assistance

Relationship between Federal-State-Municipality and CoC funding

According to key informants, each level of government contributes to the array of services for the homeless. The scenario described by one site below is fairly typical.

- Local government (Broward County) resources are primarily targeting at emergency shelter and some transitional shelter and services.
- Federal government resources are targeted mostly at permanent supportive housing.
- The State (Florida) is a major funder of mental health services although the funding is inadequate. It has just recently begun to explore its role with funding for the CoC, especially for permanent housing.
- A new state Council and Office on Homeless Affairs was established but it is too early to assess how it will integrate with other organizations.
- The local CoC planning office compiles information on all major funding sources and funded projects so that all major funders (including private ones) are aware of what the others are doing.
- According to the Memphis site it is a constant challenge to manage varying funding criteria, as programs each have specific guidelines regarding eligible applicants, eligible clients, eligible activities, limits on amounts that can be granted, and timelines for applying for funds.
- Continuum of Care funding has allowed many applicants to secure a significant part of their funding for shelter, housing, operating costs, and services from one single source—HUD. Organizations are naturally reluctant to give up that source of funding for any other arrangement.
- For example, a transitional housing program may have 30 clients, and each of those clients may have a case manager from any one of five mainstream mental health centers. Although it might be more efficient to have the mental health system provide funds directly to the transitional housing agency for case management for its residents, agencies guard their sources of funding and are reluctant to cross-jurisdictional barriers.

## Pre-requisites for success of a CoC

Based on interviews with key informants at each site, and a review of written material including limited site evaluations, the following key learnings are seen as pre-requisites for a successful CoC system:

Planning

- Develop an inclusive coordinating body or network and a structure that allows broad participation from different types of stakeholders. Include participants with expertise in specific tasks.
- Be specific in terms of your mission, goals and action steps. Focus your energy to minimize getting off-track. Build in rewards and time to reflect on progress.
- Meet frequently. Obtain on-going feedback and refine your work as needed.
- Collect data. Understand your population and your community's resources.
- Assemble a variety of people, organizations, skills and talents. Understand regional differences that affect your efforts.
- Don't stop. Use your existing processes to submit applications for other funding sources and to advocate for your community's needs

Implementation

- Each component of the system should reflect local needs and the diversity of the local homeless population. Focus on all components, but with special attention to those parts that need the most work. Develop a system that serves all sub-populations
- Create multiple in-take points. Homeless people can be found in all settings
- Coordinate housing and service delivery. Information sharing and networking with other providers is key to eliminating gaps. Have written agreements with other providers and avoid duplicating efforts.
- Case management helps facilitate movement through the components and keeps people housed and engaged in necessary services.
- Know your clients. Collect and update data and develop tracking systems

Identifying gaps and priorities

- Let your data point the way. Use the consolidated plan, provider input and other reliable sources, including surveys, to learn what you currently have and what you still need.
- community's current top needs.
- Develop projects that fit the top gaps.
- Use a fair and rational selection process. Use accepted criteria to select the best projects for your community's application.

Supplemental resources

- Involve key funders early. Include affiliates of the resources needed as participants in the CoC meetings.
- Build partnerships and get to know your potential sources
- Contact the sources you know but also branch out to others – think of federal, state and local governments, private foundations, businesses and other organizations. Use mainstream and other programs.

- Get letters, memorandums of understanding and other commitments in writing.

## The Applicability of the CoC model for Canada

Seventeen individuals working in the area of homelessness provided their professional opinion regarding the applicability of the American CoC model for Canada. (Appendix B provides a list of the stakeholders surveyed.) Their collective views are reflected in this section and are based on their review of the research results. It should be noted that the informants were not asked to review the CoC program, just the case studies and the draft overview document.

The general consensus among Canadian stakeholders in the area of homelessness is that the CoC has many elements that could work in Canada, and that the model has some transferable principles and processes. At the same time there are differences between the United States and Canada that would need to be taken into account when considering the applicability of the CoC model for Canada. While it was not within the scope of this research to examine the Canadian policy framework for homelessness, stakeholders did raise some general issues regarding the transferability of the model.

### Strengths and benefits of the American CoC Model

Canadian stakeholders agreed with their American counterparts at the four sites studied regarding the generic strengths of the CoC model. These features were key to the effectiveness of the model in the United States, and would also be effective in implementing a similar model in Canada.

- the requirement for collaborative planning
- the competitive application process
- the focus on integrated services
- the attention to the needs of specific homeless subgroups
- the acknowledgment of the importance of support services to enable homeless persons to move along the service spectrum

### Weaknesses and limitations of the American CoC Model

Again, Canadian stakeholders agreed with their American counterparts that there were a few key weaknesses or limitations in the CoC model. These features made it a challenge to implement the model in the United States, and would equally do so in Canada:

- the lack of resources for planning
- the burden of the application process on front line agencies

- the lack of a long term permanent affordable housing component[11]

**Potential opportunities for Canadian implementation of the CoC Model**

According to Canadian stakeholders, the following elements are currently not consistently available in Canada's array of programs for the homeless, but would be valuable components of a Canadian CoC model:

- the requirement for local co-coordinated action plans
- formal recognition and sharing of best practices
- outcome evaluations that could inform decision-making
- the development of a national standardized individual tracking and statistics-gathering tool for the purpose of evaluation

**Challenges**

According to Canadian stakeholders, the following features of the American CoC experience would also present challenges here in Canada:

- local health and social services can still be in silos and resistant to integration
- it is a slow process to develop the formalized agreements that are necessary for linking services into a continuum
- a big city approach is not appropriate for smaller or rural communities
- the focus on systemic causes of homelessness (such as poverty) can get lost in the need to attend to symptoms and individual response

***Control and accountability***

According to Canadian stakeholders, the following questions related to control and accountability would have to be answered to successfully implement the CoC model in Canada:

- how could there be a centre for overall control and accountability when authority for services is fragmented by jurisdiction or even by government department?
- who has the lead for crucial health and social services, and how can these key players be induced to co-operate?
- how could clear roles and responsibilities among different levels of government be negotiated?
- what would motivate local, provincial, and federal governments to co-operate and bring resources to the table?
- who is responsible for the sustainability of funded initiatives?

[11] According to HUD's 2000 Notification of Funding Availability (NOFA), legislation was passed in 1999 by Congress which dictates 30% of the CoC local funding must be directed towards permanent housing solutions

***Community involvement***
According to Canadian stakeholders, community involvement would be essential to the implementation of the CoC model in Canada, with particular attention to the following issues:

- planning must be collaborative and include all local players
- consumers should be involved in developing service plans
- communities vary in their ability to gain local political or private sector buy-in
- local philanthropic traditions vary among communities

***Funding criteria and money flow structures***
Canadian stakeholders noted that the following outstanding questions would have to be answered for the model to be effective in Canada:

- should a proportion of funding be prescribed for capital and for services?
- should matched or leveraged dollars be required in all situations?
- should funds only be provided to the community planning body to disburse?
- should funds be available for administration and contract supervision of funded projects by the local coordinating body?
- should the federal government fund municipalities or local planning bodies without requiring provincial involvement?

***Housing outcomes***
Canadian stakeholders agreed that a consideration of the applicability of the CoC model in Canada should be informed by the housing outcomes of the funded initiatives. It would be useful to know what kinds of efforts are most successful at helping homeless people gain and retain long-term housing. However, as yet it is difficult to assess best practices by outcomes. Currently outcomes are being gathered by HUD-funded agencies, but not in all states. There are also many local homelessness initiatives that are not funded by HUD. Therefore only partial outcome data exists.

A further consideration with respect to housing outcomes is the extent to which the model prescribes the development of actual housing opportunities. For instance, HUD funding to communities requires that 30% of funds be allocated to the development of supportive housing, so that housing opportunities are created along with response services. Outcome measures such as “gain housing” would thus be made more achievable, at least for the special homeless sub-groups that require supportive housing. In Canada, the Supporting Community Partnership Initiative - part of the National Homelessness Strategy - does not require any proportion of funds to be devoted to the development of housing stock. It only permits funds to be used for transitional housing. In summary, while successful housing outcomes are the goal of

most homelessness efforts, these outcomes will be heavily influenced by the availability of appropriate affordable housing stock. Consideration therefore needs to be given to the extent to which a model like the CoC model sets up a mechanism for creating housing opportunities in Canada.

## Transferable principles and processes

In considering the applicability or adoption of the CoC model to Canada, stakeholder's comments appear to highlight a number of principles and processes of the CoC model that could contribute to its effective implementation in Canada. Some of these processes may already be in place through the development of a plan for the Supportive Community Partnerships Initiative.

- a community planning process with a lead entity
- the requirement for a needs assessment that identifies local sub-groups
- evidence of partnerships (including non-traditional) and collaboration
- the requirement for implementing a continuum of co-coordinated services
- a consolidated proposal and selection process
- consistent data collection and evaluation
- sharing of best practices
- a focus on prevention
- funds earmarked for developing housing opportunities
- the desirability of matched or leveraged funds where possible

## Is the CoC Model a good model for Canada?

The majority of stakeholders working at the local program level were of the opinion that the American CoC model had much to offer. These respondents, however, felt strongly about the importance of building on what is already in place in Canada. They were in favour of incorporating the best features of the American CoC into existing Canadian best practices, rather than simply replacing existing programs. They also noted the necessity of applying Canadian values, policies and legislation to the CoC model if it were to be implemented in Canada.

### *Extent to which integral components of the CoC Model are present in Canada*

The first section of this report outlined the fundamental elements of the CoC model – outreach, intake, referral, emergency shelter, and permanent supportive housing. (Prevention, while not at first listed as a key component of the CoC model, quickly became a key strategy.) The responses from stakeholders working at the provincial level are mixed in terms of whether the integral elements of the CoC model are currently present in Canada. There appears to be some regional differences in the responses to this question. In fact, the extent to which all the components are in place in different parts of Canada appears to depend more on the stage of municipal and provincial development in the area of homelessness than on a national requirement, For instance,

stakeholders from western regions of the country were more likely to respond that the essential elements were present than those from other parts of the country. (In Alberta all community plans must address the same elements as the CoC.) Most local stakeholders surveyed were of the opinion that many of the necessary elements are present at the local level. However, Canada has provincial/territorial rather than federal programs for the development of permanent supportive housing – the national program is a strong feature of the American model. Many stakeholders complimented the Canadian SCPI program as being the driving force that has brought local providers together around the table for planning purposes, similar to the US CoC.

***What could help make the CoC Model work in Canada?***

Most respondents were in agreement that the federal government should play a stronger role in making sure the conditions are there for a model like the CoC to work. Most provincial stakeholders felt that the federal government should continue with the National Homelessness Initiative and increase the scope of SCPI. As well, most thought that better collaboration between federal and provincial governments is needed at the planning stages, particularly in the area of housing opportunities and support services.

Stakeholders deemed it critical to have all three levels of government and different provincial ministries such as Health, and Housing working together to address homelessness in their jurisdiction. Most respondents reported that this is not happening yet. Some stakeholders held the view that formal agreements were needed among different levels of government to strengthen the relationship between different types of providers (health, social services, housing) in order to facilitate the movement of homeless people through the continuum at the local level.

Respondents at both the provincial and municipal levels of government called for further research into the needs of different sub-groups of homeless and a fuller analysis of the homelessness problem in general, particularly the root causes of homelessness. As well, baseline research is needed into how different service components are currently linked and how well they are facilitating the movement of people through the system to permanent housing. To date, most of the research has occurred at the local level – a "bottom-up" approach that doesn't necessarily inform the system at a broader level.

According to some local stakeholders, there is a need to address leadership and resource issues at the municipal level before the CoC could be applied. If the local community is expected to lead the planning process it will be important to have the resources in place for this to happen.

***Existing initiatives, programs and policies that would facilitate the CoC***

When asked what existing initiatives, programs and policies would facilitate the CoC model in Canada, most stakeholders pointed to the federal SCPI program. SCPI is seen as a good foundation for the CoC model. As noted, a number of respondents drew parallels between SCPI and the CoC with respect to the coordinated community planning process.

Municipal respondents report that there are already local steering committees and planning groups in place and that these would serve as a natural stepping stone. However, currently there are jurisdictional issues among all three levels of government pertaining to the delivery of health, housing and social services that would hinder the development of a CoC. In Ontario, for example, stakeholders felt there needs to be a strong show of commitment from the ministers and senior management of three key departments - housing, health and social services – in order for the CoC to be effective.

***Existing factors that hinder the CoC***

According to respondents, some key factors that would hinder the development of a CoC model and indeed any ideal model to address homelessness in Canada are:

- the way housing and health services cross political jurisdictions
- the lack of sustainable funding for local agencies
- the lack of local resources for the planning required
- the lack of funding for permanent housing

**Advice from stakeholders based on lessons learned from the CoC model**

Stakeholder's comments highlighted the following general advice about the implementation of a CoC model in Canada:

- Encourage all levels of government to work toward the same goal through a common housing and homelessness strategy.
- Make sure the approach is not too "top down" and allows for local differences.
- Ensure that the application process is not too onerous for agencies.
- Support the planning process at the local level through the provision of resources and necessary technical expertise.
- Conduct follow up research and evaluation to determine and share best practices.

# APPENDIX A INDIVIDUAL CASE STUDIES

The information presented in each of the case descriptions given below comes from a combination of the site's Funding Proposal (Exhibit One[12]) to HUD, interviews with key informants at each site and detailed questionnaires completed by key informants at each site.

## Case Study Site: Broward, County Florida

### Brief Description of Continuum of Care Implementation Experience

A Site Characteristics

Broward County's 2001 Homeless Continuum of Care Consolidated Application encompasses 14 geographic areas[13] within the County. Broward County has a population of 1,490,300 and is one of the fastest growing counties in the United States. The main industries in this southern urban area are retail and tourism.

B Characteristics of the Homeless Population

Broward County has an estimated 7,165 homeless people at a point in time. This represents .0048% of the population. 4,035 are sheltered or housed and 3,129 are unsheltered. The majority is male between the ages of 18 and 49 years, single and were born out of Florida but in United States. Almost half are chronic substance abusers; one-third seriously mentally ill and one-third physically disabled. 88.5 % are individuals and 11.5% are persons in families with children. Almost one-half of homeless persons In Broward County are white, another 37% are black and the remaining 14 % include other racial groups including Native American (1%).

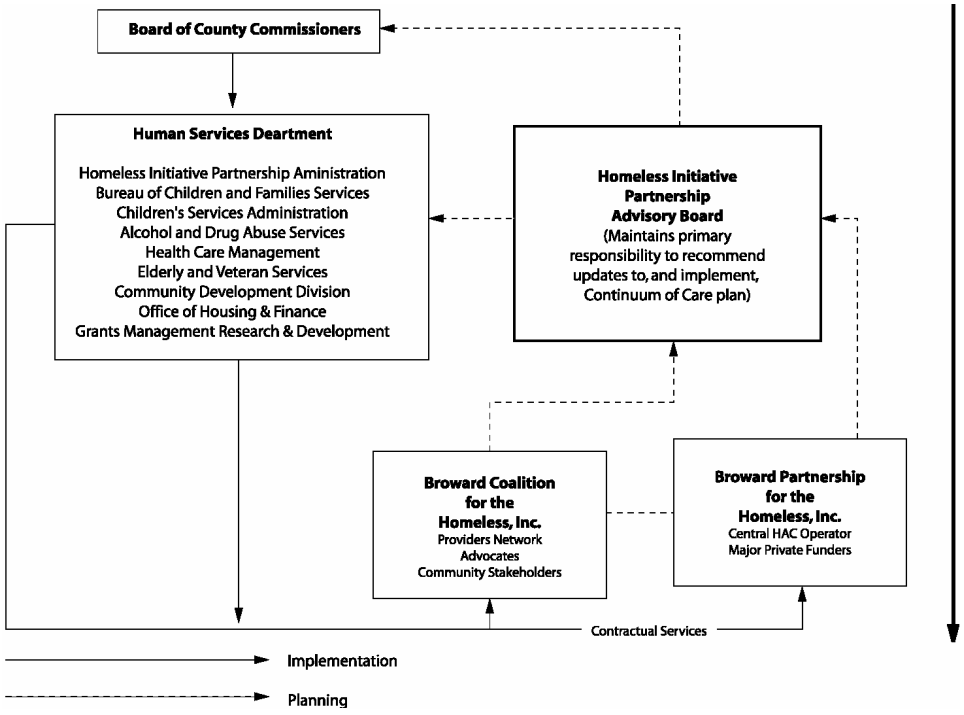
C Planning Process

The Homeless Initiative Partnership (HIP) Advisory Board is the lead entity for the County's Homeless Continuum of Care planning process. The HIP Board has 22 members appointed by the Broward County Board of County Commissioners including a County Commissioner and ex-officio memberships by Broward Coalition for the Homeless, Inc. and Broward Partnership for the Homeless, Inc. representing service providers and business community partners respectively and the County's South Homeless Assessment Center (HAC). The Organization Flow Chart is depicted in Exhibit 1.

[12] Exhibit One typically takes about six months to develop and provides detail on all aspects of a site's CoC system.

[13] Broward County consists of 30 cities of which 13 are part of the CoC and receive a share of the CoC money.

## Exhibit 1: Broward County, Florida: Organization Flow Chart




The Homeless Initiative Partnership (HIP) Advisory Board's mission is to *Help, Influence* and *Promote* solutions and reform to homelessness in Broward County. The Broward County Homeless Initiative Partnership Advisory Board (staffed by Homeless Initiative Partnership Administration - HIP Admin.) serves in an advisory capacity to the Board of County Commissioners, making recommendations regarding the development, implementation and coordination of homeless assistance programs within Broward County. Such programs include, but are not limited to siting, constructing, funding and operating homeless assistance centers and a complete continuum of care of housing and services. Several HIP Board committees focus on issues related to: funding priorities (along with a sub-committee that includes representatives of the Broward League of Cities), strategic planning, and facility operations. The HIP Board and Administration updates the County's Continuum of Care strategic plan annually, which is revisited through the HUD Homeless Continuum of Care Application "Exhibit One" that is incorporated into the Consolidated Plan and distributed to all entitlement communities within Broward County. The plan is also shared and coordinated with the Coordinating Council of Broward community-wide strategic planning efforts. The Homeless Initiative Partnership Administration is part of the Broward County Human Services Department.

The year round community planning process brought together 216 participants representing 107 agencies including: homeless and formerly homeless persons, state and local governmental agencies, nonprofit organizations, banks, neighbourhood

groups, housing developers, businesses, foundations, service providers[14] and others. Participants reviewed the 2001 Gaps Analysis based on data gathered through the community process, and established the 2001 community priorities and project priorities.

Except for contract administration, which is 2.5% of awarded contract funds, no support is received from HUD for administration, planning and coordination. Approximately 4% ($250,000) of the total CoC budget is allocated to administration, planning and coordination derived from a number of different sources including Broward County Human Resources Department, assistance from other divisions within the department and the community. Four full-time staff members[15] are dedicated to the Homelessness Initiative Partnership -- an administrator, a special project officer, secretary and a contract administrator. Part-time assistance is brought in as required and arrangements with the not-for-profit agencies help coordinate meetings. The main administrative support comes from the county.

## D CoC under Development

The vision of Broward County's Homeless Continuum of Care is *an effective, integrated approach to homelessness in this community that empowers homeless persons to access and remain in permanent affordable housing, and provides necessary supportive services to facilitate the highest degree of self sufficiency possible for each person*. Broward County achieves this vision through adequate resource development and a dynamic and inclusive community process that was formally initiated in 1993 with the adoption of a Countywide Strategic Plan and involves all stakeholders. The primary organizations that plan and implement the County's strategic plan include: Homeless Initiative Partnership (HIP) Advisory Board and Administration, Human Services Department, and Broward Coalition for the Homeless, Inc.

Strategic planning is the foundation of Broward County's homeless Continuum of Care initiative. Strategic planning methodology ensures that an intentional, targeted and holistic approach guides the effective and efficient delivery of services to Broward County. Broward County's Continuum of Care strategic plan, the "Broward County Initiative: Working Together to Address Homelessness," best describes Broward's community strategy and vision to combat homelessness. The primary goals of the 2001 strategic plan are as follows:

> 1: Maintain and expand the existing supply of permanent affordable and supportive housing and transitional housing throughout the County.

[14] Service providers included those serving the following sub-populations: severely mentally ill, substance abusers, youth, HIV/AIDS, veterans, victims of domestic violence.

[15] According to the Administrator of the Homeless Initiative Partnership, staff dedicated exclusively to the homelessness file is the exception than rather than the norm for CoCs nationally.

2: To increase the capacity of the emergency shelter phase of the Continuum of Care by establishing three (3) regional homeless assistance centers as Continuum entry points.

3: To establish new public/private partnerships and involve mainstream sources to fund the three (3) homeless assistance centers and other new homeless facilities and services.

4: Improve existing linkages among service providers to facilitate the ability of homeless persons to move through the Continuum of Care, thereby helping to "break the cycle of homelessness."

5: Improve performance outcomes and standards among Continuum providers.

6: Pursuant to Broward County Comprehensive Plan Policy 8.4.6: The Human Services Department, in cooperation with the Community Development Division and the Office of Housing Finance, shall develop a consolidated funding plan to implement the Broward County homeless initiative.

7**:** Continue to develop volunteers, mentors and support groups including with faith-based groups.

8: Develop programs to fill other identified gaps in the continuum (e.g. aftercare, prevention, medical respite care, tiered incentive beds targeted to chronic substance abusers, "Sobering Station" and housing for persons in recovery).

9: Implement a strategy to address Institutional Discharges to Homelessness by expanding existing and establishing new aftercare facilities and housing opportunities for homeless persons being discharged from hospitals, in-patient psychiatric units, correctional facilities and for foster children aging out of State foster care programs.

The action steps and associated target dates for each goal comprising the strategic plan are almost completed, completed or ongoing. Responsibility for action undertaken, for the most part, is assigned to key organizations identified in the organization chart and community provider organizations.

## E Fundamental Components of the CoC System

All phases of the Continuum of Care system are present in Broward County including: permanent affordable and supportive housing, emergency shelter, transitional housing, homelessness prevention, outreach, supportive services and aftercare. Broward County CoC features three regional full service Homeless Assistance Centers (HACs) as entry points to transitional and permanent supportive housing. HACs differ but typically provide emergency shelter with case management, aftercare, and other supportive

services for homeless individuals and families. The CoC also features a public/private partnership that has recently generated nearly $4 million in private funds and $6.9 million annually from a public dedicated recurring funding source; and ongoing efforts to maintain and create formal interagency linkages, data sharing and outcome measurement. Broward County's Continuum of Care received a *John J. Gunther HUD Blue Ribbon Practices in Housing and Community Development Award* from the U.S. Department of Housing and Urban Development in 1998.

F Sub-Populations Targeted

The sub-populations of homeless individuals and families targeted by the CoC system include veterans, seriously mentally ill, substance abusers, persons with HIV/AIDS, victims of domestic violence and youth. The two sub-groups established by the 2001 relative priority process to be in highest need of housing and services are the dually-diagnosed (mentally ill and substance abuse) and veterans.

G Client Movement and Component Linkage

Movement of homeless persons through the components of the Continuum of Care to specifically needed services is accomplished through well-established linkages between community providers. Contracts and written agreements define and ensure service delivery from provider to provider. All County contracts for homeless services require shelters in one phase to identify shelters or housing within the next or preceding continuum phases from which they will accept referrals and make placements, and the specific number of referrals that will be accepted from or placed at that shelter, on an annual basis. A formal collaborative case management system ensures and facilitates the movement of homeless people through various components of the Continuum of Care. The components are also linked through interagency agreements, meetings, case management consultation, client referrals, record sharing, and client transport.

Several general population and targeted sub-population emergency shelter providers (e.g. Salvation Army) also provide their own transitional housing and, in some cases, permanent affordable housing, as well as supportive services, which facilitates their own clients' graduation to transitional phase programs in-house.

The Homeless Assistance Center concept formalizes movement through the Continuum by establishing a "Common Care Plan" (As part of Standards of Care) with the homeless individual/family. This plan ensures the provision of needed services contingent upon the individual/family's participation in self-sufficiency activities and continuity if the client moves to other shelters. Progress is tracked through case management activities.

Action steps are underway to enhance component linkage and client movement through the Continuum using a shared electronic database, uniform referral formats and tracking of shelter beds and service slots. Specific processes have been developed to ensure the movement of identified sub-populations from one linked component of the system to

another. This Client Management System/ Sharelink network will begin to facilitate electronic inter-agency referrals. Case records are released only with the written permission of the client.

H Gaps and Priorities

Data Collection activities and methods employed to establish gaps and priorities include the following four community activities:

1. survey of number of homeless persons and needs assessment to count homeless individuals and families with children and assess their needs;

2. survey of existing shelter & services designated for homeless persons;

3. focus groups (two) comprised of homeless persons and service providers to capture their experience and impressions of homeless conditions; and

4. community planning workshops (two) where facilitators presented data from the above activities and moderated discussion, which resulted in a consensus on the community's relative priorities for 2001.

Continuum of Care gaps are determined by subtracting the available services from the current homeless population-- based on information obtained from the two surveys. Current beds/unit inventory for all phases and sub-populations was established by adding current inventory, assumed to be 100% occupied, with the survey results of unsheltered homeless persons. The results of the 2001 Gaps Analysis are presented in Exhibit 2.

**Exhibit 2: Broward County, Florida: Gaps Analysis Chart**

| | | Estimated Need | Current Inventory | Unmet Need/Gap | Relative Priority |
|---|---|---|---|---|---|
| **Individuals** | | | | | |
| Example | Emergency Shelter | 115 | 89 | 26 | M |
| Beds | Emergency Shelter (1) | 880 | 872 | 8 | L |
| | Transitional Housing (1) | 1693 | 1527 | 166 | M |
| | Permanent Housing (3) | 2320 | 541 | 1779 | H |
| | **Total** | **4893** | **2940** | **1953** | |
| Estimated Supportive Services Slots - Individuals | Job Training (enrolled point-in-time) | 1468 | 649 | 819 | H |
| | Case Management (enrolled point in time) | 4893 | 1592 | 3301 | H |
| | Substance Abuse Treatment (1 day) | 2251 | 1289 | 962 | M |
| | Mental Health Care (1 day) | 1517 | 1005 | 512 | M |
| | Housing Placement (p/month) | 782 | 333 | 449 | L |
| | Life Skills Training (enrolled point in time) | 4893 | 1426 | 3467 | H |
| | Legal Aid | 1713 | 106 | 1582 | M |

| | | | | | |
|---|---|---|---|---|---|
| Estimated Sub-Populations | Chronic Substance Abusers | 1174 | 1056 | 118 | M |
| | Seriously Mentally ill | 538 | 336 | 202 | M |
| | Dually-Diagnosed (Mentally ill & Sub Abuse) | 979 | 448 | 531 | H |
| | Veterans | 489 | 49 | 440 | H |
| | Persons with HIV/AIDS | 391 | 142 | 249 | M |
| | Victims of Domestic Violence | 294 | 87 | 207 | M |
| | Youth | 440 | 216 | 224 | M |
| | Physically Disabled | 441 | 268 | 173 | M |
| | Elderly | 98 | 96 | 2 | L |
| | General and Non-Treatment (4) | 49 | 474 | NONE | L |
| **Persons in Families with Children (2)** | | | | | |
| Units (2) | Emergency Shelter | 74 | 45 | 29 | M |
| | Transitional Housing | 123 | 102 | 21 | L |
| | Permanent Housing (3) | 297 | 179 | 118 | H |
| | **Total** | **494** | **326** | **168** | |
| Estimated Supportive Services Slots - Families | Job Training (enrolled point in time) | 247 | 123 | 124 | H |
| | Case Management (enrolled point in time) | 494 | 231 | 263 | H |
| | Substance Abuse Treatment (1 day) | 173 | 72 | 101 | M |
| | Mental Health Care (1 day) | 119 | 94 | 25 | L |
| | Housing Placement (p/month) | 100 | 93 | 7 | L |
| | Life Skills Training (enrolled point in time) | 494 | 144 | 350 | H |
| | Legal Aid | 198 | 20 | 178 | M |
| | Child Care (5) | 765 | 200 | 565 | H |
| Estimated Sub-Populations | Chronic Substance Abusers | 108 | 4 | 104 | H |
| | Seriously Mentally ill | 45 | 41 | 4 | L |
| | Dually-Diagnosed (Mentally ill & Sub Abuse) | 84 | 16 | 68 | H |
| | Veterans | 10 | 0 | 10 | L |
| | Persons with HIV/AIDS | 99 | 43 | 56 | M |
| | Victims of Domestic Violence | 69 | 12 | 57 | M |
| | Youth | 25 | 8 | 17 | M |
| | Physically Disabled | 49 | 1 | 49 | M |
| | General and Non-Treatment (4) | 5 | 201 | NONE | L |

1) 200 emergency and transitional beds scheduled to open for individuals and families by 2001 in north County, which is underserved
2) One unit = 4.6 beds or individuals
3) Permanent is defined by HIP as permanent supported housing
4) General includes emergency and transitional beds that offer a variety of supportive services but are not targeted to a specific sub-population
5) Need based on number of families needing service x 2.5 children per family needing service.

Based on the Gaps Analysis, Planning Workshop participants agreed that permanent supportive housing is the highest priority. New permanent supportive housing, and permanent housing and transitional renewals, targeted to certain sub-populations, were prioritized by consensus. The Priority list recommendations were presented to the HIP

Board for further review and discussion and final adoption of Year 2001 Community Priorities

1. New Permanent Housing targeting individuals in recovery from substance abuse, and the dually diagnosed (substance abuse and severe mental illness). The project may also target other sub-populations (e.g. persons with HIV/AIDS, veterans, elderly and physically disabled). The project may involve any eligible SHP[16] use and should total no more than $1, 250,000 (pending any adjustments to pro-rata need share and /or factors such as renewal application submissions/withdrawals).

2. Permanent Housing Renewal for individuals and families.

3. SHP Renewals Family Transitional.

4. SHP Renewal Individual Adults Transitional**.**

5. SHP Renewal Youth (Individuals and Families) Transitional.

6. SHP Renewal Geriatric Mentally Ill Transitional**.**

7. New Shelter Plus Care targeted to families with at least one disabled family member (cost range of $600,000 to $750,000 pending any pro-rata adjustments).

8. Single Room Occupancy (SRO) Mod-rehabilitation with New SHP/SSO services companion.

9. Shelter Plus Care Renewal.

The final Priorities were advertised with the request for proposals and distributed at the applicant workshop. The Priorities were then used as the basis for the Ranking Committee to prioritize this year's project applications.

I Project Selection and Priority Placement Process

The project priority selection process was structured to be fair, giving equal consideration to all proposed projects. The community-wide advertisement of the Notice of Funding afforded all interested parties an equal opportunity to consider and respond. A cross-section of expertise among the reviewing committees contributed to the impartiality of the review, affording equal consideration to each nonprofit project submission. Also, care was taken so that none of the reviewers were affiliated with the project sponsors whose applications were under consideration.

The Gaps Analysis priorities and the Continuum of Care strategic plan, that were the basis of the criteria used to evaluate the projects, were developed through community

[16] SHP is the acronym for Supportive Housing Program.

input. The application review criteria were standardized to ensure that each reviewer used the same criteria to rate the applications.

All applications were processed through the same review process. No preferential treatment was given to one organization or project under consideration. All applicants were notified in the same manner of the priority ranking of their project. No ratings were changed or modified outside of the review process.

The project priorities and a draft of this consolidated application were presented to the Homeless Initiative Partnership Advisory Board (HIP) at a regular public meeting where they were discussed and ratified by unanimous consensus. The inclusive membership of the HIP Board is described in Section C. Subsequently, the completed consolidated application was submitted to the County Administrator for review and signature.

A team consisting of Broward County Human Services staff provided technical assistance to project applicants. This assistance involved the comprehensive review of all components of submitted applications to determine compliance with HUD requirements and to ensure overall quality consistency with the consolidated application.

J Planned Activities

Eleven projects have been selected and submitted to HUD for funding in a consolidated application in order of priority. Ranking of projects took into consideration the rating of each project, community need and cost-effectiveness.

Broward County is seeking $6,289,720 in HUD CoC funding to increase permanent affordable and supportive housing by 110 new beds; 40 permanent renewal beds; 298 transitional renewal beds; and 100 non-competitive permanent renewal beds and expanded and renewed supportive services. The total leveraged dollars for which written commitment on type of contribution and dollar value has been obtained from the community is $ 8,547,048.

Selected projects in order of priority:

1. Broward County Substance Abuse and Health Care Services Division: SHP Request: $1,250,000

Thirty-two (32) new permanent supportive housing beds for homeless substance abusing individuals. Addresses high priority for individuals in recovery from substance abuse, and the dually diagnosed. High relatively priority for permanent housing for individuals and medium relative priority for chronic substance abusers.

2. Volunteers of America of Florida: Renewal SHP Request: $343,033

Forty (40) current permanent supportive housing beds for homeless disabled veterans, chronically mentally ill and dually diagnosed families and individuals located in Hollywood, Fort Lauderdale & Pompano Beach. Addresses high relative priority for permanent housing for individuals and veterans sub-population.

3. The Salvation Army: Renewal SHP Transitional Request: $301,284

Seventy-two (72) current beds targeted to families. Low relatively priority per Continuum of Care Gaps Chart, however, if the project is not renewed the gap will be larger. The initial consideration for this renewal priority was based on need of the sub-population relative to other sub-populations. It was felt that the gap alone was not reflective of the gap that would remain if the project were not renewed.

4. The Salvation Army: Renewal SHP Transitional Request: $214,583

Ninety-eight (98) beds targeted to families. Low relatively priority per Continuum of Care Gaps Chart, however, if the project is not renewed the gaps will be larger. The initial consideration for this renewal priority was based on need of the sub-population relative to other sub-populations.

5. The Salvation Army: Renewal SHP Transitional Request: $202,878

Sixty (60) current beds targeted to individuals. A medium priority per the Continuum of Care Gaps chart. The initial consideration for this renewal priority was based on need of the sub-population relative to other sub-populations.

6. Covenant House: Renewal SHP Request: $191,713

Twenty-four (24) current beds to support transitional housing and services for youth under the age of 21. Medium relative priority, however, if the project is not renewed the gap will be larger. The initial consideration for this renewal priority was based on need of the sub-populations relative to other sub-populations.

7. Nova Southeastern University: SHP Renewal Request: $996,917.

Forty-four (44) current transitional beds to support homeless elders ages 55 and older who have a serious, persistent mental illness. Addresses a low relatively priority for the elderly. However, if this project is not renewed the gap will be larger. The initial consideration for this renewal priority was based on need of the sub-populations relative to other sub-populations.

8. Catholic Charities: New Permanent Shelter + Care (S+C), Companion to Project #9. S + C Request :$ 455,640

Fifty-three (53) beds to support homeless families with a member who is disabled due to mental illness, substance abuse, a physical disability or dual diagnosis. This is a high

relative gap priority for permanent housing for families. However, all renewals received higher rankings, after the first priority new permanent housing project, in order to avoid displacing persons already housed.

9. Catholic Charities: New Supportive Services Only, Companion to Project #8, listed above. SHP Request: $294,210.

Services to be provided to the fifty-three (53) clients to be housed in Project #8. They include: outreach, case management, basic necessities i.e. toiletries, residential support, transportation, counseling, child care, health care, legal assistance and education/vocational counseling. This is a high relative gap priority for permanent housing for families.

10. Volunteers of America of Florida (VOA): SHP Permanent Request: $1,246,874

Twenty-five (25) new beds to offer intensive support to homeless disabled, dually diagnosed individuals. High relative priority for permanent housing for individuals who are dually diagnosed. Not recommended to be ranked #1 by the Ranking Committee because of a slightly lower rating and lower initial leveraging than the project that was selected for Priority #1. Recommended to be included in this consolidated application since no SRO application (originally slated for this priority) was submitted this year by a qualified applicant.

11. Broward County Housing Authority: S + C Renewal Request: $792,588

One hundred (100) current beds targeted for psychiatrically disabled persons. Non-competitive.

K Coordination with Mainstream Programs

To ensure coordination of CoC programs with mainstream programs, a requirement will be added to the adopted Standards of Care (an action step in the strategic plan for Goal # 5). The requirement stipulates for any County contracted homeless service provider that all homeless clients be screened (or to document that the client was previously screened) for eligibility for mainstream programs[17]. If a client is deemed to be eligible for any of these programs the contracted agency will be responsible, to the extent it is possible for the agency to do so, for obtaining the service or benefit for the client. The target date for inclusion in the Standards of Care is June 2001. The Broward Coalition for the Homeless will promote voluntary compliance with the Standard by non-County funded service providers.

[17] Programs including but not limited to are: Medicaid, Children's Health Insurance Program, Temporary Assistance to Needy Families, Food Stamps, and services funding through the Mental Health Block Grant and Substance Abuse Block Grant programs, Workforce Investment Act and Welfare-to-Work grant program.

Additionally, a Mainstream Resources Access Committee recently was formed, comprised of an initial seven (7) members, representing community stakeholders. The purpose of the Access Committee is to research each mainstream source and recommend strategies to facilitate client access to these benefits and services and to increase the overall level of each source's availability to the homeless in Broward County.

## L Evaluation

Broward County is in the process of developing standards for each phase of the continuum and uniform performance outcome measures to improve the service delivery to homeless people. Generated reports will be incorporated into the existing computerized Client Management System. After a year of tracking to establish benchmark outcomes for their community, goals will also be adopted for each phase of the continuum. These goals will be specific to targeted sub-populations and based on national "best practices" and local administrative data. Customized software for aggregate reports, bed/phase tracking, and a Level Of Difficulty Assessment (LODA) screen that briefly assesses clients' needs over a range of parameters upon intake and at various stages of their progress, is currently being developed under contract. The system will include all contracted providers, which comprises 25% of the CoC beds. Non-funded providers of housing and services are encouraged to evaluate their programs independently and to participate in the CoC evaluation process. The target date for the initial electronic outcome measurement system to be place is October 2001 in targeted date for completion is December 2001.

Work in the area of outcome measurement for contracted providers has been underway in Broward County for the past two years. The chart below provides an example of the type of information sought and the reporting format for each program by provider. Most programs have been able to attain or surpass the performance indicators developed for their program.

| **Race/Ethnicity** | Asian | Black | Caucasian | Haitian | Hispanic | Native American | Unknown/Other | Total |
|---|---|---|---|---|---|---|---|---|
| | | 17 | 43 | | 4 | 1 | 4 | 69 |

| **Age** | 0-5 | 6-10 | 11-13 | 14-17 | 18+ | Unknown | Total |
|---|---|---|---|---|---|---|---|
| | | | | | 69 | | 69 |

| **Gender** | Female | Male | Unknown | Total |
|---|---|---|---|---|
| | 10 | 59 | | 69 |

| **Performance indicator** | **Attained** | **Met** |
|---|---|---|
| 80% of clients will remain drug-free and complete 50% of their treatment consisting of an assessment, minimum of 51:1 sessions, 5 group sessions, and 1 initial urinalysis and 1 follow-up urinalysis | 64% | Yes |
| 40% of clients successfully completing The Starting Place Program will be employed when they leave Broward Outreach center | 96% | Yes |
| 40% of clients responding to a survey will report they have remained drug free | 288% | Yes |

Total clients served: 69

HUD has invited Broward County to present on its continuum of care at state and national conferences and seems especially pleased with their local dedicated recurring funding.

# Case Study Site: City of Memphis, Tennessee

## Brief Description of Continuum of Care Implementation Experience

A Site Characteristics

The population of Memphis/Shelby is approximately 650,000. Predominantly urban as few homeless people are reported in the suburban and rural area outside the city limits. The annualized estimate of homelessness (including turnaways) is approximately 1.6% or 10,400 persons. Point-in-time estimates indicate that 34% of the homeless population is comprised of families (including children) and 66% single people.

B Characteristics of the Homeless Population

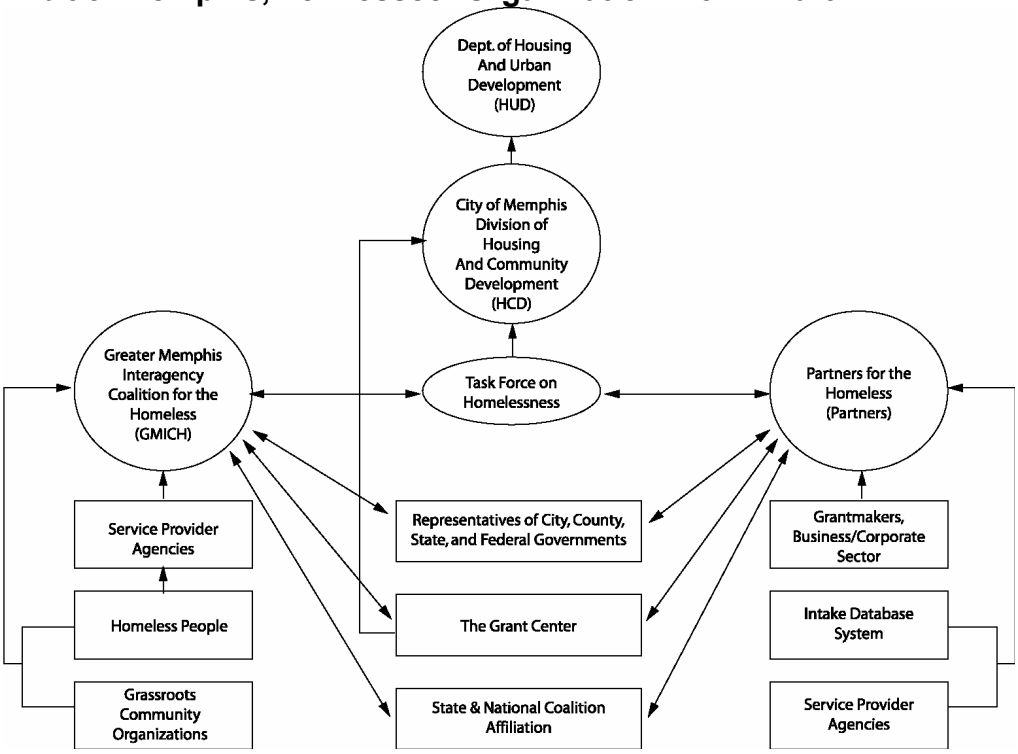
The majority of individuals unaccompanied by children are male and almost all are chronic substance abusers, have a serious mental illness or mental disorders and/or are dually diagnosed (mental illness complicated by substance abuse). Homeless women unaccompanied by children exhibit these same problems. Approximately 5% of homeless adults unaccompanied by children are also HIV positive or have AIDS. Educational levels are low and most have poor job skills. Many suffer from serious health problems, i.e., high blood pressure, diabetes, hypertension, seizures, etc., often strongly correlated with or a result of substance abuse. A recent survey of homeless families reflected that approximately 37% of primary caregivers (all were single mothers) in families with children self-reported substance abuse.

C Planning Process

The City of Memphis' Division of Housing and Community Development (HCD) is the lead entity for the CoC planning process for the Memphis/Shelby County's Continuum of Care. HCD administers HUD funds and other funds for housing and community needs and is the catalyst for the broad-based planning through its Consolidated Planning process. To ensure a community-wide, yearlong planning process, HCD contracts with two representative organizations: the Greater Memphis Interagency Coalition for the Homeless (GMICH) and Partners for the Homeless (Partners). This planning consortium unites approximately 75 nonprofit service providers, including major providers with government entities, bankers, the faith community, housing developers, homeless and formerly homeless people, and business and foundation leaders through the CoC planning process. While each organization conducts specific planning activities, there is continuous, consistent collaboration and coordination between the contracted organizations throughout the planning process. In addition, both executive directors serve on other homelessness related organizations and committees.

The City also contracts with The Grant Center to provide assistance in grant writing and capacity building to area nonprofit groups, including applicants for CoC funding. The planning structure organization chart is shown in Exhibit 3.

## Exhibit 3: Memphis, Tennessee: Organization Flow Chart




*Planning process activities include:*

Partners' responsibilities

- Collection and analysis of quantitative data provided by approximately 30 agencies participating in the Intake Database System developed and administered by Partners
- Coordination of point-in-time shelter count concurrent with GMICH's street count
- Preparation of the Homelessness Needs Assessment and Gaps Analysis for the Continuum of Care and the City's Consolidated Plan.
- Provision of technical assistance to providers about the CoC process, mainstream resources, etc.
- Proactive coordination and development of programs and initiatives to help fill identified gaps in services and housing options
- Coordination and facilitation of the community's consolidated CoC application process
- Preparation of Exhibit One of the CoC application

GMICH responsibilities

- Coordination of monthly meetings of the GMICH's Service Providers Group (represents approximately 75 not-for-profit service providers) which provides a forum

for addressing unmet needs, networking, exchanging information to strengthen the informal referral system, developing partnerships, and presentations on CoC issues, process, and resources, with time set aside in one meeting per quarter for planning

- Coordination of annual community-wide retreat designed to secure crucial qualitative input for the CoC and Consolidated Planning processes from the grassroots community organizations, service providers, government officials, neighbourhood groups and homeless individuals
- Coordination of bi-monthly GMICH board meetings
- Coordination of monthly meetings of the GMICH's Executive Committee
- Coordination and conduct of point-in-time street count
- Survey of homeless clients to ensure their voices are heard

Partners' total budget is approximately $220,000 per year, with the vast majority of that budget supporting Partners' data collection and analysis, coordination of the application process, and resource coordination and development--all of which are necessary for a successful application and for developing the CoC system of services and housing. The city provides approximately 27 percent of Partners' budget, the county approximately 18 percent, foundations approximately 37 percent, and business/corporations and other sources approximately 18 percent. GMICH's budget is approximately $100,000 per year, with 95 percent of that funding coming from city funds, and the other 5 percent resulting from the agency's annual "Walk for the Homeless." City and county contributions are "pass-through" funds from HUD's Community Development Block Grant program.

D CoC under Development

Memphis/Shelby County's vision for combating homelessness remains rooted in the principle that any strategy for successfully combating homelessness must focus on two primary fronts: 1) breaking the cycle of existing homelessness; and 2) preventing future homelessness. Reality has forced them to acknowledge that so long as the social ills that plague their community and their nation continue, ending homelessness is highly unlikely. To combat homelessness, however, the strategy of Memphis/Shelby County is to continue the development of programs needed to help individuals and families break the cycle of homelessness—and to prevent homelessness from occurring whenever and wherever possible.

Memphis has made extraordinary progress in the development of transitional housing programs to help homeless people recover from substance abuse, and in the development of emergency shelter, services, transitional and permanent supportive housing for homeless people with HIV/AIDS. Much progress has been made as well in the development of transitional housing for families with children, including families in which the primary caregiver is in recovery from substance abuse and/or the family is recovering from the effects of domestic violence, often resulting from substance abuse.

Serious gaps still exist, however, in services, emergency shelter and /or "Safe Haven" accommodations, transitional housing, and permanent supportive housing for people

with severe and persistent mental illness and dual diagnoses. Serious gaps also exist in permanent supportive housing for persons in recovery from chronic substance abuse, in transitional housing for families with children and in street outreach to chronic substance abusers, many of whom have simply given up hope of ever recovering from the devastating effects of alcohol and other drug addictions. In addition, there is a need for a central assessment program to assess and assist, as appropriate, the large numbers of families with children who request, but are not admitted to local emergency shelters and transitional housing programs.

To help fill those gaps, Memphis/Shelby County envisions a highly focused effort to increase coordination and integration of mainstream programs with existing and proposed homelessness-specific programs. Shifting services costs to more appropriate funding streams will allow more appropriate use of Continuum of Care funds to develop the transitional and permanent supportive housing that is absolutely essential to recovery, residential stability, and self-sufficiency. They also envision a strong focus on developing and implementing more comprehensive and effective homelessness prevention strategies, particularly for persons with mental illness and families with children. A Task Force on homelessness, comprising senior-level public and private policy/grantmakers, has been jointly appointed by the city and county mayors. This Task Force has been charged with the task of developing and facilitating implementation of a “Blueprint” to guide the community in more effectively coordinating and utilizing public and private resources to combat homelessness.

## E Fundamental Components of CoC System

Memphis/Shelby County CoC system has some elements of all the essential components (prevention, outreach/assessment, emergency shelter, transitional housing, and permanent housing) in place. These elements are provided mainly by community not-for-profit organizations, churches and lay ministries represented on the GMICH.

Their Continuum of Care system includes outreach and assessment to treatment/service-resistant populations through drop-in centers and street outreach, emergency shelter for individuals and families with children, supportive services, and transitional housing. The transitional housing is specifically for individuals with chemical dependencies, HIV/AIDS, severe mental illness and/or dual/multiple diagnoses, and veterans. As well the CoC continuum includes transitional housing for families with children, with units specifically for families with children in which the caregiver has a serious mental illness and/or is in recovery from the effects of substance abuse and/or domestic violence. The system also has a limited number of permanent supportive housing beds for persons with HIV/AIDS and/or mental illness.

F Sub-populations Targeted

The sub-populations of homeless individuals, families and children targeted for programs include chronic substance abusers, seriously mentally ill, dually diagnosed, veterans, persons with HIV/AIDS and victims of domestic violence.

G How System Facilitates Movement Between Components of the CoC System

In the past, strong informal relationships sufficed to link the various components of the Continuum of Care system. As new programs have been developed, agencies have been strongly encouraged to formalize relationships, referrals and collaborations through memorandums of understanding/agreement. To encourage these linkages, Memphis has instituted systemic incentives:

1) in addition to standard points awarded for coordination in applications for funding through the Continuum of Care, applicants are now awarded bonus points for written evidence of agreements between agencies outlining respective roles and responsibilities; and
2) the Intake Database System, now utilized by most providers, provides for standardized intake and serves as a basis for future linkages through technological means.

To help facilitate movement between components, the Greater Memphis Interagency Coalition for the Homeless (GMICH) produces a directory of providers of services and facilities for homeless and at-risk individuals and families. The directory is updated annually and is used as a resource and referral guide to the next component in the system by local agencies. Partners for the Homeless (Partners) produces and distributes a companion list, updated as resources change. Other strategies employed include the distribution of cards of a drop-in center's address and a map depicting the location for use by downtown workers and residents in referring homeless people and/or panhandlers for assistance.

Agencies such as the Salvation Army, the Calvary Street Ministry, and Memphis Union Mission which operate several components of the CoC (prevention, emergency and transitional/ rehabilitation programs) link clients directly between these components programs and/or to programs operated by other agencies.

H Gaps and Priorities

The methods employed for establishing gaps and priorities includes the collection of point-in-time street and shelter counts, data extrapolated from unduplicated, annualized data (including turnaway data) collected by participating agencies and qualitative and quantitative information from providers, clients, and the broader community. Memphis/ Shelby County chose these methods to ensure a solid basis for applying logic to numbers in estimating the need for services, shelter, transitional housing and permanent housing.

Partners collected, compiled and analyzed the above information, and presented it for review and revision if needed to those persons most knowledgeable about the existing inventory and unmet needs--providers of services to specific sub-groups of the homeless population. In March 2001, approximately 35 agencies participated in reviewing the inventory for each sub-group, the estimated numbers for each sub-group, and the logic applied in analysis of quantitative and qualitative information to determine estimated needs and gaps in services, shelter, and housing options. Partners then made additions and corrections as noted by the providers and provided it to the Steering Committee for use in computing/assigning tentative relative priorities. This information was then incorporated into the Homelessness Needs Assessment and Gaps Analysis prepared by Partners for the City's Consolidated Plan and subsequently approved by HUD. Exhibit 4 below shows the Continuum of Care Gaps Analysis chart.

## Exhibit 4: Memphis, Tennessee: Gaps Analysis Chart

| INDIVIDUALS | | | | | |
|---|---|---|---|---|---|
| | | **Estimated Need** | **Current Inventory** | **Unmet Need/Gap** | **Relative Priority** |
| **Example** | **Emergency Shelter** | **115** | **89** | **26** | **M** |
| **Beds/Units** | Emergency Shelter | 570 | 387 | 183 | **L** |
| | Transitional Housing | 724 | 699 | 25 | **M** |
| | Permanent Supportive Housing | 408 | 70 | 338 | **H** |
| | Total | 1702 | 1156 | 546 | |
| | | | | | |
| **Supportive Services Slots** | Job Training | 724 | 699 | 25 | **M** |
| | Case Management | 724 | 699 | 25 | **M** |
| | Substance Abuse Treatment | 361 | 335 | 26 | **L** |
| | Mental Health Care | 165 | 66 | 99 | **H** |
| | Housing Placement | 724 | 699 | 25 | **M** |
| | Life Skills Training | 724 | 699 | 25 | **M** |
| | Health Care | 1311 | 1311 | 0 | **L** |
| | Outreach/Assessment | 350 | 175 | 175 | **H** |
| | | | | | |
| **Sub-Populations** | Chronic Substance Abusers | 1170 | 788 | 382 | **L** |
| | Seriously Mentally Ill | 322 | 129 | 193 | **H** |
| | Dually-Diagnosed | 193 | 77 | 116 | **H** |
| | Veterans | 286 | 267 | 19 | **M** |
| | Persons with HIV/AIDS | 106 | 80 | 26 | L |
| | Victims of Domestic Violence | 43 | 43 | 0 | **L** |
| | Youth | 0 | 5 | 0 | **L** |
| | Other | N/A | N/A | N/A | **N/A** |
| | | | | | |
| PERSONS IN FAMILIES WITH CHILDREN | | | | | |
| | | **Estimated Need** | **Current Inventory** | **Unmet Need/Gap** | **Relative Priority** |
| **Beds/Units** | Emergency Shelter | 67 | 37 | 30 | **M** |
| | Transitional Housing | 492 | 292 | 200 | **H** |
| | Permanent Supportive Housing | 52 | 0 | 52 | **H** |
| | Total | 611 | 329 | 282 | |
| | | | | | |
| **Supportive Services Slots** | Job Training | 492 | 292 | 200 | **M** |
| | Case Management | 492 | 292 | 200 | **M** |
| | Child Care | 1180 | 701 | 479 | **M** |
| | Substance Abuse Treatment | 108 | 108 | 0 | **L** |

| | | | | | |
|---|---|---|---|---|---|
| | Mental Health Care | 133 | 83 | 50 | **M** |
| | Housing Placement | 492 | 292 | 200 | **H** |
| | Life Skills Training | 492 | 292 | 200 | **M** |
| | Health Care | 1672 | 1672 | 0 | **L** |
| | Outreach/Assessment | 29 | 0 | 29 | **H** |
| | | | | | |
| **Sub-Populations** | Chronic Substance Abusers | 110 | 110 | 0 | **L** |
| | Seriously Mentally Ill | 42 | 21 | 21 | **H** |
| | Dually-Diagnosed | 0 | 0 | 0 | **L** |
| | Veterans | 7 | 7 | 0 | **L** |
| | Persons with HIV/AIDS | 50 | 20 | 30 | **H** |
| | Victims of Domestic Violence | 98 | 58 | 40 | **M** |
| | Other | N/A | N/A | N/A | **N/A** |
| | | | | | |

## I Project Selection and Priority Placement Process

The Steering Committee for the 2001 application process consisted of two representatives of local government; two representatives of service providers; and two community representatives selected by Partners.

After reviewing the inventory, estimated need, and qualitative information compiled by Partners for the gaps analysis, the Steering Committee assigned tentative Relative Priorities (high, medium, low) to each service/shelter/housing need based on the following weighted, quantified criteria:

- absolute gap in need, calculated by subtracting estimated need from the inventory;
- percentage of unmet need;
- consumer perceptions;
- provider perceptions;
- Vulnerability of the population;
- potential of the service to stabilize individuals and/or families;
- availability of other public or private resources to meet the needs; and
- collective wisdom of the Steering Committee.

Approximately 150 organizations were invited, in writing, to attend the application "kickoff" meeting on March 19, 2001. The application process, major changes in the Notice of Funding Availability, and Relative Priorities tentatively assigned by the 2001 Steering Committee were presented for review and revision, if needed.

Approximately 40 providers and other key stakeholders attended, were presented with the information, and encouraged to comment on and/or provide the Committee with additional information/documentation that might result in higher or lower priorities for specific categories.

Potential applicants were also provided with copies of the criteria used by the Steering Committee in the initial assignment of relative priorities for the Continuum of Care competition, and with copies of the project review sheet and criteria to be used in reviewing, and scoring projects. As no additional information or comments were received, the Steering Committee subsequently relied on the Relative Priorities as assigned in prioritizing projects.

In addition, potential applicants were strongly encouraged to attend the workshop to be presented by the Grant Center, and to take advantage of the grant-writing and technical assistance, which is provided by the organization each year to Continuum of Care applicants.

To help ensure that their community responds to the critical need and HUD's clear mandate to develop permanent supportive housing, the process included meetings of the Steering Committee and applicants to explore possibilities for ensuring that funding would be available within the community's pro rata need for a new permanent supportive housing project. The need for additional information regarding start dates and expected dates of future requests for renewals was identified at the first meeting. That information was promptly provided to Partners for synthesis and analysis. All applicants then met with the Steering Committee and were provided with a chart reflecting that within two years, funding one year of renewals would significantly exceed the community's pro rata need amount. With the clear understanding that funding for new projects in the future would be extremely limited, all applicants, other than the Shelter Plus Care project which, by statute, must be funded for five or ten years, submitted applications for funding for two years.

Applications were submitted to Partners for distribution to the Steering Committee. Each application was thoroughly reviewed and scored by two Steering Committee members, with all other Steering Committee members also reviewing the applications. All reviewers were encouraged to submit questions regarding the applications to the Steering Committee chair. Applicants were then provided with a list of questions regarding their applications and invited to meet with the Steering Committee to respond to questions raised by reviewers. All applicants subsequently met with the Steering Committee. As a result of the interviews, many of the applicants revised their applications to more accurately reflect their request for funding and/or leveraging. The city employee excused herself from review or participation in the ranking or prioritization of the city's application. Applications were scored as submitted, taking into account, as appropriate, clarifications by the applicants, according to the following criteria:

- Experience/Capacity (25 points)
- Project Summary (0-5 points)
- Population to be Served (0-10 points)
- Housing Where Participants will Reside (0-15 points)
- Supportive Services the Participants will Receive (0-15 points)
- Accessing Permanent Housing (0-15 points)

- Achieving Self-sufficiency (0-15 points)

Also included in the scoring were bonus points to be awarded for: 1) leveraging above and beyond the cash match required by HUD (0-10 points); and 2) coordination and collaboration (0-10), with 0-5 points awarded for participation in GMICH Service Provider Meetings, training, and other CoC planning activities, the Database, and Quality Standards, and 0-5 points for clear (written) evidence of collaboration and coordination with other providers. In addition to the project scores, criteria for prioritizing consisted of:

- the gap that will be created if the application for renewal of a project is not funded;
- the relative priority assigned to the services, shelter, or housing to be provided;
- the need to respond to HUD's encouragement to develop permanent housing; and
- the impact of the project on the Continuum of Care system.

Since the scoring and prioritization were driven by and in accordance with the Gaps Analysis, Relative Priorities, and criteria established prior to the review, scoring, and prioritization, no votes were taken. Any variances in scoring by Steering Committee members were discussed, with members presenting reasons for scoring lower or higher until the Committee members reached consensus. Inasmuch as the criteria for scoring was very specific, very little variance in reviewers' scores was noted.

Full consideration was given to non-profits applying for funding as evidenced by the fact that seven of the eight projects submitted in the 2001 application are operated by non-profits. The Shelter Plus Care application by local government was listed as the first priority to help fill the critical gap in this area and to take advantage of the $500,000 incentive offered by HUD to encourage development of permanent supportive housing. Other than the eight projects included in this application, only one other project was submitted. During the technical review, it was noted that the agency had spent less than a third of the three-year grant amount; the agency was contacted, subsequently submitted a request for an extension, and withdrew the application from consideration.

J Planned Activities

The eight projects selected reflect the community's priorities and will fill a gap in the Continuum of Care System. They include:

- A new project to help fill the critical gap in permanent supportive housing for homeless persons with severe mental illness
- Five renewal projects for ensuring the continuation of programs providing transitional housing for homeless veterans and families with children, including those in which

the primary caregiver is pregnant or is in recovery from the effects of substance abuse and/or domestic violence
- Renewal of a project providing supportive services for homeless clients with disabilities, and
- A new transitional housing project to help fill the gap in transitional housing for families with children.

Memphis/Shelby County requested $3,886,833 from HUD for these 8 projects. As part of HUD requirements, each sponsor of the priority projects is responsible for obtaining additional, leveraged, resources from community provider agencies accompanied by a written commitment on type of contribution and dollar value. The sponsors collectively procured a $6,968,598 commitment from community providers.

K Evaluation

No formal outcome evaluations of the model as a whole have been conducted. The Continuum of Care application process offers an opportunity to review progress (or lack of progress) in achieving goals for developing programs to fill gaps in services and housing. Insufficient data is available at this point to measure client outcomes for the system as a whole. Nor have outcome indicators for the system been developed.

Some agencies conduct outcome evaluations to some degree, but few conduct long-term outcome evaluations. An exception is the Metropolitan Inter-Faith Association (MIFA), an organization that provides transitional housing. MIFA's evaluation reports indicate high success rates for those who complete the Estival Communities transitional housing program for families with children. For example, 85% move to permanent housing when they leave the program; 80% are not homeless 12 months after leaving the program, and 70% are not homeless 24 months after leaving the program. It should be noted that the program only accepts those who are willing and able to make the commitment necessary for success.

# Case Study Site: City of Philadelphia, Pennsylvania

## Brief Description of Continuum of Care Implementation Experience

A Site Characteristics

The wholly urban population of Philadelphia is approximately 1.5 million of whom between 25,000-35,000 are homeless [2.9% = 43,500 according to a recent Dennis Culhane study]. As no comprehensive data capture system yet exists (a system is currently under development), no breakdown between types is available, neither is cost overall or per person. However, several sub-populations are assisted [see below].

B Characteristics of the Homeless Population

The sub-populations identified and assisted are: Veterans, Seriously Mentally Ill [including dually diagnosed], Substance Abusers [including dually diagnosed], HIV/AIDS infected, Domestic Violence cases, and Youth, however the latter sub-group does not have a specifically targeted homeless program.

C Planning Process

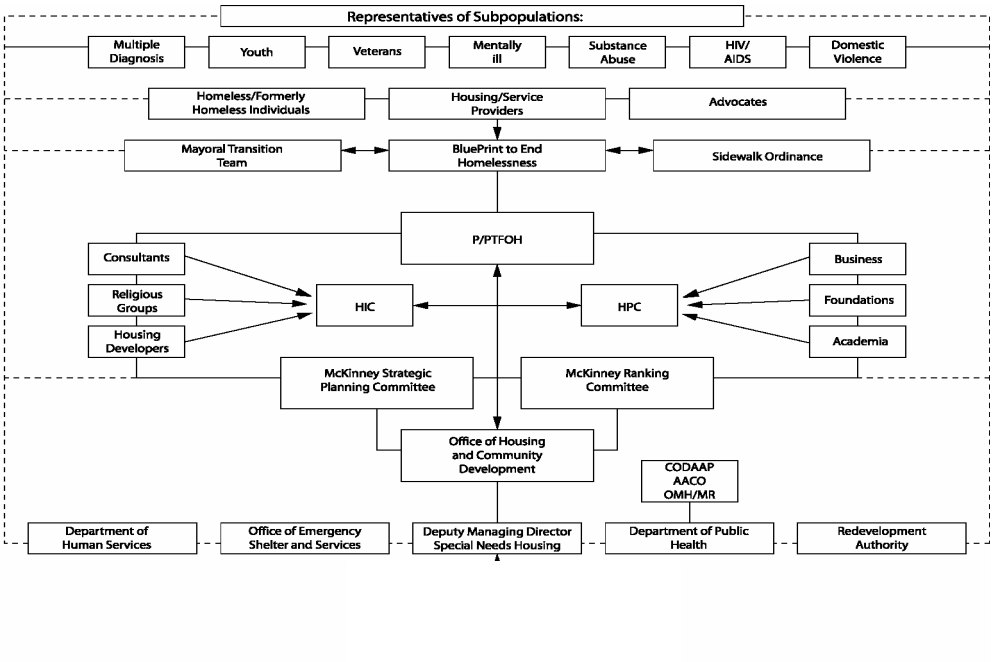
The City of Philadelphia undertakes this program under the Office of Housing and Community Development, Special Needs Housing. The CoC strategy is based on needs identified and developed through a City-wide process involving government officials, homeless housing/services providers, formerly homeless persons, homeless advocates, religious leaders, the business community, neighbourhood groups, academics, the local United Way and local foundations.

In 1998 a planning study produced a report entitled “The Blueprint to End Homelessness” which was a tactical document crated to plan for and implement targeted strategies to end homelessness in Philadelphia. This was updated in 2000. The overall coalition in the Philadelphia Continuum of Care Planning Structure is the McKinney Strategic Planning Committee, which is composed of 12 members drawn from representatives of other coalitions, homeless housing/service providers and advocates, and municipal government. The committee is responsible for: determining priorities of applications, examining the fairness and efficiency of the process; recommending suggestions to potential applicants, and working to foster collaboration between project sponsors. It meets throughout the year.

Planning process activities include setting goals to increase the ability of the Phila homeless housing/services community to secure funding to support their efforts, to maintain established, successful housing and services models for the homeless, to decrease the duplication of services, and, to encourage solutions to ending homelessness.

Partners responsibility is shared by the municipal government, the homeless housing/services and advocacy communities, and, the coordinated efforts of past and present coalitions formed to assist the homeless, all in a collaborative manner. Exhibit 5 shows the Philadelphia Continuum of Care organizational structure.

**Exhibit 5: Philadelphia, Pennsylvania: Organization Flow Chart**




Within the City of Philadelphia, the following agencies contribute towards the homeless program:

- Office of Housing & Community Development
- the Deputy Managing Director of Special Needs Housing
- the Office of Emergency Shelter and Services
- the Department of Public Health,
- the Department of Human Services
- the quasi-city agency: the Redevelopment Authority and
- the public agency: the Philadelphia Housing Authority

The 2001 Consolidated Application to HUD was for $24.3 m., with an expected $20.3 m to be leverage from a variety of public and private sources to undertake 26 projects.

D CoC under Development

The City of Philadelphia's vision for combating homelessness is in the Blueprint described as:

> "Ending homelessness in Philadelphia, ensuring that every person and family has a safe, decent and affordable place to live, and a chance to achieve self-esteem as a productive member of the community"

Specific Goals are:

- homelessness prevention
- solutions for those on the streets
- shelter and services
- housing
- employment

Website: http://www.homelessphila.org/

E Fundamental Components of CoC System

Philadelphia has all of the essential elements covered, either by the city or by partners. Some examples are:

Prevention: six neighbourhood centres and crisis management and financial assistance under the Office of Adult Services

Outreach/Assessment: outreach teams are largely composed of formerly homeless people. A recent focus has been on the chronically homeless individuals and the City has doubled the number of year-round mental health and substance abuse outreach workers on the streets, expanded the hours of outreach availability and designated teams to respond to calls for assistance.

Emergency Shelter: 1270 emergency shelter beds were available in 2001 for individuals and 401 units for families, as well as centres for bridges to substance abusers and mentally ill who are not ready for a structured clean and sober environment that serve 400 people every day.

Transitional Housing: 1647 units available for individuals and 993 for families, with three Safe-Havens for hard to reach mentally ill; Progressive Demand Residences, recovery houses and step down residences for substance abusers and HIV/AIDS, and rental vouchers.

Permanent Supportive Housing: 3714 units available in four categories of rental assistance: tenant based, sponsor based, project based, and Single Room Occupancy (SRO), with catering to disabilities which include: substance abuse, mental illness, dual diagnosis, HIV/AIDS, veterans, victims of domestic violence and emancipated youth.

Permanent Housing: Section 8 program, conventional public housing administered through the PHA and private market rentals and sales and supported low-income rental

and sale housing development. As well development of a 5 year plan that encompasses a real-needs budget, and the development of policies that counter the deterioration and abandonment of housing stock, combats NIMBYism and fights housing discrimination.

Supportive Services: case management, employment training and placement, substance abuse services, mental health services, life skills training, child care services, education, transportation, prepared meals and nutritional counseling.

F Sub-populations Targeted

The sub-populations of homeless individuals, families and children targeted for programs include chronic substance abusers, seriously mentally ill, dually diagnosed, veterans, persons with HIV/AIDS and victims of domestic violence.

G How System Facilitates Movement Between Components of the CoC System

Philadelphia's Continuum moves households from emergency shelter to transitional housing to permanent housing, while providing supportive services. The primary means of achieving movement is through case management and the referral process. These are linked through the homeless housing services provider network. Ideally, this movement occurs simultaneously to the provision of supportive services which guarantee self-sufficiency and self-determination with dignity. Ongoing efforts are being carried out by the City and its collaboration with homeless housing/services providers to create a seamless transition of homeless persons from dependency to self-sufficiency.

H Gaps and Priorities

The methods employed for establishing gaps and priorities include reviewing the goals and priorities by the planning committee, which meet over a four month period to establish priorities.

Exhibit 6 shows the gaps between estimated needs, the current inventory, the resulting unmet need, and the priority Philadelphia has put on this

## Exhibit 6: Philadelphia, Pennsylvania: Gaps Analysis Chart

| INDIVIDUALS | | | | | |
|---|---|---|---|---|---|
| | | **Estimated Need** | **Current Inventory** | **Unmet Need/Gap** | **Relative Priority** |
| **Example** | **Emergency Shelter** | | | | |
| **Beds/Units** | Emergency Shelter | 3,653 | 1,274 | 2,379 | **H** |
| | Transitional Housing | 11,188 | 1,558 | 9,630 | **M** |
| | Permanent Housing | 7,991 | 1,299 | 6,692 | **H** |
| | Total | 22,832 | 4,131 | 18,701 | |
| | | | | | |
| **Supportive Services Slots** | Job Training | 19,407 | 1,088 | 18,319 | **H** |
| | Case Management | 22,832 | 4,131 | 18,701 | **M** |
| | Substance Abuse Treatment | 11,093 | 4,490 | 6,603 | **H** |
| | Mental Health Care | 8,858 | 7,347 | 1,511 | **H** |
| | Housing Placement | 18,836 | 3,482 | 15,355 | **M** |
| | Life Skills Training | 22,832 | 4,131 | 18,701 | **L** |
| | Transportation | 19,407 | 1,938 | 17,470 | **L** |
| | | | | | |
| **Sub-Populations** | Chronic Substance Abusers | 11,093 | 4,490 | 6,603 | **H** |
| | Seriously Mentally Ill | 8,858 | 7,347 | 1,511 | **H** |
| | Dually-Diagnosed | 7,529 | 4,117 | 3,412 | **H** |
| | Veterans | 4,135 | 773 | 3,362 | **M** |
| | Persons with HIV/AIDS | 4,407 | 833 | 3,574 | M |
| | Victims of Domestic Violence | 1,141 | 176 | 964 | **M** |
| | Youth | 5,144 | 2,107 | 3,037 | **L** |
| | Other | N/A | N/A | N/A | **N/A** |
| | | | | | |
| PERSONS IN FAMILIES WITH CHILDREN | | | | | |
| | | **Estimated Need** | **Current Inventory** | **Unmet Need/Gap** | **Relative Priority** |
| **Beds/Units** | Emergency Shelter | 1,641 | 445 | 1,196 | **M** |
| | Transitional Housing | 5,026 | 984 | 4,042 | **M** |
| | Permanent Housing | 3,590 | 2,189 | 1,401 | **H** |
| | Total | 10,257 | 3,618 | 6,639 | |
| | | | | | |
| **Supportive Services Slots** | Job Training | 8,718 | 2,190 | 6,528 | **H** |
| | Case Management | 10,257 | 3,618 | 6,639 | **M** |
| | Child Care | 8,718 | 7,700 | 1,018 | **H** |
| | Substance Abuse Treatment | 5,501 | 868 | 4,633 | **H** |
| | Mental Health Care | 4,776 | 328 | 4,448 | **H** |
| | Housing Placement | 8,463 | 2,524 | 5,939 | **M** |
| | Life Skills Training | 10,257 | 3,618 | 6,639 | **L** |
| | Transportation | 8,718 | 2,619 | 6,100 | **L** |
| | | | | | |
| **Sub-Populations** | Chronic Substance Abusers | 5,501 | 868 | 4,633 | **H** |
| | Seriously Mentally Ill | 4,776 | 328 | 4,448 | **H** |
| | Dually-Diagnosed | 4,776 | 593 | 4,183 | **H** |
| | Veterans | 925 | 44 | 881 | **L** |
| | Persons with HIV/AIDS | 1,090 | 156 | 935 | **M** |
| | Victims of Domestic Violence | 2,566 | 1,110 | 1,456 | **M** |
| | Other | N/A | N/A | N/A | **N/A** |

## I Project Selection and Priority Placement Process

Applications for projects are reviewed by the planning committee, reviewing under: homeless housing projects, rental assistance, and renewal projects. Private organizations are also involved, especially helping in identifying people to review applications at the local level. On each of the committees there is a 50:50 public/private representation.

## J Planned Activities

In terms of output goals, Philadelphia's main priority is to encourage more permanent housing as there is now a disparity between transitional and permanent housing – transitional clients often have no where to move – need to get a better balance – Philadelphia does not have quantitative goals in terms of reducing homelessness or adding housing stock – just directional goals.

For 2001, Philadelphia's Consolidated Application to HUD requests renewal funding for sixteen supportive housing program projects and one Shelter Plus Care project, five new housing development projects, one supportive services only project for a total of 26 new and renewal projects totaling $20.3m.

## K Evaluation

No formal output or outcome evaluations of the model as a whole have been conducted in Philadelphia, however the outreach program now works more closely with the police, the intake process and array of services have been strengthened and Philadelphia has always had a fairly good number of transitional housing options – and are maintaining this. However there is a need fir more permanent housing and supportive housing and this is a recognized need to maximize the coordination of existing services.

When HUD evaluated them they were told that leveraging was their weak spot and their strength is their partnerships and the responsiveness of their system

# Case Study Site: Seattle-King County, Washington, USA

## Brief Description of Continuum of Care Implementation Experience

A Site Characteristics

The population of Seattle-King County is approximately 1.4 to 1.7 million. All areas of King County, Washington are included in the regional Continuum of Care system. King County includes the City of Seattle, thirty-eight suburban cities, and unincorporated areas of the county. The geographic areas covered by the Continuum of Care includes King County, and major cities such as Seattle, Auburn, Bellevue, Federal Way and Shoreline. Note that references are sometimes to Seattle-King County – this recognizes the relative size of Seattle, but King County includes the City of Seattle.

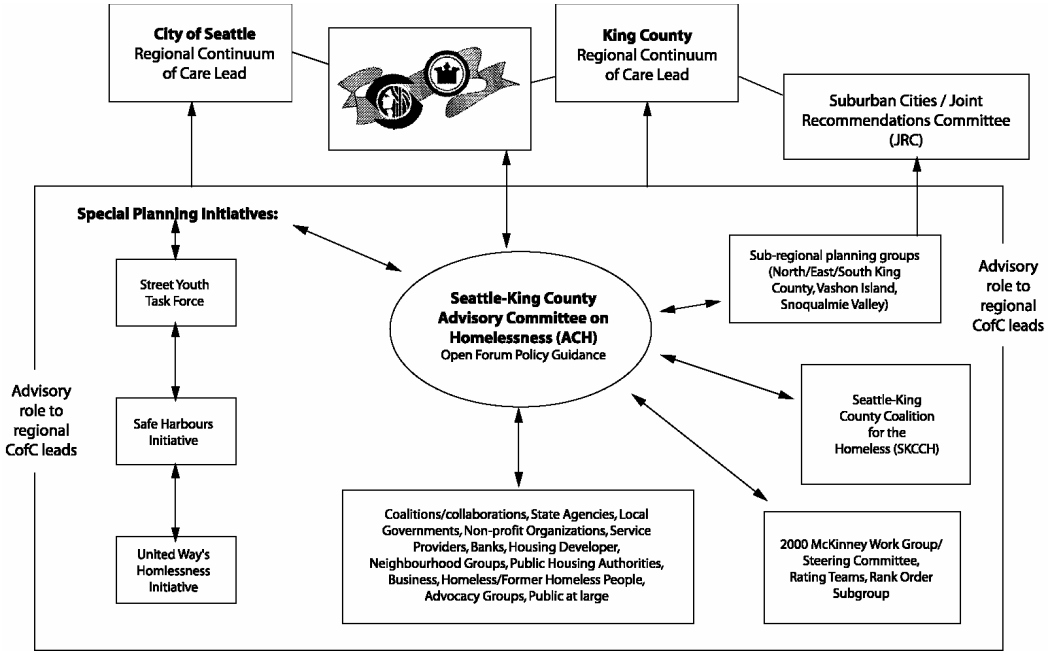
B Characteristics of the Homeless Population

The majority of individuals are youth, single adults, and families. Seniors, and other special needs populations such as persons with HIV/AIDS, victims of domestic violence, chronic substance abuse, dually diagnosed, severely mentally ill, etc. are also serviced. There aren't any populations that are not being reached but there are a couple of sub-populations for which there is very limited service such as some culturally relevant services/housing for East African immigrants and CPI housing (chronic public inebriates). Breakdown estimate: 33% families and children (mainly < age 15); 10% youth and single adults; 60% single adults with mental health and substance abuse issues. King County has found that youth have a lot of health problems – also the majority of homeless Vets have substance abuse problems

On any given night, about 6,000 in King County are homeless 3-4000 in Seattle alone out of total population of 1.7 million (Seattle comprises about half of this population), this represents about 4% of the population. 35-40% are people of colour including African Americans, refugees & immigrants, recently they have noticed increases in large families (4+ members) – largest increases are in refugees and immigrants although most of the children born locally.

C Planning Process

**Exhibit 7: Seattle-King County, Washington: Organization Flow Chart**

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King County's CoC initiative is organized under its Department of Community and Human Services, Community Services Division. The website is: http://www.metrokc.gov/dchs/CSD/Housing/Homeless.htm

King County has a well-organized coordinating council, network or other organizational structure which meets regularly. The City of Seattle and King County share the lead for the region's Continuum of Care planning process. In this capacity, we are responsible for the policy framework that embodies the region's response to homelessness. Many other stakeholders including local jurisdictions, numerous coalitions and major funders are critical to the development and continual updating of the Continuum of Care.

Recently, State level government departments such as Corrections, - also more homeless people. More and more funders are becoming involved in the planning process – also more involved in helping to set the goals

The Seattle-King County region has a long, proactive history of developing strategies and projects to prevent homelessness, alleviate immediate crises for those who are homeless, and restore homeless people to their fullest potential. During the past 30 years, an extensive network of housing and services has evolved into a comprehensive countywide response.

In 1994 and 1995, the City of Seattle, King County, and the Seattle-King County Coalition for the Homeless conducted an intensive community-based planning process that resulted in Continuum of Care frameworks for each jurisdiction and a joint application for McKinney Homeless Assistance funds. Extensive updates completed in 1996 and 1997 built upon this partnership. In 1998, with increasing numbers of people turned away from shelters and finding families with children living on the streets – and limited resources with which to address the problem - the Seattle-King County Homelessness Advisory Committee was convened. This "local board" examined the current state of homelessness in King County and generated a shared vision coupled with a series of recommended strategies for how to more effectively tackle the problem. These recommendations were incorporated in both the King County and City of Seattle's Consolidated Plans, formed the basis for public budgets, and guided the 1999 McKinney project selection process.

**Recent planning process activities include:**

For the year 2000, the planning structure has been broadened to take advantage of several new initiatives and to expand citizen participation in the Continuum of Care. This shift is *in addition* to numerous on-going and ad hoc planning groups in the community.

A priority in 2000 is the Safe Harbors Initiative. Under the leadership of a City of Seattle council member, this initiative commenced in September 1999 with passage of a resolution to develop implementation plans for a computerized system to facilitate timely, efficient, and effective access to needed services and supports for homeless persons in Seattle and King County. Through an extensive community-based planning process, recipients of housing and services, various non-profit and mainstream providers, policy makers, and other stakeholders will generate a roadmap for significant improvements to the Continuum of Care.

Simultaneously, there are two new initiatives – United Way's Homeless Initiative and the Street Youth Task Force. The United Way is engaged in a series of community meetings to discuss the root causes of homelessness and identify gaps in the Continuum of Care. Workgroups have been formed to address outreach/engagement, shelter/housing, and mental health/substance abuse. A collaboration of this initiative is the Street Youth Task Force. Its purpose is to generate a set of priority strategies that would solve major challenges facing King County Continuum of Care for homeless youth and to seek funding and other resources to implement these improvements.

Moreover, this is more reliance on the emergence of sub-regional (North, East, South, Vashon Island and Snoqualmie Valley) planning groups in King County that are focusing attention on human services and homelessness. In unincorporated King County, communities have developed an inventory of existing human services and implemented strategies to improve or expand those services, specifically for homeless populations. These sub regional planning efforts are incorporated into the region's Continuum of Care.

To bridge the various planning efforts, Seattle-King County has decided to convene an open forum process, called the Advisory Committee on Homelessness (ACH), rather than appoint a time-limited advisory committee. This is in response to a need to find better ways to encourage more participation by citizens, neighbourhood groups, homeless and formerly homeless people, refugees/immigrants, and people of colour in the Continuum of Care planning process. The ACH is used as an ongoing forum for policy guidance on our Continuum of Care, including the use of federal, state, and local resources to address homelessness in the county.

Partners' total budget is approximately $34.6 m for 2000 for 111 projects [HUD funding was approx. $28.7m].

## D CoC under Development

King County's vision for combating homelessness is:

"a community that works to end homelessness and its underlying causes. To achieve this, we commit public and private resources to develop housing and services for the region's homeless residents. Collaboration, compassion, flexibility, and creativity, ensure the wise use of these resources".

This vision was adopted by the Seattle-King County Homelessness Advisory Group in 1998, and subsequently incorporated in both Seattle's and King County's Consolidated Plans.

## E Fundamental Components of CoC System

King County CoC's system has all of the fundamental components as outlined by HUD – prevention, outreach, intake & assessment, emergency shelter, transitional housing, and permanent housing, all with supportive services.

## F Sub-populations Targeted

The sub-populations of homeless individuals, families and children targeted for programs include chronic substance abusers, seriously mentally ill, dually diagnosed, veterans, persons with HIV/AIDS and victims of domestic violence, youths, and persons who have limited English speaking skills and/or cultural/religious/diets requirements. Recently in King County, there has been an increase in East African [mainly Somali] refugees.

## G How System Facilitates Movement Between Components of the CoC System

The primary goal of the CoC is to ensure that there is "no wrong door." Homeless people can and do enter the system regardless of their situation or their stage of

homelessness. Prevention providers are critical to the CoC for they are the first response to people experiencing a housing crisis. During intake and assessment, providers identify the circumstances that led to the housing crisis, coordinate resources to stabilize the individual or family, and refer these clients to other providers as appropriate. Prevention program staff aim to stabilize people as quickly as possible in their current housing or relocate them permanently in a more suitable situation. Emergency shelters, transitional housing programs and permanent housing are linked by interagency agreements and through coalitions and networks established to streamline linkages between providers. Implementation plans are currently being developed to improve access to housing and services and to facilitate movement of homeless people through the CoC via better linkages. The **Safe Harbors System** will be a countywide computerized coordinated intake and referral system. Its aim is to ensure timely linkages of individuals and families to the services and supports they need to provide accurate data about the nature and extent of homelessness in Seattle - King County and to identify and address system gaps and utilization barriers.

## H Gaps and Priorities

The methods employed for establishing gaps and priorities include completing a gap analysis but this is not reliable data on the needs of all of the sub-populations. This will be accomplished with the development of the Safe Harbors project.

The King County Gap Analysis Chart follows in Exhibit 8

## Exhibit 8: Seattle-King County, Washington: Gaps Analysis Chart

| Year 2000 | | Estimated Need | Current Inventory | Unmet Need/Gap | Relative Priority |
|---|---|---|---|---|---|
| **Individuals including Youth and Young Adults** | | | | | |
| Beds/units | Emergency Shelter | 1800 | 1544 | 256 | Medium |
| | Transitional Housing | 600 | 37 | 563 | High |
| | Permanent Housing | 600 | 76 | 524 | High |
| | Total | 3000 | | | |
| Supportive Services Slots | Job Training/Counseling | 1980 | 1510 | 470 | Medium |
| | Case Management | 2250 | 750 | 1500 | High |
| | Substance Abuse Treatment | 1800 | 211 | 1708 | High |
| | Mental Health Care | 1200 | 101 | 1099 | High |
| | Housing Placement | 1500 | 1350 | 150 | Medium |
| | Voice Messaging | 1980 | 1125 | 855 | Low |
| | Life skills Training | 1950 | 750 | 1200 | Low |
| Estimated Sub-populations | Chronic Substance Abusers | 1440 | 211 | 1229 | Medium |
| | Seriously Mentally Ill | 750 | 101 | 649 | High |
| | Dually Diagnosed | 1140 | 193 | 947 | Medium |
| | Veterans | 575 | 364 | 211 | Low |
| | Persons with HIV/AIDS | 90 | 55 | 35 | Low |
| | Victims of Domestic Violence | * See persons in families with children | | | |
| | Youth | 500 | 83 | 417 | Medium |
| | Chronically Homeless Women | 360 | 316 | 44 | Medium |
| **Persons in Families with Children** | | | | | |
| Beds/Units | Emergency Shelter | 1200 | 1009 | 191 | Medium |
| | Transitional Housing | 900 | 108 | 792 | High |
| | Permanent Housing | 900 | 36 | 864 | High |
| | Total | 3000 | | | |
| Supportive Services Slots | Job Training | 660 | 547 | 113 | Medium |
| | Case Management | 2250 | 300 | 1950 | High |
| | Child Care | 1368 | 339 | 1029 | Medium |
| | Substance Abuse Treatment | 400 | 115 | 245 | Medium |
| | Mental Health Care | 1380 | 92 | 1288 | Medium |
| | Housing Placement | 640 | 300 | 340 | Medium |
| | Voice Messaging | 660 | 375 | 285 | Low |
| | Life Skills Training | 650 | 300 | 350 | Low |
| Estimated Sub-populations | Chronic Substance Abusers | 320 | 155 | 165 | Low |
| | Seriously Mentally Ill | 138 | 92 | 46 | Low |
| | Dually Diagnosed | 150 | 92 | 58 | Medium |
| | Veterans | 230 | 86 | 144 | Low |
| | Persons with HIV/AIDS | 300 | 36 | 264 | Low |
| | Victims of Domestic Violence | 306 | 36 | 270 | High |
| | Teen Mothers | 260 | 4 | 256 | Medium |

## I Project Selection and Priority Placement Process

Seattle and King County, in concert with the McKinney Steering Committee, the Advisory Committee on Homelessness and members of the community, designed and implemented a fair and inclusive process for determining project priorities. There is a five-stage process:

1. Work with HUD to identify all potential renewal projects.
2. Work with the community to identify 2000 priorities for McKinney funds.
3. Conduct an open solicitation of proposals.
4. Implementation of a stringent review process using community established priorities and review criteria.
5. The application was rank ordered with an appropriate array of projects to ensure balance and health in the overall homeless response system.

Seattle and King County solicited proposals as follows:

- **Public notice of HUD NOFA and announcement of Proposers' Conference.** Over 550 organizations, including those with renewal projects, were notified by mail of the McKinney Notice of Funding Availability and the 2000 Seattle-King County process.
- **Intent to Apply Forms**. Organization considering applying under the 2000 consolidated application was asked to submit an "intent to apply" form by March 31. Over 43 intent to apply forms were received. This initial "call" resulted in requests of $28.4 million in renewals, and $1.9 million in new projects.
- **Proposers' Conference**. Held on March 28, 2000 and attended by 74 persons. Staff reviewed HUD requirements and eligible activities and the Local Guidelines, including the rating criteria and ranking process that would be used.
- **Submission of Project Sponsor Applications.** Applications were due on April 20, 2000. These included 36 renewal applications and three new projects.

Project Selection Criteria includes aspects such as:

- uniqueness of the program
- geographic areas being served
- high performance outcomes
- extent of collaboration
- cost is not a major factor – varies with the type of program

King County priorities have changed a bit over time – now larger families, particularly immigrant families are more of a priority – are trying to reach out more to this client groups and include them in the planning process.

They have seen a larger % of their target population being served over time – not sure if this means they are being successful if numbers keep going up.

J Planned Activities

In King County, for 2000, a Work Group of the McKinney Steering Committee met from October through March to develop a set of recommended guidelines that clarified the parameters, principles, and rating criteria for the Seattle King County Consolidated McKinney application. Their input was published in the "Local Guidelines for the McKinney 2000 Continuum of Care Application," published on March 28, 2000. For 2000, the community identified the following top priorities:

- **Preserve successful housing and services -** Maintain the current infrastructure of transitional and permanent housing resources for homeless people.
- **Performance Counts -** Implement projects appropriately, serve the target population, and demonstrate that residential stability is increased because of the housing/services provided.
- **Focus on New Projects –** Respond to any special HUD incentives. Bring additional fixed, long-term affordable permanent or transitional housing capacity to the region.
- **Balance geographic and Sub-Population Interests** - (suburban versus urban areas) and (families, youth, and single adults) ensuring a healthy CoC.

K Evaluation

The King County CoC system has been evaluated by HUD [see below] and is well on the way to meeting its goals. Each agency of the CoC maintains information on their clients (the target-population) outcomes. Each agency is required to have measurable outcomes for self-determination, increasing income/skills and permanent housing. The agencies report the outcomes to Seattle/King County for each of the three areas mentioned above. King County can report the following for the target-populations: numbers served, demographic/race information, educational achievement/progress, income, case management hours received, substance abuse treatment received, housing counseling received, number of people placed in emergency, transitional and permanent housing, how many received vouchers and other rental assistance, numbers receiving food/clothing/physical health assistance; etc.
However, outcomes in the future would be affected if HUD reduced the McKinney funding, which would mean underfunding to maintain the current array of housing and services and possible cutbacks of services/housing that are vital to the CoC system. The City of Seattle has a housing levy which provides thousands of dollars for housing

and supportive services. The levy expired in 2000 and there is discussion in the community about presenting to the voters another housing levy. If the levy is not successful, then King County CoC system would lose a valuable fund source. Similarly, the County has faced some budget cuts that has resulted in a loss of funds for human services programs. If this trend continues, King County would have to reduce some services/housing as part of CoC since the county's human services dollars do support some of the CoC system.

HUD has done some visits – have found that agencies are now working together where before they all worked on their own – over the last 6 years since they began the program the number of agencies collaborating has increased.

One problem is that without having good data, King County cannot make shifts in the program

According to the HUD evaluation, the King County model's weaknesses were that although they thought that the model is a good one but that HUD's criteria is too restrictive in terms of policies and procedures for each component – better to keep things flexible – would prefer a block funding approach and also need to have more private sector funding but with out "strings" attached – it's hard to get supportive services funded. On the other hand HUD thought that King County's CoC model's strengths were the fact that so many agencies are working together now – they have a lot of agencies and it is difficult to find common ground sometimes – it all takes time – 6 years isn't really long enough – some of the agencies have received funding for more than 20 years and are used to a certain way of doing things.

# APPENDIX B LIST OF CANADIAN STAKEHOLDERS

Atlantic region

Jim Graham, Nova Scotia Housing & Municipal Affairs
Tel: 902-424-3224; Fax: 902-424-0661; Email grahamjd@gov.ns.ca

David Dell, New Brunswick Housing Corporation (responsible for homelessness)
Tel: 506-453-8356; Email Dave.dell@gnb.ca

Jocelyn Greene, Executive Director, Emmanuel House, St. John's, NFLD
Tel: 709-754-2072; Email sbc@roadrunner.nf.net

John Eldon Greene, Consultant, PEI Community Homeless Plan
Tel: 902-368-1975; Emailjegreen@isn.net

Cathy Wright, Saint John Human Development Council
Tel: 506-633-4636; Email cwhdc@nbnet.nb.ca

Quebec

Claude Roy. Société d'habitation du Québec
Tel: 514-873-9622; Fax: 514-873-2849; Email claude.roy@shq.gouv.qc.ca

Suzanne LaFerrière
Conseillère en développement de l'habitation (habitation sociale)
Service de l'habitation
Ville de Montréal
303, rue Notre-Dame Est, 4e étage
Montréal (Québec)
H2Y 3Y8
Email: slaferriere@ville.montreal.qc.ca

Ontario

Peggy McKenzie, Ministry of Community Services
Tel: 416-325-5420; Email peggy.mackenzie@css.gov.on.ca

Robert Yamashita, Manager, Homeless and Housing Initiatives, Region of Peel
Tel: 905-453-1300. Ext. 2930; Fax: 905-453-5002; Email robert.yamashita@region.peel.on.ca

Alice Gorman, City of Toronto, Health Officer
Email agorman@city.toronto.on.ca

Central

Nancy Higgitt, University of Manitoba
Tel: 204-474-8053; Email mailto:higgitt@ms.umanitoba.ca

Joan Dawkins, Main Street Project, Winnipeg.
Tel: 204-982-8240; jdawkins@mainstreetproject.ca

Tom Young, Saskatchewan Housing Corporation
Tel: 306-787-1791 Email tyoung@mah.gov.sk.ca

West

Kildy Yuen, Alberta Community Development, Housing Innovation Research
Tel: 780-422-8133; Email kildy.yuen@gov.ab.ca

Debbie Saidman, Executive Director, Edmonton Housing Trust Fund
Tel: 780-496-2626; dsaidman@ehtf.ca

Jeanine Ratcliffe, Gregory Steves, B.C. Ministry of Social Development & Economic Development
Tel: 250-387-0615; Email Jeanine.ratcliffe@gems6.gov.bc.ca
Gregory.steves@gems9.gov.bc.ca

North

Dan Boyd, Yukon Housing Corporation,
Phone 867 667 5751
Fax 867 667 6274
Email: Dan.Boyd@gov.yk.ca

# APPENDIX C A BRIEF DESCRIPTION OF SCPI

### A brief description of Canada's federal initiative addressing homelessness: Supporting Communities Partnership Initiative (SCPI)

In Canada, the cornerstone of the federal government's strategy to address homelessness is the *Supporting Communities Partnership Initiative (SCPI).* The government launched this initiative administered through Human Resources Development Canada in December 1999 with an investment of $305 million for the first three years. SCPI has five broad objectives:

1. To ensure that no individuals are involuntarily on the street by ensuring that sufficient shelters and adequate support systems are available;
2. To reduce significantly the number of individuals requiring emergency shelters and transition and supportive housing (through for example, health services, low cost housing, discharge planning, early intervention, prevention initiatives);
3. To help individuals move from homelessness through to self-sufficiency, where possible;
4. To help communities strengthen their capacity to address the needs of their homeless population; and
5. To improve the social, health and economic well-being of people who are homeless.

SCPI was developed to address those most in need with an emphasis on absolute homeless, i.e., people living on the streets, in temporary shelters or in locations not meant for human habitation. About 80% of SCPI funding has been directed to the ten largest urban centres in Canada where available reports and data suggest the largest numbers of absolute homeless.

Although not explicitly modeled after the American CoC model, SCPI shares with HUD's CoC program, the belief that local communities are best placed to devise effective strategies to both prevent and reduce homelessness. SCPI also encourages local collaboration and partnerships and hopes to enable participating communities to engage public, private and voluntary sector partners in developing and implementing a local action plan to fight homelessness. The initiative aims to provide communities with the necessary resources to bring partners to the table, identify service gaps and put in place a continuum of support to address homelessness.

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