**OPENING DOORS IN WESTERN MASSACHUSETTS**

**ROADMAP FOR ENDING HOMELESSNESS AMONG INDIVIDUALS**

**Reaching and maintaining functional zero for chronically homeless individuals**

**Setting a path to end all homelessness**

**DRAFT January 2015**

**DATA: Understand the problem**

**EXISTING DATA and DATA SOURCES**

**Point-in-Time Count** At a given time, there are 750-900 homeless adult individuals (without children) in Western Massachusetts. About 400 are in emergency shelter, and 350 in transitional housing. At the last point-in-time count in January 2015, there were 29 unsheltered individuals identified.

**Annual Estimate- Annual Homeless Assessment Report (AHAR)** Each Continuum of Care (CoC) submits an annual report to HUD for the Annual Homeless Assessment Report (AHAR), which comes from data in the CoC’s Homeless Management Information System (HMIS). This covers emergency shelter and transitional housing that reports HMIS data, but excludes programs that do not participate in HMIS.Although the data set is incomplete, it provides demographic and comparison data useful for planning.It alsoindicates that over 2200 individuals use the region’s emergency shelters throughout the course of a year.

The charts on the next page summarize the data from the Hampden County CoC’s 2015 AHAR report for individuals accessing emergency shelter during the period October 1, 2014 through September 30, 2015. The data set covers 81% of emergency shelter beds for individuals in the county. Because only 32% of the CoC’s 121 transitional beds for individuals are in HMIS, the transitional bed data is not included.

**Summary of Hampden County 2015 AHAR Emergency Shelter - Individuals Data**

**Chronically Homeless** The 2015 PIT identified 147 single adult individuals in Western Massachusetts experiencing chronic homelessness—individuals having both a disabling condition and extended periods of homelessness. This represents 19% of all adult individuals counted during the PIT.

*Opening Doors* includes ending chronic homelessness as a key priority. There are several reasons for this focus: chronically homeless people often have multiple disabilities and are especially vulnerable; chronically homeless people use a disproportionate amount of resources; and there is an identified strategy—Housing First—that is successful in stably housing chronically homeless people. The federal goal is to end chronic homelessness by the end of 2017.

In Western Massachusetts, Springfield has had a strong emphasis on ending chronic homelessness since 2007, and the Hamden County CoC participates in the Zero 2016 campaign, which has a goal of ending chronic homelessness by 2016. As a result, Hampden County has experienced a steady decline in the number of chronically homeless individuals counted each year during the point-in-time count. Providers throughout the region use a Housing First model and house chronically homeless individuals, and the Three County CoC experienced a large drop in the number of chronically homeless individuals between 2014 and 2015.

**Chronically Homeless, defined**

The term “chronically homeless” refers to homeless people who are disabled and have been homeless a year or longer, or 4 or more times in the last 3 years.

HUD has recently published a new rule, effective January 15, 2016, which makes some adjustments to the previous definition of chronically homeless. The new rule adds the following requirements to meeting the definition of 4 episodes in 3 years:

* The four episodes have to add up to a total of 12 months; and
* The time between periods of homelessness must last at least seven days for each to be considered an “episode.”

Also, under the previous rule, people who exited institutional care facilities after spending fewer than 90 days there would not have had that period counted toward their homelessness. Now, it will be.

**Zero 2016 Campaign and a Take-Down Target** The Zero 2016 campaign has used the Hampden County CoC’s 2015 PIT data to estimate how many chronically homeless people the CoC needs to house throughout 2015 and 2016 in order to end chronic homelessness, a number the campaign refers to a “take-down target.” The number includes those who were counted as chronically homeless in the 2015 PIT count, plus those who are expected to become chronically homeless or who are already chronically homeless and come into Hampden County during 2015 and 2016.

The campaign estimates that the CoC needs to house 106 non-Veteran chronically homeless individuals during the period January 2015 through December 2016, or an average of 4 chronically homeless individuals per month. For the 2015 calendar year, the CoC housed an average of 6 chronically homeless individuals per month.

**By-Name List and Vulnerability Assessment** Whilea take-down target provides an estimate of the number of people that need to be housed over time, a by-namelist provides more exact knowledge of how many need to be housed and enable providers to collectively focus on the actual individuals who are chronically homeless. The Hampden County CoC has begun keeping a by-name list. The list has been created by identifying chronically homeless individuals in HMIS and adding long-term homeless individuals who are known by outreach workers, hospitals, and police departments. The list is maintained by the CoC and updated at least monthly.

The CoC uses the list and a vulnerability assessment to determine which individuals should be offered placements in permanent supportive housing units when they become available. Providers seek to understand the level of vulnerability of each individual on the list by administering a Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). The VI-SPDAT yields a score for each person assessed, which is an objective standard of the individual’s level of vulnerability. Among those who are chronically homeless, the CoC houses those who are most vulnerable first.

As of December 31, 2015, there were 54 individuals on the Hampden County list, and the CoC had VISPDAT scores for 26 of these individuals, and had assessed another six individuals as “vulnerable.”

**Permanent Supportive Housing Units** As is discussed below, an effective strategy for ending chronic homelessness is providing permanent supportive housing (PSH) targeted to chronically homeless individuals. Both CoCs are incrementally increasing the stock of PSH units. Both CoCs target 100% of CoC-funded PSH to those experiencing chronic homelessness.

**Other Target Populations**  While the current priority goal is ending chronic homeless, there are other populations among homeless individuals which are also the subject of data analysis and creation of population-specific strategies. These include youth under 25 and veterans, each of which is addressed by the Network’s Youth and Veterans Committees, respectively, each of which is creating a targeted roadmap. The Network has workgroups that focus on the needs of victims of domestic violence and registered sex offenders.

***Older Individuals*** The PIT count does not report of the number of older individuals, but the AHAR does. The Hampden County 2015 AHAR identified 59 individuals 62 or older, and other 242 individuals aged 50 to 61. In 2016, the Hampden County CoC will analyze data about older individuals to gain a better understanding of this population.

***Homeless Women*** Hampden County’s 2015 AHAR report indicates that 25.82% of individuals accessing HMIS-reporting shelters were women, and 25.73 of individuals counted at the 2015 PIT were women. The Hampden County CoC plans to more fully analyze data regarding this population in 2016.

***Sex Offenders*** Sex offenders subject to registration requirements face unique barriers to accessing housing. Buffer zones restrict where sex offenders are able to live, and many landlords screen out this population. However, criminal justice experts indicate that sex offenders present less of a risk if they are stably housed. The CoCs do not have data on the numbers of homeless individuals who are registered sex offenders.

***People Living with HIV/AIDS*** The 2015 PIT count identified 6 persons living with HIV/AIDS in Hampden County.

**What Data and Information is Missing?** Data helps the CoCs and Network understand the population, its needs, and gaps in the service delivery system. Opportunities to improve data access and use include:

* Broader HMIS coverage; in particular, including outreach data in HMIS will provide more information to enable CoCs to identify individuals who meet the definition of chronically homeless.
* The new definition of chronically homeless will require more information from HMIS to verify an individual’s eligibility for programs serving chronically homeless individuals. The Hampden County CoC may want to consider moving to an open HMIS, where providers can view an individual’s record across programs.
* The Springfield Police Department has been a valuable source of information about unsheltered homeless individuals; the Hampden County CoC will contact other police departments to increase awareness of unsheltered individuals.

**GOAL 1: End chronic homelessness**

The Network has committed to ending chronic homelessness by the end of 2017, the goal set by the federal government. The Hamden County CoC has committed to ending chronic homelessness by the end of 2016.

The U.S. Interagency Council on Homelessness (USICH) has not yet defined the measures it will use to determine whether chronic homelessness is ended in a particular community. While it seems apparent that ending chronic homelessness means that there will be no one in the community who meets the definition, there is recognition that people meeting the definition may newly come into an area, or individuals may newly progress to meet the definition, or there may be chronically homeless individuals who have no interest in being housed. Based on what has taken place regarding the goal of ending Veteran homelessness, it is likely that the USICH will set criteria for this goal within the next two years.

**Functional Zero** The Zero 2016 campaign has set a target of “functional zero” for its definition of having ended chronic homelessness. Functional zero means: at any point in time, the number of individuals experiencing chronic homelessness is no greater than the current average monthly housing placement rate for chronically homeless individuals. This goal requires CoCs to track monthly housing placements.

**By Name List** As communities move toward maintenance of a by-name list, the measure of progress toward ending chronic homelessness will be the number of chronically homeless individuals still on the list who have not yet been housed. Knowing this number at a given time requires ongoing updates to the by-name list, which are based on comprehensive outreach.

**OPENING DOORS STRATEGIES**

**Primary strategies for ending chronic homelessness** The federal *Opening Doors* plan identifies 4 key strategies for ending chronic homelessness:

* Create more supportive housing by redirecting existing housing resources
* Leverage Medicaid and behavioral health systems to provide supportive services
* Improve the targeting of supportive housing units to people experiencing chronic homelessness
* Implement best practices like Housing First and assertive outreach and engagement

**GOAL 2: Set a path to end all types of homelessness**

While an initial goal for addressing homelessness among individuals is to end chronic homelessness, a complementary goal is creation of systems that make sure all people who are experiencing a housing crisis get the help they need. That includes both the homelessness service system and the mainstream systems — [housing](https://www.usich.gov/solutions/housing), [employment](https://www.usich.gov/solutions/jobs), [education](https://www.usich.gov/solutions/education), [health care](https://www.usich.gov/solutions/health-care), and benefits — that can help people stay stably housed.

An effective crisis response system:

* Identifies people experiencing or at risk of experiencing homelessness
* Prevents homelessness whenever possible
* Provides immediate access to shelter and crisis services without barriers to entry, as stable housing and supports are being secured
* Quickly connects people who experience homelessness to housing assistance and/ or services tailored to the unique strengths and needs of households and which enable them to achieve and maintain permanent housing

**OPENING DOORS STRATEGIES**

**Primary strategies for setting a path to end all types of homelessness** The federal*Opening Doors* Plan prioritizes three key strategies for system transformation:

* Development of coordinated entry systems that link individuals with the most appropriate assistance they need to prevent and end homelessness
* Collaboration to leverage and integrate resources of mainstream systems, in the areas of housing, employment, education, health care, and benefits
* Increasing the amount of rental housing that is [affordable](https://www.usich.gov/solutions/housing/affordable-housing)to people with the lowest incomes, including people with disabilities who are living with incomes far below the federal poverty level

**OUTREACH: Identify and engage homeless individuals**

*In an effective crisis response system built upon Housing First principles, homeless outreach is coordinated as well as collaborative. Outreach providers coordinate with one another to ensure full community coverage, connect people to local coordinated assessment processes, connect people to needed health care and emergency services, and work as part of a system for connecting people to stable housing using a Housing First approach. Outreach must also coordinate with programs that assist people experiencing homelessness, such as Health Care for the Homeless programs and youth drop-in centers. Also critical is collaboration with and “in-reach” into other settings and service sectors outside of traditional homeless services like hospitals, correctional institutions, child welfare agencies, and schools.*

The *Opening Doors*plandescribes the goals for outreach as follows:

**Outreach Resources**

***Eliot Community Human Services*** Using a federal Projects for Assistance in Transition from Homelessness (PATH) grant, the state of Massachusetts contracts with Eliot Community Human Services to provide homelessness outreach statewide.

***Health Care for the Homeless*** Mercy Hospital is a Health Care for the Homeless provider serving Hampden and Hampshire Counties. [Does it serve Franklin?] The program provides street outreach in cities in Hampden County.

***Mental Health Association*** MHA’s REACH program coordinates street outreach with connections to the agency’s permanent supportive housing units.

***Springfield Police-BHN Outreach Initiative*** In 2016, the Springfield Police Department and Behavioral Health Network are beginning an effort in which police officers and mental health professionals will undertake regular joint shifts to approach unsheltered individuals on the street in an effort to engage individuals. The genesis for this project is that the police 24/7 presence in the community makes them particularly aware of the locations of unsheltered individuals, and they often develop relationships with these individuals. The presence of the BHN worker with the police will bring the expertise needed to focus engagement on housing and/or treatment.

**Collaboration and Coverage**

It can be a challenge to ensure that limited outreach staff are able to find and engage every person who spends time unsheltered, especially when many of these individuals transition through so many settings. In Springfield, a workgroup of outreach workers, police, mental health workers, emergency room staff and shelter providers have been meeting monthly to identify individuals who are very vulnerable and frequently ion the street. The group provides information for the CoC’s By-Name List, and also helps to identify those whose needs may be too great even for permanent supportive housing. The CoC has a Critical Response Team which can focus on the challenging needs of these individuals to identify solutions that will get them off the street.

**OPENING DOORS STRATEGIES**

Promote data-driven client engagement and housing placement efforts in which communities set specific short-term goals to connect people experiencing homelessness to housing and services appropriate to their needs and where data on engagements and housing placements is used to track performance against those goals.

Connect permanent supportive housing to street outreach, shelter, and institutional “in-reach” that can identify and engage people experiencing chronic homelessness.

Promote targeted outreach strategies to identify people experiencing homelessness who are most likely to end up in an emergency room, hospital, jail, or prison, and connect them to the housing and support they need.

**COORDINATED ENTRY: Moving from homelessness to housed**

Coordinated entry is a system-wide process for enabling people to access services, which uses standard tools to identify and assess needs, and to make prioritization decisions based on needs.

The Hampden County CoC is in the early implementation phase of coordinated entry, and has submitted an application in the current CoC competition application for Friends of the Homeless to add staff to support this system. The 3-County CoC has submitted an application for Veterans Inc. to operate a coordinated entry system.

In 2015, HUD released a policy brief which defines the characteristics of effective coordinated entry:

* **Prioritization.** Those with thegreatest needs receive priority for available housing and homeless assistance.
* **Low Barrier.** People arenot screened out of assistance because of perceived barriers to housing or services, including, but not limited to, lack of employment or income, drug or alcohol use, or having a criminal record.
* **Housing First orientation.** The focus is on housing people quickly, without preconditions or service participation requirements.
* **Person-Centered.** The coordinated entry process incorporates participant choice, which may be facilitated by questions in the assessment tool or through other methods.
* **Fair and Equal Access.** All people have fair and equal access to the coordinated entry process, regardless of where or how they present for services.
* **Standardized Access and Assessment.** All coordinated entry locations and methods (phone, in-person, online, etc.) offer the same assessment approach and referrals using uniform decisionmaking processes.
* **Referral to projects.** The process makes referrals to all projects receiving Emergency Solutions Grants (ESG) and CoC Program funds, including emergency shelter, RRH, PSH, and transitional housing (TH), as well as other housing and homelessness projects. Projects in the community that are dedicated to serving people experiencing homelessness fill all vacancies through referrals, while other housing and services projects determine the extent to which they rely on referrals from the coordinated entry process.
* **Referral protocols.** Programs that participate in the CoC’s coordinated entry process accept all eligible referrals unless the CoC has a documented protocol for rejecting referrals that ensures that such rejections are justified and rare and that participants are able to identify and access another suitable project.
* **Outreach.** The coordinated entry process is linked to street outreach efforts so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the coordinated entry process.
* **Safety planning.** The coordinated entry process has protocols in place to ensure the safety of the individuals seeking assistance. These protocols ensure that people fleeing domestic violence have safe and confidential access to the coordinated entry process and domestic violence services, and that any data collection adheres to the Violence Against Women Act (VAWA).

**RESOURCES: What’s available?**

**HOUSING RESOURCES**

**Permanent Supportive Housing (PSH).** PSH includes affordable (subsidized) housing plus individualized support services.

***CoC PSH****.* CoC providers operate permanent supportive housing for chronically homeless individuals.

***Other PSH.***

**Time-Limited Services and Housing Support (Prevention and Rapid Rehousing)**

**Other Permanent Housing.**

**Transitional Housing**

**FINANCIAL BENEFITS AND SERVICES**

***Disability benefits: SSI/SSDI.*** In addition to veteran-specific benefits, disabled veterans may also be eligible for federal Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). A veteran can start an application for SSI or SSDI online, by phone, or by visiting a local Social Security office.

***Employment***. (Are there programs/efforts to link veterans that access SSVF to employment?)

***Documents* – DD214, birth cert, social security card**

**PREVENTION: Stop homelessness before it happens**

**Eviction prevention**

* Housing Court
* TPP
* PHAs – early intervention

**Substance abuse**

* Release from SA treatment

**Criminal justice system**

* Mental Health Court
* Release from jail/prison
* After Incarceration Support Services

**High-End Users**

**[Foster Care addressed in youth workgroup]**

**INDIVIDUAL HOMELESSNESS 2016-2018 WORKPLAN**

**Items to consider for incorporation into workplan:**

**Network Individual Services Committee**

**Joint Individual Services Committee-CoC**

**CoCs**

**Appendix**

**Terms and Definitions**

Chronically Homeless

Continuum of Care

Functional Zero

Homeless

Homeless Management Information System

SRO

Zero 2016

**Resources – Providers, Programs and Contacts**

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| Social Security Administration | 70 Bond Street  Springfield, MA 01104  Second Floor  200 High Street  Holyoke, MA 01040 | **1-800-772-1213** | Social Security Card  Social Security Disability Insurance (SSDI)  Supplemental Security Income (SSI) |
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| South Middlesex Opportunity Council |  |  |  |
| Springfield Partners for Community Action |  |  |  |
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