PREPARING FOR THE HEARTH ACT: PREVENTING AND ENDING HOMELESSNESS AT THE LOCAL LEVEL

by

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ABSTRACT

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The HEARTH Act of 2009 expands care to people experiencing homelessness by giving communities more freedom in allocation of their resources based on their ability to produce measurable results. Although HUD has not yet released regulations on this legislation, communities, called Continuums of Care, can prepare for program changes by monitoring current data for areas in need of growth within the system.

One of the goals included in the statute is to move a homeless family from an emergency shelter to permanent supportive housing within 30 days. This paper uses data from the Annual Progress Reports from grantees in the Continuum of Care in Fort Worth, Texas to analyze current length of stay compared to the national average. To meet this goal under HEARTH, it is recommended that the Continuum improve data quality, maximize programs on domestic violence, increase use of mainstream services, and continue progress toward a central intake facility.

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CHAPTER 1

INTRODUCTION

People have experienced homelessness for as long as people have experienced communities. After years of managing the problem and historical public policy, the federal government has taken monumental steps in finding a solution. In 2009, President Barack Obama said, “It is simply unacceptable for individuals, children, families, and our nation’s veterans to be faced with homelessness in this country” (U.S. Interagency Council on Homelessness 2010).

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, passed in 2009 as an amendment to the McKinney-Vento Homeless Assistance Act of 1987, creates opportunities and encourages local communities to “retool the crisis response system” by redirecting and introducing new resources, such as reducing transitional housing and increasing homeless prevention and rapid re-housing (U.S. Interagency Council on Homelessness 2010). Within the constraints of the Continuum of Care model, city and county politics, and local resources, the federal government is paving the way to prevent and end homelessness in the next 10 years (U.S. Interagency Council on Homelessness 2010).

This paper examines this federal leadership and asks how a community can prevent and end homelessness at the local level. Federal initiatives and best practices are not ideal or applicable for every community. By comparing Annual Progress Report data for the TX601 Fort Worth/Arlington/Tarrant County Continuum of Care to national data, this paper identifies opportunities and strategies for growth. In particular, current length of stay data is compared to the goal outlined in the HEARTH Act to move an individual from homelessness into permanent

housing within 30 days. Although federal collaboration, guidance, funding, and support are crucial to prevent and end homelessness, they rely heavily on the expertise and implementation of local service providers.

This paper theorizes that, to prepare to meet these goals, local communities must have reliable data and knowledge of existing resources. Currently, there is no research or guidance to assist communities in preparing for the HEARTH Act, but several reporting requirements are in place to give service providers and local governing structures a sense of the current number of people experiencing homelessness in their area and how individuals and families move through their crisis response system.

CHAPTER 2

THEORETICAL FRAMEWORKS

Much of the research on homelessness evaluates targeted or regional approaches to specific subpopulations. Research by government contractors such as Abt Associates and academics like Dennis Culhane, have not attempted to find methods to prevent homelessness, but have studied what is being done to end it well. In recent years, their research and passionate advocates have developed what are now known as best practices in the field. Among these are the Housing First model and systems theory.

2.1 Housing First

The goal of case managers working with this special population is to transition people without homes into housing, possibly temporary but eventually permanent. This approach is referred to as the Housing First model or rapid re-housing. Similar to Maslow's hierarchy of needs, it is thought that if a person has a home, he or she will be able to find employment, overcome substance abuse, maintain mental health medication, or face other barriers easier. By housing a client first, he or she has more potential to become a successful and contributing member of society.

The Housing First model has three "critical elements": a focus on getting individuals and families into permanent housing without time restrictions as quickly as possible, a variety of either short- or long-term supportive services to encourage individuals to maintain housing, and that housing not be contingent on service usage (National Alliance to End Homelessness 2010). Increasingly considered a best practice model in the United States, Housing First has been supported by research on mental health and substance abuse recovery among the homeless.

The Housing First model is attributed to Sam Tsemberis at Pathways to Housing in New York City. His work at the agency and subsequent research have shown "participants in the

Housing First program were able to obtain and maintain independent housing" despite housing professionals who believed they were not "housing ready" (Tsemberis, Gulcur and Nakae 2004). HUD now encourages use of the Housing First model, and several cost benefit analysis studies show that it saves the community money to house the homeless than to continue to pay for emergency services.

2.2 Systems Theory

People interact through systems, which can cause or reinforce homelessness. Systems theory "focuses on the interactions between individuals and various systems in the environment" (Kirst-Ashman and Hull 2006, 9). A system could be a family, school, workplace, or community. Individuals interact within systems – affecting them and being affected by them. Systems can either create barriers for individuals or assist them in reaching their goals. These interactions, collectively known as system theory, "provide social workers with a conceptual perspective that emphasizes interactions among various systems" (Kirst-Ashman and Hull 2006, 9). This theory also extends to other professions and is sometimes referred to as substantive theory.

Because people interact through systems, it is important to engage each part of the system to prevent and end homelessness. In levels of leadership, this means interagency collaboration. On a case management level, this means relationships and resources surrounding a client.

2.3 Planning Perspective and the Right to Public Space

Direct service providers are not the only advocates for disenfranchised populations. As an alternative to rational comprehensive planning, advocacy planning emerged with Paul Davidoff in the 1960s to answer to anomalies that did not fit into previous planning methods. The role of the planner became to advocate for less empowered groups (Davidoff 2003). Similarly, equity planning uses the planner as an advocate for equity throughout the population (Krumholz 1994). Planners "use their research, analytical, and organizing skills to influence

opinion, mobilize underrepresented constituencies, and advance and perhaps implement policies and programs that redistribute public and private resources to the poor and working class" (Metzger 1996).

Often, urban planners who follow rational comprehensive theory do not have to face the homeless population unless the city or public asks for shelters, or loitering, begging, and other illegal acts interfere with business. Community and economic development have the opportunity to, rather than "hide" the homeless, find fitting places in society through grant funding, zoning restrictions, and collaboration with social service providers.

Beginning with Henri Lefebvre in the late 1960s and resurged in the past decade, urban planners, geographers, and academics have questioned who has the "right to the city" (Mitchell 2003). According to Don Mitchell (2003), "the solution to the perceived ills of urban public spaces over the past generation has been a combination of environmental change, behavior modification, and stringent policing…to assure that public spaces remain 'public' rather than hijacked by undesirable users" (2).

Ideally, every person has the same right to public space, but "homeless men and women—who disproportionately consist of stigmatized and marginalized populations" experience their rights "routinely abrogated, curtailed, and hedged about" or as a "rallying call" (Klodawsky and Blomley 2009, 573). These conflicting options allow planners to impact social justice. Space can be used as "an instrument of exclusion" or as a means for the homeless to "produce what Mitchell and Heynen term geographies of survival, ad hoc and vulnerable networks, institutions, and practices through which the homeless are able to…sustain themselves in urban spaces" (Klodawsky and Blomley 2009, 574).

In recent years, the "criminalization of the homeless" has gained the attention of media and homeless advocates. A 2009 report by the National Law Center of Homelessness and Poverty and the National Coalition for the Homeless tracks laws restricting activity in public spaces or "select enforcement of more neutral laws" (The National Law Center on

Homelessness and Poverty and the National Coalition for the Homeless 2009, 9-10). The report cites 47 percent of cities studied prohibited begging and 33 percent prevent camping in public places (The National Law Center on Homelessness and Poverty and the National Coalition for the Homeless 2009). The U.S. Interagency Council on Homelessness includes “reduce criminalization of homelessness” as strategy in the Federal Strategic Plan to Prevent and End Homelessness “by defining constructive approaches to street homelessness and considering incentives to urge cities to adopt these practices” (U.S. Interagency Council on Homelessness 2010, 48).

CHAPTER 3

MEASURING HOMELESSNESS

Depending on the definition of “homelessness,” there are varying amounts of quantitative data on the number of people experiencing homelessness in a community. The differences in these definitions are further discussed in legislation on homelessness. There is no shortage, however, of qualitative data. Because homelessness affects every type of community, from urban to suburban to rural, it conjures images that range from people living and begging in public spaces to people bouncing between friends’ sofas.

3.1 Historical Measurements

Understanding the extent of the problem is useful in developing a solution. Although people experiencing homelessness have been documented in the United States (U.S.) with the development of railroads and after the Civil War, the first estimated number of homeless people came during the Great Depression. In a letter to President Franklin Roosevelt in 1933, the President’s Economic Council cited “two million homeless people migrating around the country” who could not find work in agriculture due to severe drought and price decrease (President's Economic Council 1933). Although this number is a rough estimation, it provides indication of the highest number of people experiencing homelessness in American history.

From the 1960s to the 1970s, deinstitutionalization of state psychiatric hospitals caused another surge in people living in places not meant for human habitation and emergency shelters. While the number of people who subsequently became homeless is not known, between 1955 and 1979 around 390,000 state hospitals closed (Talbott 1979). This shift in mental health philosophy placed strain on the new Medicaid, Medicare, and Supplemental Security Income programs. People experiencing homelessness have higher rates of disability than people experiencing poverty or the entire U.S. population. Currently, over two-thirds of the

sheltered homeless have a disability[1] (U.S. Department of Housing and Urban Development 2010).

The social services community has historically assisted people experiencing homelessness. The work of Jane Addams and urbanization from the industrial revolution led to the settlement house movement and the first homeless shelters in the late 19th century (DuBois and Miley 2005). Today, there are at least 2,295 homeless shelters in the United States (Homeless Shelter Directory 2010) funded by HUD, nonprofits, community grants, mental health and substance abuse grants, foundations, and/or faith-based organizations.

3.2 Current Measurements

According to the fifth Annual Homeless Assessment Report to Congress, "on a single night in January 2009, there were an estimated 643,067 sheltered and unsheltered homeless people nationwide" (U.S. Department of Housing and Urban Development 2010). This is a 3.2 percent decrease since 2008 and a 15.3 percent decrease since 2006[2], the first year that baseline data is available[3]. Figure 3.1 shows this trend in Point in Time counts. Although steadily decreasing, 2010 numbers may show less of a decline due to the current economic crisis.

[1] HUD's regulations on "disability" include mental health and substance abuse. The HEARTH Act defines a "disability" as "a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post traumatic stress disorder, or brain injury," a "developmental disability," or "the disease of acquired immunodeficiency syndrome" (U.S. Department of Housing and Urban Development 2009). Disability of at least one family member is an eligibility requirement for all of HUD's targeted homeless permanent housing projects (U.S. Department of Housing and Urban Development 2010).

[2] "While the decline is welcome news," the AHAR states, "it is difficult to disentangle the effects of successful policy interventions from nationwide improvements in [Point in Time] enumeration methods that have lead to greater accuracy" (U.S. Department of Housing and Urban Development 2010).

[3] Advocates had previously estimated the number of people experiencing homelessness nationally, but the 2006 Annual Homeless Assessment Report was the first reliable numbers from HMIS (U.S. Department of Housing and Urban Development 2007)

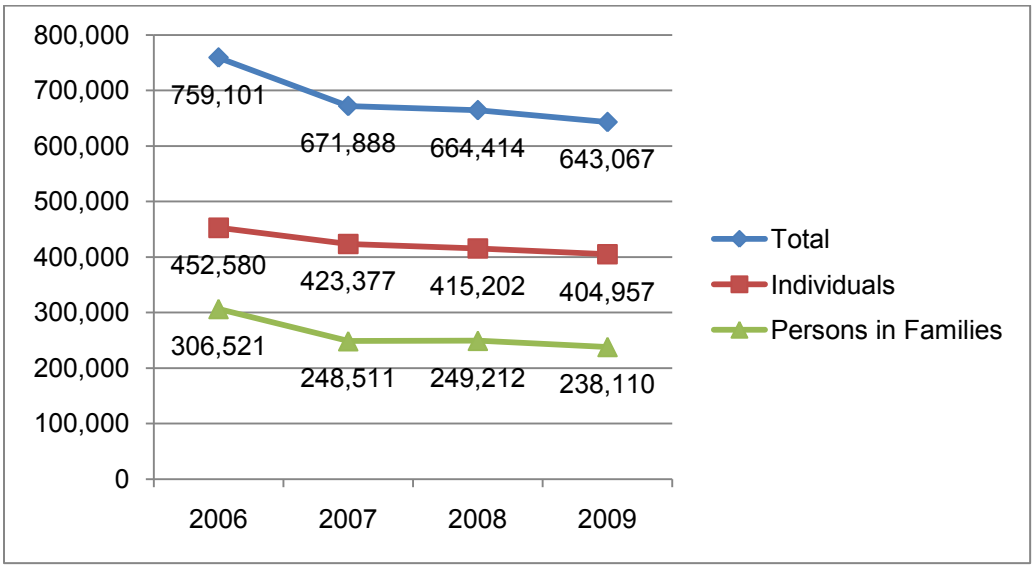

Figure 3.1: Trends in Homeless Point in Time Counts, 2006 to 2009 (U.S. Department of Housing and Urban Development 2010, 11)

CHAPTER 4

FEDERAL REPORTING

Since all definitions of homelessness rely on access to safe, stable, and decent housing through homeownership or rent, the U.S. Department of Housing and Urban Development (HUD) has the strongest connection to homelessness in the United States. HUD offers the most targeted homeless programs with a strong focus on data collection and reporting through the Office of Community Planning and Development Office of Special Needs Assistance Programs.

4.1 Other Federal Agencies

The U.S. Department of Education tracks homeless children and youth through the designated liaison per Local Education Agency (i.e. school district). According to the McKinney-Vento Homeless Education Improvement Act of 2001, "each State educational agency shall ensure that each child of a homeless individual and each homeless youth has equal access to the same free, appropriate public education, including a public preschool education, as provided to other children and youth" (U.S. Department of Education 2004). Required activities include ensuring transportation, enrollment in free lunch programs, and services such as school supply and coat drives (U.S. Department of Education 2004). While the liaisons collect data on their clients and their families to ensure they meet their homeless definitions, this information is not released or reported in an annual report.

While the U.S. Department of Health and Human Services readily provides healthcare and supplemental income supports, they do not ask questions about housing status and, therefore, do not have record of the number of homeless clients they serve. As part of the objective to "transform local crisis response systems," the U.S. Interagency Council on Homelessness (USICH) is working to increase use of mainstream resources using data from HUD's Annual Performance Reports (U.S. Interagency Council on Homelessness 2010). The

enactment of the Affordable Care Act in 2010 will expand Medicaid to many people experiencing homelessness in 2014 by including adults without children (Kaiser Health News 2010).

4.2 U.S. Interagency Council on Homelessness

USICH was enacted in the McKinney-Vento Act "as an 'independent establishment' within the executive branch to review the effectiveness of federal activities and programs to assist people experiencing homelessness, better promote coordination among agency programs, and inform state and local governments and public and private sector organizations about the availability of federal homeless assistance" (U.S. Interagency Council on Homelessness 2010). The HEARTH Act designed a new mission for USICH: "to coordinate the Federal response to homelessness and to create a national partnership at every level of government and with the private sector to reduce and end homelessness in the nation while maximizing the effectiveness of the Federal Government in contributing to the end of homelessness" (U.S. Department of Housing and Urban Development 2009).

While USICH does not manage programs or collect data, they are an integral part in setting goals to prevent and end homelessness, including measuring success. The HEARTH Act requires the agency to write the first Federal Strategic Plan to Prevent and End Homelessness as well as subsequent annual reports on its progress (U.S. Department of Housing and Urban Development 2009).

The Council is comprised of 19 Departments and agencies: U.S. Departments of Agriculture, Commerce, Defense, Education, Energy, Health and Human Services, Homeland Security, HUD, Interior, Justice, Labor, Transportation, and Veterans Affairs; Corporation for National and Community Service; General Services Administration; Office of Management and Budget; Social Security Administration; United States Postal Services; and the White House Office of Faith-Based and Community Initiatives. The current Chair is HUD Secretary Shaun Donovan (U.S. Interagency Council on Homelessness 2010). Each of the agency's

homelessness initiatives and the USICH Federal Strategic Plan is further discussed under federal initiatives.

CHAPTER 5

CONTINUUM OF CARE REPORTING

5.1 Continuum of Care

To organize HUD grants and encourage collaboration at the local level, the McKinney-Vento Act created the Continuum of Care (CoC) model. From 1988 to 1993, the annual Notice of Funding Availability asked each individual service provider to submit an application. The creation of the Continuum of Care in 1994 "required each community to come together to submit a single comprehensive [CoC] application" (U.S. Department of Housing and Urban Development 2009, 7). HUD intended to "stimulate community-wide planning and coordination of programs for individuals and families who are homeless" (U.S. Department of Housing and Urban Development 2009, 7).

The purpose of a CoC is twofold: "develop a long-term strategic plan and manage a year-round planning effort that addresses the identified needs of homeless individuals and households; the availability and accessibility of existing housing and services; and the opportunities for linkages with mainstream housing and services resources" and to prepare the consolidated application for the competitive grants (U.S. Department of Housing and Urban Development 2009, 3). In 2009, HUD distributed $1.6 billion to 453 Continuums across the United States (U.S. Department of Housing and Urban Development 2010). These funds provide resources for communities to build and maintain transitional and permanent housing, HMIS networks, and supportive service programs. Within the grant contracts, CoCs are able to sub-grant the housing and services to meet the needs of their communities according to the listed eligible activities. HUD funds renewals before new competitive bonus grants, so communities can continue to rely on these resources as long as they are able to show good stewardship.

HUD allows that “Continuum planning efforts…be organized at a number of geographic levels: a single city, a city and a surrounding county, a region, or a state” (U.S. Department of Housing and Urban Development 2009, 13). Most CoCs cover a single county (52 percent in 2007). Most states have a balance of state, which covers the remaining areas not included in other CoCs, usually rural areas. In 2007, six states have a statewide CoC (U.S. Department of Housing and Urban Development 2009, 15).

According to systems theory, a strong CoC will include representatives from each aspect of a potential clients’ life, such as child welfare agencies, school districts, criminal justice system, mental health and substance abuse service providers, medical services, and donation banks for furniture and clothing. Because cities have regulations dictating what is allowed in public space, a strong CoC will also involve the city council members and police officers who are assigned to the areas where homeless tend to congregate. These relationships ensure that an area is zoned properly, given adequate public transportation, and monitored for criminal activity, such as drug and sex trade. While extremely positive, these types of relationships also require a large amount of planning and collaboration.

5.2 Reporting Methods

HUD requires several reports of aggregate numbers from CoCs. These numbers are used to track trends in national homelessness, identify CoCs that need technical assistance, and report to Congress. Each CoC is asked to complete a Point in Time Count, Annual Performance Report, Housing Inventory Chart, Grant Inventory Worksheet, Annual Homeless Assessment Report to Congress, and program-specific reports as necessary. Those cited in this paper are discussed further.

5.2.1. Homeless Management Information System

In order for a CoC to produce these reports, HUD requires the use of a Homeless Management Information System (HMIS). This system is “typically a web-based software

application that homeless assistance providers use to coordinate care, manage their operations, and better serve their clients" (U.S. Department of Housing and Urban Development 2010). HMIS can "produce an unduplicated count of homeless persons, understand patterns of service use, and measure the effectiveness of homeless programs" (U.S. Department of Housing and Urban Development 2010). Although there a several large HMIS providers, it is up to each CoC to either develop or contract their system (personal communication, Cindy J. Crain).

Every HMIS must include the universal data requirements prescribed by HUD, such as name, social security number, birth date, race, gender, and veteran status. Specific programs require other data elements, such as income and sources, non-cash benefits, physical disability, and chronic health condition (U.S. Department of Housing and Urban Development 2009). This information is reported to HUD at the aggregate level so that no personal identifying information is included. In addition, victims of domestic violence are not included in HMIS (personal communication, Cindy J. Crain).

5.2.2. Annual Performance Report

In 2010, the Annual Performance Report (APR) replaced the Annual Progress Report. The report is required by all of HUD's competitive grant programs including permanent and transitional housing. APRs are required of each service provider on an annual rolling cycle according to grant terms. The reports are currently entered by hand, but will be moving to e-SNAPS, the data management system of the Office of Special Needs Assistance Programs, in 2010. Data requirements are within the HMIS universal elements (U.S. Department of Housing and Urban Development 2010). This is primary source of data for the case study on Tarrant County and will be discussed further.

5.2.3. Point in Time Counts

The Point in Time (PIT) count is required biennial from CoCs during the fourth week of January. Although required biennially, most CoCs complete a PIT annually. The information reported is shown in Table 5.1.

Table 5.1: Data Collected in Point in Time Counts (U.S. Department of Housing and Urban Development 2006)

	Sheltered			
Part 1: Homeless Population	Emergency	Transitional	Unsheltered	Total
Number of families with children				
1. Number of persons in families with children				
2. Number of single individuals and persons in households without children				
Total persons (add lines 1 and 2)				

Part 2: Homeless Subpopulations	Sheltered	Unsheltered	Total
a. Chronically homeless (for sheltered, list persons in emergency shelters only)			
b. Severely mentally ill			
c. Chronic substance abuse			
d. Veterans			
e. Persons with HIV/AIDS			
f. Victims of domestic violence			
g. Unaccompanied youth (under 18)			

The information is useful for a community to “determine the size and scope of the homeless problem,” “plan services and programs to address local needs,” “measure progress,” and “measure performance” (U.S. Department of Housing and Urban Development 2006, 3). HUD uses the data to “understand the extent and nature of homelessness,” “provide Congress with information on services provided and gaps in services,” “report to Congress and OMB on performance,” and “make funding decisions” (U.S. Department of Housing and Urban Development 2006, 4).

5.2.4. Annual Homeless Assessment Report to Congress

The Annual Homeless Assessment Report to Congress (AHAR) consists of the estimated PIT sheltered and unsheltered count of people experiencing homelessness on one night and a one-year estimate of the number of sheltered people experiencing homelessness

using HMIS (U.S. Department of Housing and Urban Development 2010). Only CoCs with "adequate data quality" may participate in the successive HMIS data. In 2009, 246 communities were chosen to participate (U.S. Department of Housing and Urban Development 2010).

HUD publishes the aggregate report annually to give Congress up-to-date information on the number of and trends in people experiencing homelessness. The AHAR also includes supplemental reports on spatial analysis and veterans. HUD "considers AHAR participation a benchmark of HMIS implementation" (U.S. Department of Housing and Urban Development 2010).

CHAPTER 6

LEGISLATION ON HOMELESSNESS

As referenced, there is one piece of American legislation on homelessness with one significant amendment[4]. The McKinney-Vento Homeless Assistance Act of 1986 created targeted and extended mainstream programs to those experiencing homelessness (U.S. Department of Housing and Urban Development 2007). The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 expands homeless prevention, emphasizes rapid re-housing, continues focus on permanent supportive housing for the chronically homeless including families, and introduces a new rural assistance program (National Alliance to End Homelessness 2009).

6.1 The McKinney-Vento Act

The McKinney-Vento Act is the primary piece of legislation that provided direction and funding to homeless providers. Before it, programs to address homelessness "were created, funded, and administered at the grass-roots level" (U.S. Department of Housing and Urban Development 2007). After pressure for the federal government to get involved, Congress passed parts of the Homeless Persons' Survival Act beginning in 1986. The Urgent Relief for the Homeless Act later that year included more legislation on "emergency relief provisions for shelter, food, mobile health care, and transitional housing" (U.S. Department of Housing and Urban Development 2007). Before being signed into law in 1987 by President Ronald Reagan,

[4] It was also amended by the No Child Left Behind Act in 200 for the U.S. Department of Education to broaden the definition of homelessness and create programs directed toward homeless children and youth (National Center for Homeless Education n.d.).

it was renamed the McKinney-Vento Homelessness Assistance Act (U.S. Department of Housing and Urban Development 2007).

McKinney-Vento outlines Continuum of Care, Supportive Housing, Shelter Plus Care, Single Room Occupancy, and Emergency Shelter Grants Programs. It also includes a federal definition of homelessness, establishes USICH and the Emergency Food and Shelter Program, requires federal agencies to make surplus federal property available for assistance, and extends the Supplemental Nutrition Assistance Program (formerly Food Stamps) and Veterans Job Training Act to the homeless (U.S. Department of Housing and Urban Development 2007).

6.1.1. Definition of Homelessness

The McKinney-Vento Act includes the first federal definition of homelessness in Title 42, Chapter 119, Subchapter 1. Individuals must meet two criteria: "[lack] a fixed, regular, and adequate nighttime residence," and have "a primary nighttime residence" that is an emergency shelter or transitional housing, an institution, or a public or private space not meant for human habitation, such as parks, train or bus stations, or abandoned buildings (U.S. Department of Housing and Urban Development n.d.). HUD regulations and technical assistance enable CoCs to understand and implement this definition.

6.1.2. Targeted Homeless Programs

McKinney-Vento created two types of homeless programs targeted to provide shelter for people experiencing homelessness within HUD's Office of Community and Planning Development Office of Special Needs Assistance Programs: non-competitive and competitive grants. According to systems theory, targeted programs are not the only solution. They are designed to serve an unmet need for the most disadvantaged in conjunction with mainstream services that are beneficial to the general population. HUD's targeted programs focus on housing or shelter with supportive services like case management.

Non-competitive, or formula, grants are administered under the Emergency Shelter Grants (ESG) Program to state governments, large cities, urban counties, and U.S. territories

based on a consolidated plan. These government entities make them available to sub-grantees, either local government agencies or non-profit organizations. These formula grants do not follow the CoC model. Eligible activities using this funding include, “rehabilitation or remodeling of a building used as a new shelter, operations and maintenance of the facility, essential supportive services (i.e., case management, physical and mental health treatment, substance abuse counseling, childcare, etc.), homeless prevention, and grant administration” (U.S. Department of Housing and Urban Development 2008). With the exception of state governments, grantees must match ESG funds dollar for dollar (U.S. Department of Housing and Urban Development 2008). In 2009, HUD awarded $160 million in ESG (U.S. Department of Housing and Urban Development 2009).

McKinney-Vento also created three competitive grant programs with Notice of Funding Availability applications open to Continuums of Care. The Supportive Housing Program (SHP) “provides housing, including housing units and group quarters, that has a supportive environment and includes a planned service component” (U.S. Department of Housing and Urban Development 2008). The Shelter Plus Care (SPC) Program “provides grants for rental assistance for homeless persons with disabilities through four component programs: Tenant, Sponsor, Project, and Single Room Occupancy Rental Assistance” (U.S. Department of Housing and Urban Development 2008). The Single Room Occupancy (SRO) Program “provides rental assistance on behalf of homeless individuals in connection with moderate rehabilitation of SRO dwellings” (U.S. Department of Housing and Urban Development 2008). To be eligible for any of these programs, clients must meet the federal definition of homeless and, according to regulations, at least one family member must have a disability (U.S. Department of Housing and Urban Development 2010).

6.2 The HEARTH Act

The homeless assistance programs in McKinney-Vento were last reauthorized in the Housing and Community Development Act of 1992. Since that time, programmatic changes

were made through the annual appropriations process. Most significantly, HUD implemented the CoC model in 1995. The Senate Banking Committee approved the Community Partnership to End Homelessness Act in 2007, which closely resembled the HEARTH Act that was passed by the House Financial Services Committee in 2008. “After discussions between House and Senate staff, a compromise was agreed to that closely resembled” these two bills (National Alliance to End Homelessness 2009, 1). Congress passed the HEARTH Act as an amendment to the Helping Families Save Their Homes Act in May 2009 (National Alliance to End Homelessness 2009).

6.2.1. Changes to McKinney-Vento

Most significantly, the HEARTH Act amends McKinney-Vento by:

- Changing the name of the Emergency Shelter Grant to the Emergency Solutions Grant to shift the focus to prevention and rapid re-housing in addition to emergency shelter
- Consolidating the SPC, SHP, and SRO Programs into a single CoC Program with the same eligible activities including rapid re-housing
- Expanding the HUD definition of homelessness to those “at imminent risk of homelessness or where a family or unaccompanied youth is living unstably” (National Alliance to End Homelessness 2009)
- Asking HUD to set aside funding and “to provide incentives for strategies that are proven to reduce homelessness,” including rapid re-housing for homeless families and permanent supportive housing for chronically homeless individuals and families (National Alliance to End Homelessness 2009)
- Expanding the U.S. Interagency Council on Homelessness to more agencies and requiring the Council to produce and update annually a Federal Strategic Plan to End Homelessness

HUD was asked to release regulations for HEARTH by November 2010 (National Alliance to End Homelessness 2009), but, at the time of this paper, only regulations on the definition have been released for public comment.

6.2.2. Definition of Homelessness

Under HEARTH, the definition of homelessness is broader to include other federal definitions, expands chronic homelessness to families, and specifies serving clients who will lose their housing within the next 14 days. There are four parts to the definition. The first part is similar to the McKinney-Vento definition that identifies persons "who [lack] a fixed, regular, and adequate nighttime residence" and have a "primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings" or a "publicly or privately operated shelter designed to provide temporary living arrangements," or are exiting an institution and previously met one of these criteria before entering that institution (U.S. Department of Housing and Urban Development 2010).

The second part of the definition expands the definition of "homeless" to include persons who "will imminently lose their housing" (e.g., court order or eviction notice) and have "no subsequent residence" and "resource or support networks needed to obtain…permanent housing" (U.S. Department of Housing and Urban Development 2010).

The third part will extend HUD homeless programs to a new category of persons: "unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes" (U.S. Department of Housing and Urban Development 2010). Currently, the only other Federal statute is the No Child Left Behind Act, which includes families living "doubled-up" or in unsatisfactory conditions, such as a trailer park or motel, as homeless to ensure the same opportunities to every child (National Center for Homeless Education n.d.). For the HUD definition, these youth and families must "have experienced a long term period without living independently in permanent housing," "have experienced persistent instability as measured by frequent moves over such period," and "can be expected to continue in such

status for an extended period of time because of chronic disabilities, chronic physical or mental health conditions, substance addiction," etc. (U.S. Department of Housing and Urban Development 2010). Because the Local Educational Agency homeless liaisons do not use HMIS and are not always involved in the CoC, it will be most difficult for grantees and service providers to document that this population meets the definition requirements.

The fourth part of the definition includes another group traditionally served by HUD homeless programs. Any person or family "who is fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or other dangerous of life-threatening conditions in [their] current housing situation" and have no other residence and lack the resources to obtain permanent housing are considered homeless (U.S. Department of Housing and Urban Development 2010).

The proposed rule for this definition closed for public comment in November 2009. The additional regulations specify timeframes not included in the original legislation, such as defining "frequent moves" as three or more and a "long period" as 90 days (U.S. Department of Housing and Urban Development 2010). In the HEARTH Act, Congress asked the U.S. Interagency Council on Homelessness to convene a meeting of all Federal agencies, respective Committees of the House of Representatives and the Senate, local and State governments, academic researchers, service providers, advocates, and persons receiving homeless funding to discuss "whether there is compelling need for a uniform definition of homelessness under Federal law" (U.S. Department of Housing and Urban Development 2010).

6.2.3. Goals for Continuums of Care

The HEARTH Act weighs heavily on data and best practices. The new CoC grant application "focus[es] more actual performance" (National Alliance to End Homelessness 2009, 4). HUD is encouraged to offer incentives for "strategies that proven to reduce homelessness" such as "rapid re-housing programs for homeless families and permanent supportive housing programs for individuals and families that experience chronic homelessness" (National Alliance

to End Homelessness 2009, 5). Selection criteria will include the community's previous performance, such as reductions in length of shelters stay and recidivism, and the comprehensiveness of the community's plan to reduce homelessness, ensure that homeless children are in school, and address the needs of subpopulations (National Alliance to End Homelessness 2009).

Standards are also in place for "high performing communities," who have low levels of homelessness and can use unlimited funding for prevention and rapid re-housing. This distinction requires: 1) an average length of stay 10 percent shorter than the previous year or less than 20 days, 2) a recidivism rate 20 percent shorter than the previous year or less than 5 percent of people who exit homelessness become homeless again in the next two years, and 3) people experiencing homelessness are encouraged participate in services (National Alliance to End Homelessness 2009).

For a CoC to be competitive in these areas, questions on these subjects are included in the Annual Progress Report (APR), as previously discussed. For example, chronic homelessness has been a recent focus of federal programs. Several questions specify one answer column for all clients and one for those who meet the definition of chronically homeless[5], such as number of persons with special needs and number of persons who receive supportive services. A CoC is also expected to adhere to the best practices. According to research and cost benefit analysis by Tsemberis and Culhane among others, for the chronic homeless, this means permanent supportive housing and Housing First, as previously discussed. The HEARTH Act states that any bonus projects awarded must give priority to proven strategies for subpopulations, namely "permanent supportive housing for chronically homeless individuals and families" (U.S. Department of Housing and Urban Development 2010, 63).

[5] The HEARTH Act considers individuals or families to be chronically homeless if they meet the criteria in the definition of homelessness continuously for one year or for four separate occasions in the past three years (U.S. Department of Housing and Urban Development 2010).

In addition to increasing expectations in the CoC grant selection process, the HEARTH Act "sets a goal of ensuring that no family is homeless for more than 30 days" (National Alliance to End Homelessness 2009, 9). The law "establish[es] a Federal goal of ensuring that individuals and families who become homeless return to permanent housing within 30 days" (U.S. Congress 2009, 33). This goal is the focus for the case study on Tarrant County.

CHAPTER 7

FEDERAL INITIATIVES

As evidenced in the HEARTH Act, the federal focus on homelessness relies on strong HMIS data reporting and an increase in permanent supportive housing. Using the Housing First model (see Appendix A), communities are asked to transition people experiencing homelessness back into permanent housing quickly, also known as rapid re-housing. Building upon the successful Homeless Prevention and Rapid Re-Housing Program in the American Recovery and Reinvestment Act of 2009, prevention and rapid re-housing are now eligible activities under the Emergency Solutions Grants Program and limited under the CoC Program (National Alliance to End Homelessness 2009).

Before the HEARTH Act, the focus of HUD has been on chronic homelessness. With the shift in resources toward permanent housing and Housing First and away from emergency and transitional shelters, there are limited resources available for supportive services. There is a clear message from the federal government that both mainstream and targeted resources are needed to prevent and end homelessness. For example, the enactment of the Affordable Care Act in 2010 will expand Medicaid to many people experiencing homelessness in 2014 by including adults without children (Kaiser Health News 2010). At the National Conference on Ending Homelessness, HUD Secretary Shaun Donovan said, “Simply put, if we want to tackle health care reform—if we want to lower costs—we must tackle homelessness. It’s that simple” (Roman 2009).

In addition to expanding mainstream (non-targeted) programs to people experiencing homelessness, the government has instituted joint demonstration programs to prove that interagency collaboration has positive results to prevent and end homelessness that in line with systems theory. These demonstration programs include HUD-Veterans Affairs Supportive

Housing Program, Veterans Homeless Prevention Demonstration, voucher demonstration program for the chronically homeless, and voucher demonstration program for families experiencing homelessness. These last two demonstration programs are signature initiatives in the Federal Strategic Plan (U.S. Interagency Council on Homelessness 2010), but, at the time of this paper, have not been funded by a Fiscal Year 2011 Congressional appropriation.

7.1 U.S. Interagency Council on Homelessness

In addition to HUD Special Needs Assistance Programs, the other 18 Departments and agencies in USICH have programs that can be applied to the homeless population. Other targeted homeless programs include:

- U.S. Department of Education—Education for Homeless Children and Youth Grants for State and Local Activities
- General Services Administration—Federal Surplus Real Property Program
- U.S. Department of Health and Human Services—Grants for the Benefit of Homeless Individuals, Health Care for the Homeless Program, Programs for Runaway and Homeless Youth, Projects for Assistance in Transition from Homelessness, Services in Supportive Housing Grants
- U.S. Department of Homeland Security—Emergency Food and Shelter Program
- HUD—Section 8 Single Room Occupancy for Individuals
- U.S. Department of Justice—Transitional Housing Assistance Grants for Victims of Sexual Assault, Domestic Violence, Dating Violence, and Stalking Program
- U.S. Department of Labor—Homeless Veterans Reintegration Program
- U.S. Department of Veterans Affairs—Domiciliary Care for Homeless Veterans Program, Grant and Per Diem Program, Health Care for Homeless Veterans Program, Homeless Veterans Dental Program, Supportive Services for Low-Income Veterans and Families, Veterans Justice Outreach Initiative (U.S. Interagency Council on Homelessness 2010, 57)

Since CoC funds are limited, it is important that Continuums are aware of these additional programs to serve the needs of their clients and contribute supplementary funding. While this is a short list of targeted programs, several non-targeted programs may also be utilized, such as Medicaid, Supplemental Nutrition Assistance Program (formerly Food Stamps), and Temporary Assistance for Needy Families. Because HUD focuses on housing, involving these other agencies improves consumers' access to a wide-range of services, as recommended by systems theory.

7.2 Federal Strategic Plan to Prevent and End Homelessness

USICH published the first Opening Doors: Federal Strategic Plan to Prevent and End Homelessness in June 2010. The Plan's vision statement is that "no one should experience homelessness—no one should be without a safe, stable place to call home" (U.S. Interagency Council on Homelessness 2010). It lays out objectives and strategies to end chronic homelessness in five years; prevent and end Veterans homelessness in five years; prevent and end homelessness for families, youth, and children in ten years; and "set a path to ending all types of homelessness" (U.S. Interagency Council on Homelessness 2010).

The Plan includes 10 themes, 52 strategies, and 4 signature initiatives to be accomplished within the next 10 years. Although all of the strategies are implemented at the local level, those particularly relevant are to "update and implement state/local plans," "involve citizens and private sector," and "reward collaborating communities" (U.S. Interagency Council on Homelessness 2010, 28-29). These fall under the first objective to "provide and promote collaborative leadership at all levels of government and across all sectors to inspire and energize Americans to commit to preventing and ending homelessness" (U.S. Interagency Council on Homelessness 2010, 30)

CHAPTER 8

HOMELESSNESS IN TARRANT COUNTY

The remainder of this paper focuses on the TX601 Fort Worth/Arlington/Tarrant County CoC as a case study. Located in within the metroplex, this CoC has cooperated with the city's comprehensive plans and gained needed local support to move the needle on homelessness. In 2010, the Texas Homeless Network named the CoC's designated lead agency, the Tarrant County Homeless Coalition (TCHC), the year's Outstanding Homeless Coalition (Texas Homeless Network 2010).

Although the CoC spans Fort Worth and Arlington, this paper focuses on the city of Fort Worth. Due to limited transportation in Arlington, a concentrated knit of homeless service providers in Fort Worth, and strong support by Mayor Mike Moncrief, the majority of the CoC's resources are utilized within downtown Fort Worth.

8.1 Continuum of Care

According to their mission statement, TCHC is "dedicated to providing leadership in the prevention and eradication of homelessness in Tarrant County" (Tarrant County Homeless Coalition 2010).TCHC is a nonprofit, 501c(3) organization formed in 1989 and led by a Board of Directors comprised mainly of homeless service providers. The agency receives input from at least one current or former client who sits on the Board, a consumer council, and an annual consumer forum.

The Coalition consists of over 100 member organizations including service providers, churches, local government, health and community centers, school districts, and individuals. Each of these areas also has representation on the Board of Directors. Government membership includes the City of Arlington, the City of Fort Worth, and representation from Tarrant County (Tarrant County Homeless Coalition 2010).

As the lead agency, TCHC is charged with submitting the application to the annual Notice of Funding Availability and distributed the federal funds throughout the Continuum. The agency also provides professional development for service providers, sets standards and best practices, expands services and identify gaps in services, implements performance measures, increasing housing stability, and maintaining data for the CoC (Tarrant County Homeless Coalition 2010).

The 2009 Point in Time count showed approximately 2,181 people in emergency shelters, in transitional housing, and unsheltered in Tarrant County on any given night (Tarrant County Homeless Coalition 2010). This compares to 5,675 homeless in Dallas (Metro Dallas Homeless Alliance 2009), 2,585 in Travis (Austin/Travis County Ending Community Homelessness Coalition 2010), and 7,576 in Harris Counties (Coalition for the Homeless of Houston/Harris County 2009) according to the HUD definition. Despite continuous federal and local support and new prevention programs, these numbers are not expected to decrease in 2010 due to the recent economic crisis. In Tarrant County, unlike years before, the number of homeless staying in emergency shelters rose 1.8 percent in 2010, according to Cindy J. Crain, TCHC Executive Director.

8.2 City Involvement

To meet the goals around ending homelessness, local involvement, planning, and funding is needed in addition to federal. Since 2008, the City of Fort Worth's Directions Home Plan has placed over 200 formerly homeless people in transitional or permanent supportive housing according to Susan Cockrell, Special Programs Housing Administrator for the Fort Worth Housing Authority. Crain stated that over 350 formerly homeless individuals have been placed in housing through the entire CoC.

Social workers are not the only service professionals who encounter the homeless. Executives, developers, and city planners indirectly affect the homeless through zoning and economic development. In Fort Worth, most homeless services are concentrated on East

Lancaster Avenue. Before the Lancaster Corridor Redevelopment Project and the creation of this centralized location, people experiencing homelessness were known to sleep in Sundance Square and bathe in the Water Gardens, according to Crain. This raised the issue of the right to public space. East Lancaster is now zoned for Planned Development (City of Fort Worth, Texas n.d.), which the city uses to "provide for increased compatibility and effective mitigation of potentially adverse impacts" (City of Fort Worth, Texas 2010). Uses under this zone are halfway houses, residential dwellings, gambling facilities, animal or automotive racing, firing ranges, hotels, automotive repair, industrial and manufacturing including hazardous waste and landfill, oil drilling, and packing plants including animal slaughter (City of Fort Worth, Texas 2010). These uses are not ideal for residential buildings.

Often at the request of city officials and service providers, police officers patrol, search, and arrest in areas near homeless shelters for violence, narcotics, public intoxication, and prostitution. From January 1 to October 31, 2009, the Fort Worth Police Department reported 822 arrests for public intoxication, 137 for violent offenses, and 143 for narcotics near East Lancaster Avenue (Petrovich and Spence-Almaguer 2010).

Meeting every person's need involves an entire system that does not always receive reimbursement. Hospitals and emergency medical services provide the homeless with healthcare and do not collect on their bills. The University of Texas at Arlington Community Services Center is currently researching the amount of money the City of Fort Worth saved John Peter Smith Hospital and MedStar Emergency Services by housing individuals through Directions Home.

8.3 Service Providers

At this time, the Fort Worth community has three night shelters: Salvation Army, Presbyterian Night Shelter, and Union Gospel Mission, which relies on donations without federal funding. One day shelter, the Day Resource Center for the Homeless, provides laundry, showers, storage, and offices for supportive services including their own case management and

support groups. Other service providers include the Samaritan House that provides housing and healthcare for people with HIV and AIDS, Safe Haven of Tarrant County domestic violence shelter, ACH Child and Family Services, outreach services by the Catholic Charities SOS team and MHMR PATH team, Broadway Baptist Church and First Street Methodist Mission that provide food and clothing, Cornerstone Assistance Network that provides clothing and household supplies, Recovery Resource Council substance abuse treatment and counseling, and MHMR mental health and addiction services. John Peter Smith Hospital has committed to building a centralized intake facility on East Lancaster in the near future (personal communication, Cindy J. Crain). Each of these providers is a member of the Continuum of Care. Most are also sub-grant recipients of ESG, SHP, SPC, or Directions Home funding.

8.4 Annual Performance Report Data

Due to the limited reporting functions of the HMIS, this paper relies on the consistent data submitted by every sub-grantee in the Annual Progress Report (APR). The annual reports are submitted by mail to HUD at the end of each contract year, varying by agency. Dedicated staff persons enter the data and check with CoCs for errors and missing information as necessary. In 2009, 6,144 agencies submitted an APR nationwide serving 706,433 persons during the year. In the CoC, 47 agencies submitted an APR serving 7,527 persons. Percentages are used to compare the CoC to the national average to spot trends and areas for needed improvement. In addition, data on length of stay by program type is analyzed to meet the goals of the HEARTH Act.

8.4.1. Demographics

As shown in Table 8.1, the clients in this Texas CoC are more likely to be Hispanic than in the rest of the nation. Almost two-thirds are white and most of the remaining third are black.

Table 8.1: Race and Ethnicity, CoC and Nation (2009 APR data)

	CoC	Nation
Ethnicity (percent of participants)		
Hispanic	26%	14%
Race (percent of participants)		
White	62.87%	43.57%
Black or African American	32.25%	38.07%
Other Multi-Racial	1.45%	6.17%
Black/African American and White	0.99%	0.72%
American Indian or Alaskan Native	0.76%	1.68%
Asian	0.61%	0.95%
American Indian/Alaskan Native and White	0.23%	0.59%
Native Hawaiian or other Pacific Islander	0.11%	0.81%
Asian and White	0.04%	0.11%
American Indian/Alaskan and Black/African American	0.00%	0.27%

The age and gender distribution is relatively consistent with national data (see Table 8.2). Over 80 percent of clients are between ages 18 and 50.

Table 8.2: Age and Gender, CoC and Nation (2009 APR data)

	CoC	Nation
Age and Gender (percent of participants)		
62 and over	1.00%	2.21%
Male	60.71%	65.84%
Female	39.29%	34.16%
51-61	10.23%	13.60%
Male	60.98%	66.36%
Female	39.02%	33.64%
31-50	47.56%	43.74%
Male	37.11%	50.49%
Female	62.89%	49.51%
18-30	34.33%	31.10%
Male	13.91%	29.10%
Female	86.09%	70.90%
<17	6.88%	9.35%
Male	49.98%	46.85%
Female	50.02%	53.15%

Data in Table 8.3 shows 38 percent of the CoC's clients have experienced domestic violence, compared to only 13 percent of the nation's clients. On the other end of the spectrum,

the CoC has a lower rate of mental illness among clients (16 percent) than the nation (28 percent). Despite the large difference, the CoC spends almost the same amount on mental health services ($635,923 or 11 percent) as the nation (14 percent).

Table 8.3: Special Subpopulations, CoC and Nation (2009 APR data)

	CoC	Nation
Special Subpopulations (percent of participants)		
Special needs		
Mental illness	16%	28%
Alcohol abuse	13%	20%
Drug abuse	0%	24%
HIV/AIDS and related diseases	3%	2%
Developmental disability	1%	2%
Physical disability	4%	12%
Domestic violence	38%	13%
Veterans status	4%	9%
Chronically homeless	11%	20%

8.4.2. Persons Served

Compared to the nation, the CoC has a lower number of disabled adults who are chronically homeless (see Table 8.4). Of those who are chronically homeless, the overwhelming majority are in emergency shelters versus living on the street. The CoC also has a higher percentage of families represented among their clients.

Table 8.4: Persons Served, CoC and Nation (2009 APR data)

	CoC	Nation
Chronic Homeless (percent of participants)		
Percentage of all entering adults who are chronically homeless	11.42%	19.92%
Percentage of disabled adults who are chronically homeless	35.76%	50.00%
Percentage of single adults who are chronically homeless	21.23%	30.37%
Prior living situation for chronically homeless participants		
Streets	18.85%	47.97%
Emergency shelter	81.15%	52.03%
Persons Served on the Last Day of the Year (percent of participants)		
Percent of singles not in families	42.08%	53.55%
Percent of adults in families	22.58%	18.47%
Percent of children in families	35.34%	27.98%
Percent of families	20.29%	15.41%

Of those who were served, most are in Shelter Plus Care Programs (see Table 8.5). The CoC does not have any Single Room Occupancy Programs.

Table 8.5: Program Distribution, CoC and Nation (2009 APR data)

	CoC	Nation
Beds in Place (percent of beds)		
Supportive Housing Program	41.77%	53.40%
Shelter Plus Care	58.23%	44.80%
Single Room Occupancy	0.00%	1.80%

8.4.3. Living Situation

Table 8.6 shows the situation of clients prior to receiving services. The CoC has a very small number of people who were living on the streets (4.43 percent compared to 23.70 percent nationally) and a very large number of victims who were fleeing domestic violence when compared to national data (34.56 percent compared to 8.51 percent nationally).

Table 8.6: Prior Living Situation, CoC and Nation (2009 APR data)

	CoC	Nation
Prior Living Situation (percent of participants)		
Non-housing (street, park, car, etc.)	4.43%	23.70%
Emergency shelter	27.98%	28.26%
Transitional housing for homeless persons	6.69%	5.54%
Psychiatric facility	0.23%	0.50%
Substance abuse treatment facility	5.62%	2.85%
Hospital	0.27%	0.75%
Jail/prison	1.11%	1.55%
Domestic violence situation	34.56%	8.51%
Living with relatives/friends	11.89%	14.55%
Rental housing	4.89%	8.38%
Other	2.33%	5.40%

In contrast, Table 8.7 shows where client transition to after exiting the programs. More than half of clients move into permanent housing, higher than national data. Half of these clients move in with family or friends permanently. A relatively low number of clients move into emergency shelter. While the CoC records destination locations for more clients than the national average, 14 percent is still a concerning number of clients whose whereabouts after leaving the program are unknown. Although reasons are not recorded, one can assume it is related to case manager training on data input and quality. Of those reported, a high number of persons move in with family and friends permanently (27 percent compared to 8 percent nationally).

Table 8.7: Destination Location, CoC and Nation (2009 APR data)

	CoC	Nation
Destination (percent of adult participants who left)		
Permanent	54%	34%
Rental house or apartment (no subsidy)	20%	16%
Public housing	1%	1%
Section 8	2%	3%
Shelter Plus Care	2%	1%
HOME subsidized house or apartment	0%	0%
Other subsidized house or apartment	2%	3%
Homeownership	1%	1%
Move in with family or friends	27%	8%
Transitional	15%	11%
Transitional housing for homeless persons	8%	6%
Moved in with family or friends	7%	5%
Institution	3%	3%
Psychiatric hospital	0%	0%
Inpatient alcohol or other drug treatment	2%	1%
Jail/prison	1%	1%
Emergency shelter	9%	15%
Other	5%	9%
Other supportive housing	0%	1%
Places not meant for human habitation	1%	3%
Other	4%	5%
Unknown	14%	28%

8.4.4. Supportive Services

In line with the federal initiatives toward mainstream resources, the APR asks for client source of income at entry and exit. As shown in Table 8.8, both the CoC and the nation have low participation rates and improvement in participation rates. The CoC shows the greatest percent increase (93 percent) in Food Stamps. Although the number decreases after enrolling in programs, 40 percent of clients exit a program without any financial resources. High numbers without financial stability will cause recidivism in homelessness.

Table 8.8: Source of Income, CoC and Nation (2009 APR data)

	CoC	Nation
Source of Income (percent of participants)		
Supplemental Security Income		
At entry	4.6%	9.3%
At exit	7.9%	10.9%
Social Security Disability Income		
At entry	5.6%	4.0%
At exit	3.8%	5.1%
Social Security		
At entry	0.7%	1.2%
At exit	2.2%	1.5%
General Public Assistance		
At entry	0.1%	4.9%
At exit	0.1%	5.5%
Temporary Aid to Needy Families		
At entry	2.3%	6.7%
At exit	2.4%	7.3%
Child Support		
At entry	0.1%	0.6%
At exit	0.0%	0.7%
Veterans benefits		
At entry	0.8%	1.3%
At exit	1.0%	1.5%
Employment income		
At entry	22.0%	13.5%
At exit	28.3%	21.6%
Unemployment benefits		
At entry	0.0%	1.3%
At exit	0.4%	1.4%
Medicare		
At entry	0.2%	0.7%
At exit	0.2%	0.9%
Medicaid		
At entry	6.8%	12.6%
At exit	9.2%	14.7%
Food Stamps		
At entry	10.2%	23.2%
At exit	19.7%	26.8%
No financial resources		
At entry	59.6%	36.7%
At exit	40.5%	26.0%

The types of services provided are shown in Table 8.9. More than three-fourths of clients receive case management, compared to almost two-thirds nationally. Largely different from the nation as a whole, almost half of clients receive childcare. This alludes to large numbers of families with children who are working or looking for work. Another possible reason for the large gap is that the HMIS data reported was not de-duplicated by client.

Table 8.9: Supportive Services Provided, CoC and Nation (2009 APR data)

	CoC	Nation
Supportive Services Provided (percent of adult participants who left)		
Outreach	21%	37%
Case management	79%	63%
Life skills (outside case management)	23%	33%
Alcohol or drug abuse services	25%	22%
Mental health services	16%	23%
HIV/AIDS-related services	8%	5%
Other health care services	20%	23%
Education	6%	14%
Housing placement	18%	34%
Employment assistance	31%	25%
Childcare	46%	7%
Transportation	33%	37%
Legal	2%	10%
Other	13%	33%

Compared to the number of supportive services provided, the money spent on supportive services does not always match up. Consistent with the high volume of case management services provided, it is paid for using half of CoC supportive services dollars (see Table 8.10). The remaining money is split between mental health services and healthcare services excluding HIV/AIDS. Although almost half of adult clients received childcare from CoC funds, it comprised only five percent of the services budget.

Table 8.10: Supportive Services Financials, CoC and Nation (2009 APR data)

	CoC	Nation
Financials on Supportive Services Provided (percent of dollars spent)		
Outreach	2%	4%
Case management	50%	36%
Life skills (outside case management)	2%	7%
Alcohol or drug abuse services	5%	5%
Mental health services	11%	14%
HIV/AIDS-related services	0%	2%
Other health care services	18%	8%
Education	0%	2%
Housing placement	2%	2%
Employment assistance	1%	3%
Childcare	5%	2%
Transportation	1%	3%
Legal	0%	1%
Other	3%	12%

8.4.5. Length of Stay

Most interesting to this report, the length of stay question in the APR asks sub-grantees to aggregately mark how long clients stayed in the program. The report asks these numbers for the clients who exited the program and separately for the clients who did not leave. For this analysis, Table 8.11 includes the total for participants who left and did not leave.

Table 8.11: Length of Stay, CoC and Nation (2009 APR data)

	CoC	Nation
Length of Stay (percent of adult participants who left and did not leave)		
Less than 1 month	26.95%	18.74%
1-2 months	15.01%	13.64%
3-6 months	17.24%	20.73%
7-12 months	13.48%	17.30%
13-24 months	16.55%	13.68%
25 months-3 years	5.48%	7.75%
4-5 years	2.52%	4.00%
6-7 years	1.40%	1.88%
8-10 years	0.62%	1.20%
Over 10 years	0.76%	1.07%

Compared to national data, the TX601 CoC exits more clients within the first month at almost 27 percent. Cumulatively, 41.96 percent of clients leave within the first three months (32.38 nationally) and 59.20 percent within the first six months (53.11 percent nationally).Since the data is aggregated when submitted to HUD, the APR does not contain information that could be compared to destination locations at the client level, or track individuals over time to measure recidivism.

The goal in the HEARTH Act, however, is to "ensur[e] that individuals and families who become homeless return to permanent housing within 30 days" (U.S. Congress 2009). To prepare to meet this goal, the reported numbers for length of stay must be divided by project type, shown in Table 8.12.

Table 8.12: Length of Stay by Program Type in Percents, CoC and Nation (2009 APR data)

	<1 mo.	**1-2 mos.**	**3-6 mos.**	**7-12 mos.**	**13-24 mos.**	**25-36 mos.**	**4-5 yrs.**	**6-7 yrs.**	**8-10 yrs.**	**>10 yrs.**
CoC										
PH	2.23	8.03	11.52	16.46	28.07	16.07	7.4	5.03	2.42	2.71
SHP PH	1.19	2.38	5.95	11.31	60.71	15.48	2.98	0.00	0.00	0.00
Project-Based	0.00	11.11	0.00	33.33	22.22	11.11	22.22	0.00	0.00	0.00
Tenant-Based	2.45	9.11	12.73	17.29	21.73	16.24	8.18	6.07	2.92	3.27
SPC	2.43	9.13	12.60	17.46	21.73	16.18	8.32	6.01	2.89	3.24
Non-PH	34.90	17.24	18.97	12.50	12.93	2.03	0.94	0.27	0.06	0.15
SHP TH	12.74	17.34	18.97	20.02	29.98	0.96	0.00	0.00	0.00	0.00
SHP SSO	45.18	17.19	18.97	9.02	5.02	2.53	1.38	0.40	0.09	0.22
Nation										
PH	2.33	5.23	11.13	16.12	20.33	19.18	12.54	6.06	3.92	3.16
SHP PH	3.09	6.17	12.84	18.00	21.46	18.66	10.71	4.26	2.88	1.93
Project-Based	2.13	5.64	11.19	16.28	20.35	19.04	12.49	6.04	3.88	2.96
Tenant-Based	1.54	3.96	9.14	13.94	18.88	20.03	14.62	8.13	5.09	4.67
SPC	2.24	4.99	10.23	14.55	19.16	19.38	13.64	7.23	4.61	3.99
Non-PH	24.25	16.28	23.55	17.75	11.51	3.88	1.33	0.61	0.39	0.45
SHP TH	15.44	20.10	26.36	20.57	15.03	2.04	0.21	0.10	0.03	0.13
SHP SSO	27.95	14.67	22.37	16.56	10.04	4.66	1.80	0.82	0.54	0.59

Key	
PH	Permanent Housing
SHP	Supportive Housing Program
SPC	Shelter Plus Care
TH	Transitional Housing
SSO	Supportive Services Only

Since the goal is to move families out of homelessness and into permanent housing, and HEARTH defines homeless as living unsheltered, in emergency shelter, or in transitional housing, the useful data on SHP Transitional Housing is most useful. CoC and national data are compared in Figure 8.1.

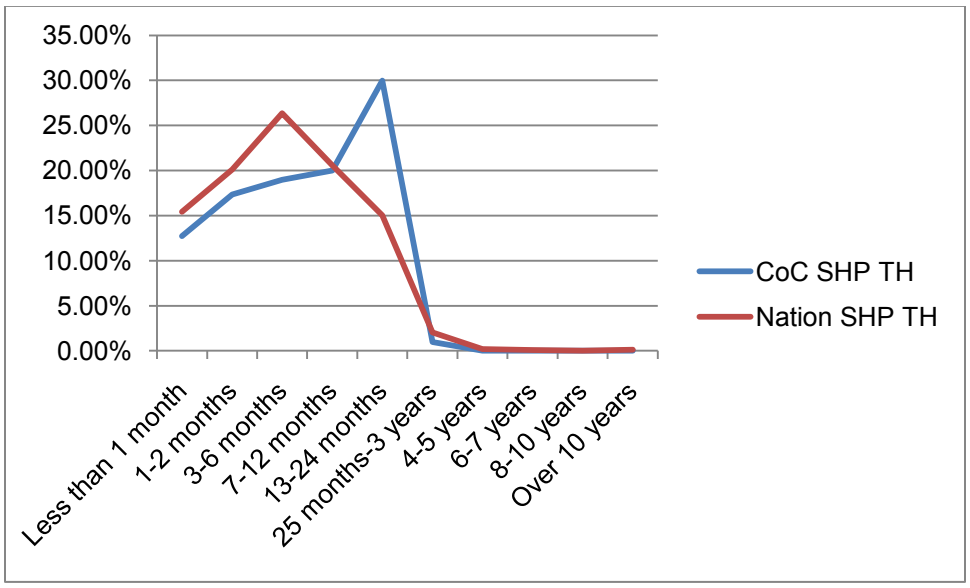

Figure 8.1: Length of Stay in Transitional Housing, CoC and Nation (2009 APR data)

According to this data, families are currently staying up to three years in the transitional program. Rather than seeing the spike in the first month as indicated in the HEARTH goal and the nationally average, the spike appears with most people exiting the program between 13 and 24 months. Permanent housing showed similar results. The peak came between 13 and 24 months at both the national and CoC level, with the exception of a slight increase in 24 months to 3 years for Shelter Plus Care at the national level. Other programs (non-permanent housing) showed most clients leaving between 3 and 6 months nationally and locally. Supportive Services Only programs often see clients only once, so the majority exit the program in the first month in the CoC and nationwide.

CHAPTER 9

SUMMARY OF FINDINGS

The TX601 CoC does several things well when compared to 2009 APR national data. The majority of their chronically homeless are sheltered. More than half of clients who exited their programs moved into permanent housing. An overwhelming majority of clients received case management services. In regards to preparing for the HEARTH Act, however, there are several areas to be identified for improvement.

9.1 Areas for Needed Improvement

First, the current HMIS does not have the reporting capabilities to measure length of stay. This hinders the Continuum from following the flow between emergency shelter, transitional housing, rapid re-housing, and permanent housing. Recording this movement would allow the CoC to identify gaps in needed types of shelter, and clogs in the system where people do not move into permanent housing quickly. HEARTH emphasizes data quality and reporting standards for use by the Continuum internally and to contend for competitive funds (U.S. Congress 2009).

Second, the CoC shows very low participation rates in mainstream benefits and very low rates of improving after being in the programs. Addressing each of the client's needs in systems theory will improve results, for example, increasing clients' financial stability will increase their chances of affording housing. This is one of the strategies in the Federal Strategic Plan to Prevent and End Homelessness to increase economic security (U.S. Interagency Council on Homelessness 2010).

Third, the average length of stay in SHP Transitional Housing is currently 13 to 24 months. The HEARTH Act sets the federal goal at 30 days. Furthermore, to qualify as a high

performing community to utilize more prevention and rapid re-housing resources, a CoC must have an average length of stay of 20 days (U.S. Congress 2009).

Part of “re-tooling the crisis response system” is ensuring resources are distributed efficiently. If clients are staying in transitional housing for up to three years, it is not being used for the transitional use that the program intended. Depending on lease agreements, these resources could be transformed into transition in place apartments where clients gradually receive less of a subsidy, or even permanent housing units using the Housing First model.

9.2 Recommendations

9.2.1. Improve Data Quality

HUD continues to stress the importance of data quality through the CoC competition, technical assistance, and public speaking engagements. In their report to Congress on improving homeless data collection, reporting, and analysis, HUD emphasized quality, data standards, coverage, and training activities (U.S. Department of Housing and Urban Development 2007).

To reach the goals in the HEARTH Act and the ones identified at the local level, a CoC must first have strong data that can illustrate discrepancies, identify gaps, and create a baseline for future growth. The Annual Progress Reports (APR) (Annual Performance Reports going forward) data provides the best snapshot of the current status, but has several limitations. Because the APR only includes competitive funds and not the formulaic Emergency Shelter Grants (Emergency Solutions Grants), it does not capture the entire system. It is recommended that the CoC analyze HMIS data on length of stay in emergency shelter. Working at the client-level will also allow for cross tabulation of families, singles, gender, prior living situation, age, etc. This information would be most useful in identifying holes and clogs in the system. Another gap in available data is a cross-tabulation between length of stay and destination after leaving the shelter. This data will assist the CoC in tracking recidivism and the effects of exiting clients from the program faster.

It would also be useful to include service providers in length of stay data who do not receive targeted CoC funding, such as the Union Gospel Mission. Since they do not receive funding, they do not submit an APR and their transitional housing numbers are not included. In 2009, Hope House of Milwaukee recruited the Milwaukee Rescue Mission, the city's largest faith-based shelter to join HMIS. As a result, the number of people included HMIS rose by 58 percent for individuals in emergency shelters and 35 percent for families (U.S. Department of Housing and Urban Development 2010). Increasing the number of agencies entering data in HMIS increases the amount of services recorded and, therefore, provides a more accurate view of the system. If reporting allows, the CoC could also compare each emergency shelter and transitional housing provider to identify local best practices.

Improving HMIS training also improves data quality. Because the CoC has gaps in data, such as an unknown destination location for 14 percent of clients exiting the program, they should provide case managers with more guidance on using the system and interacting with clients. For example, question 11 in the APR asks for client income sources at program entry and exit. If a case manager asks if a client receives Medicaid, he may answer no because he is only familiar with a name like MassHealth, the Medicaid program of Massachusetts. This information is then entered incorrectly in HMIS and the percent of clients receiving Medicaid benefits is underreported.

The Texas Homeless Network, who runs the Balance of State CoC, "conducted 150 trainings in the past year and 20 follow-up site visits, produced program-specific user manuals…, and revamped their HMIS based on user feedback and performance testing" (U.S. Department of Housing and Urban Development 2010, 9). This CoC has a strong relationship with the Texas Homeless Network and should tap into these resources.

In addition to these general reasons for improving performance measures and reporting, better data quality would enable the TX-601 CoC to address the data issues in the APRs. Most problems can only be identified by comparing HMIS data to case manager records

of services and checking for consistency between days. Incomplete or missing data, however, is obvious, such as 14 percent of clients whose whereabouts are unknown after leaving the program. The gap in data largely hinders the CoC's ability to track recidivism and suggests that case managers are exiting clients without a final interview or session.

The Continuum uses a scan card policy to ensure each client is tested for tuberculosis. Scan cards mark the homelessness of an individual and allow service providers to scan them quickly to record services. This system, however, can become backed up with poor internet connection or long lines. According to Crain, Presbyterian Night Shelter, the largest emergency shelter, serves an average of 700 men and women on a nightly basis and employs its clients to scan the cards into the system. Their HMIS data consistently under-represents the number of clients they serve. To make these ideas feasible for the community, TCHC would have to budget more money to develop the software and infrastructure. Faster internet connection or barcode equipment would enable them to record services faster and more efficiently.

9.2.2. Maximize Programs on Domestic Violence

Second, the CoC should utilize Safe Haven of Tarrant County and other local domestic violence shelters. More than one third (38 percent) of the clients served in these programs have a history of domestic violence. Before enrolling, 34.56 percent lived in a "domestic violence situation" in this CoC, compared to only 8.51 percent in the nation. According to systems theory, every part of a client's life must work together to earn stability. The potential for the CoC and the domestic violence shelter to collaborative on supportive services would be beneficial for the clients involved. Research shows that transitional housing is beneficial for victims of domestic violence to engage in group therapy and group living in a safe environment. This is one population where Housing First does not apply. After residents were able to move out of transitional housing, it would be possible to create a program with the supply of Directions Home Housing Choice Vouchers that combined scattered site apartments with domestic violence counseling and case management.

While each client may or may not need to spend time in a therapeutic shelter, on-site counseling or group sessions may be beneficial. The homeless population is often a target of continued domestic violence, especially among women (U.S. Interagency Council on Homelessness 2010). Because they are not included in HMIS, they are not as easy to follow through the system without consistent case management by specialized staff trained in their experiences.

Although "domestic violence is often intertwined with poverty and homelessness," many domestic violence and homeless shelters "continue to design their programs for two distinct populations" (Williams 2008, 66). A domestic violence shelter in Washington used grants to create a Director of Housing position and transitional housing program. Unlike other housing programs, it enrolls clients who fit into both categories: homeless and victims of domestic violence (Williams 2008).

Another domestic violence shelter in Oregon embraced the Housing First model. The shelter decided to close its doors in 2003 and reallocate funds to provide motel vouchers to homeless victims of domestic violence. Before, the shelter was full and the number of women served was limited. By offering vouchers, they were able to serve more women and keep families intact. The women continue to receive services to address the sensitive needs of the population and ready them for permanent housing (Williams 2008).

9.2.3. Increase Use of Mainstream Resources

With the exception of SSDI and Food Stamps, the number of clients who receive mainstream benefits – supplemental assistance not targeted toward homeless persons – is incredibly low in the CoC compared to the nation. At program exit, 40.5 percent of clients had no financial resources compared to 26.0 percent nationally. Resources such as Medicaid will provide services in addition to those offered by the CoC. When Section 8 vouchers and other permanent housing options are limited, these resources increase client financial stability while decreasing cost on the community.

Right to public space can also be applied to right to public services. To increase use of mainstream resources, the CoC should take advantages of opportunities to enroll clients faster and more efficiently. Texas offers a streamlined application process by using one application for Medicaid, Supplemental Food Assistance Programs (formerly Food Stamps), and Temporary Assistance for Needy Families (U.S. Department of Health and Human Services 2003).

SSI/SSDI Outreach, Access, and Recovery (SOAR) is sponsored by the U.S. Department of Health and Human Services and the Social Security Administration, and provides training for caseworkers to enroll clients in SSI/SSDI benefits. The application for benefits is known for being challenging. Nationally, about 37 percent of applications are approved on the first try (Policy Research Associates, Inc. n.d.). In Houston, 67 percent were approved in spring and summer 2009 using the SOAR program (Policy Research Associates, Inc. 2009) Because this field sees high staff turnover rates, it is important to continue to offer training sessions and technical assistance.

9.2.4. Continue Progress on Central Intake Facility

Fourth, TX601 should continue efforts to build a centralized intake facility. Centralized intake "refers to a single place or process for people to access prevention, housing, and/or other services they need. It may be only 'door' for particular kinds of assistance, or there may be other ways to access assistance" (The Cloudburst Group n.d., 1). A central intake facility improves the quantity and quality of clients entered into HMIS. Having one entry point to the CoC offers opportunity to allocate resources as necessary and coordinate better between programs. The facility that JPS Hospital has agreed to build on East Lancaster will also house offices for medical and supportive services, according to Crain.

Because this is a relatively new model, research is limited and largely focuses on central intake for families. The YWCA in Columbus, Ohio is "a national model for emergency shelters" by providing a "one-stop shop" for families (YWCA of Columbus n.d.). At one emergency shelter location, families can receive employment assistance, housing placement,

child advocacy, childcare, tutoring, access to computers, and use of children play areas (YWCA of Columbus n.d.).

Other examples of central intake facilities do not include an emergency shelter onsite, but link to shelters nearby that best meet the needs of the clients. This model is easier to replicate in Fort Worth. Cincinnati, Ohio saw that families "were being forced through an obstacle course of different phone numbers, staffing patterns, intake criteria, and access systems in order to get into an emergency shelter" (McEvilley 2008). The CoC created a homeless family hotline staffed seven days per week to connect persons with the shelter best suited to the needs of their household, availability, and their personal history with each shelter. As of 2008, the phone number received about 30 calls per day. To enact this program, the community had to find funding, create a system to track available shelter beds, and record policies for each shelter to ease in referrals. Because of the hotline, shelters operated closer to capacity (McEvilley 2008).

Research on centralized intake for the Homeless Prevention and Rapid Re-Housing Program showed that it can simplify the process for "service seekers," provide an ongoing list of referrals for service providers, and allow resources to be targeted more effectively by policymakers (The Cloudburst Group n.d., 4).Access to resources and case management means more opportunities for case managers to connect with clients. These connections lead to removing barriers to employment and permanent housing, such as teaching budgeting or job readiness skills.

9.3 Conclusion

This paper examined federal initiatives that can be compared to practices at the local level to prepare a community to utilize the new goals, priorities, and eligible activities under HEARTH to prevent and end homelessness. In many ways, the TX-601 CoC has embraced ideas such as Housing First to engage clients and systems theory to engage stakeholders and community members in this goal. In analyzing APRs, each disconnect to national average and

each subsequent recommendation can be summarized in a need for better data. For the CoC to be prepared to reallocate resources, they must be better able to chart their need and existing services. Pursuing a better HMIS platform and a central intake facility and/or hotline will make gaps more apparent and ensure standardized data quality.

The HEARTH Act offers a broad range of eligible activities through targeted programs and applicable mainstream benefits. Each CoC should analyze their existing use of resources to maximize their ability to move clients into permanent housing quickly. The HEARTH Act, the Federal Strategic Plan to Prevent and End Homelessness, and other federal initiatives are preparing to end homelessness by 2020. In order for the U.S. Interagency Council on Homelessness to reach this goal, it must happen at the local level.

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BIOGRAPHICAL INFORMATION

A native Texan, Laura Kunkel graduated from Baylor University in 2007 with a Bachelor of Social Work. In Waco, she was first exposed to homelessness on a personal level. Travel to Haiti further engrained her belief that every person has a right to safe, decent permanent housing The majority of her undergraduate and subsequent graduate studies at The University of Texas at Arlington have focused on ending homelessness.

This fall, Laura anticipates receiving a Master of City and Regional Planning with a concentration in Community and Economic Development and Housing, and a Master of Science in Social Work with a concentration in Community and Administrative Practice. During graduate school, she completed an internship with the school's Community Services Center where she worked on the evaluation of Directions Home, Fort Worth's 10-year plan to end homelessness. She was then hired by the Tarrant County Homeless Coalition as a data analyst.

In 2010, Laura was chosen as a Presidential Management Fellow. She currently lives in Washington, DC and works at the U.S. Department of Housing and Urban Development as a Special Assistant on Homelessness.