



THE BLUEPRINT

TO END CHRONIC HOMELESSNESS

IN THE CHATTANOOGA REGION IN TEN YEARS

A Collaborative Initiative Between
The City of Chattanooga & The Chattanooga Regional Homeless Coalition

The
Chattanooga
Homeless
Coalition

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THE BLUEPRINT TO END CHRONIC HOMELESSNESS IN THE CHATTANOOGA REGION IN TEN YEARS

Executive Summary

Over 4,000 different people experience homelessness in the Chattanooga region at some time during the course of each year. Homeless children comprise approximately one-quarter of this total. These numbers increase when homeless people in the counties surrounding Chattanooga and Hamilton County are counted as well.

Thousands more of the region's residents live doubled up in the homes of family and friends. Or they are at imminent risk of homelessness, living in substandard or overcrowded housing they cannot afford. In 2003, 670 individuals reported being homeless in Chattanooga and the Southeast Tennessee region for more than a year.

The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years is a long-range, comprehensive plan to help homeless people in our area return to healthy and stable lives in permanent housing. Its recommendations are evidence-based and draw from the best practices of innovative programs and initiatives across the country. *The Blueprint* is the culmination of a seven-month planning effort by the Chattanooga region's homeless service providers, government administrators, housing developers, community leaders and homeless people themselves.

As its title clearly indicates, *The Blueprint* plan is intended to end long-term, or "chronic," homelessness. This emphasis reflects a growing body of research demonstrating that members of this group are underserved by existing efforts even as they use a disproportionate share of emergency services and resources. Under the leadership of the United States Interagency Council on Homelessness, a national consensus has emerged that all levels of government must focus on improving efforts to house chronically homeless individuals and families. *The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years* is consistent with and complementary to the federal government's efforts in this area.

However, the scope of *The Blueprint* is not limited to chronic homelessness alone. When implemented over the next decade, *The Blueprint's* policy recommendations will also result in a significant reduction of all types of homelessness, including among families, youth and single adults who experience episodic homelessness.

The Blueprint will end chronic homelessness and reduce all types of homelessness over the next decade by investing our resources in a coordinated, sustained effort that addresses the underlying causes of homelessness. This effort will:

- Reduce the number of people who become homeless
- Increase the number of homeless people placed into permanent housing
- Decrease the length and disruption of homeless episodes
- Provide community based services and supports that prevent homelessness before it happens and diminish opportunities for homelessness to recur

The Chattanooga Regional Interagency Council on Homelessness

To accomplish these goals, a new mechanism will be established to coordinate our response to homelessness, *The Chattanooga Regional Interagency Council on Homelessness*. Rather than creating a new, separate bureaucracy to administer services to homeless people, *The Council* will meld the Chattanooga region's many effective, but often isolated, service and housing programs for homeless people into a coordinated *system* of homeless services and housing. To achieve this transformation, *The Council* will improve data collection and analysis, establish service standards, measure program performance, coordinate case management and establish annual numerical targets for the reduction of homelessness. *The Council* will ensure that data and research will guide, support and justify all planning efforts and policy initiatives.

The Blueprint recommends creating 1,400 units of permanent affordable housing for homeless people over the next ten years. Creating fourteen hundred units by 2014 will be achieved using a combination of rental subsidies, preservation and new development.

The Blueprint does not recommend at this time an expansion of emergency shelter and transitional housing capacity, except for some specialized populations, such as youth. Instead, *The Blueprint* recommends strategies that will move homeless people through emergency and transitional programs more quickly. This will free up shelter and program space to allow transitional programs to serve a greater number of homeless people each year. In most cases, these families and individuals can be better served by investing in an expansion of rental subsidies and ongoing, community-based supportive services delivered to formerly homeless people in permanent affordable housing.

The Costs of Homelessness and the Savings of Supportive Housing

Homelessness is not only a personal tragedy; it is expensive to the public as well. Research has clearly documented that homelessness increases people's use of costly emergency interventions, such as emergency medical care, psychiatric hospitalizations, shelter and incarceration. As much as 70% of these costs are borne by states, for psychiatric hospitalizations and additional Medicaid spending. Counties also spend substantial sums in unreimbursed medical costs and incarceration expenses related to homelessness, while localities providing shelter and other emergency assistance pay for homelessness as well.

The research documenting the costs of homelessness also points to a solution: *supportive housing* – affordable housing linked to on-site or visiting supportive social services. When homeless individuals are placed into supportive housing, their use of emergency interventions decreases by as much as 40%. This reduction produces enough public savings to pay for almost all of the annual cost of building, operating and providing services in the housing.

Prevention, Rapid Intervention and Community-based Supportive Services

The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years bases some of its recommendations on the research showing the cost-effectiveness of supportive housing. It will greatly expand the availability of supportive services and case

management in the community, and link these services to affordable permanent housing units. Following these strategies will not only house chronically homeless people who have been previously unserved, but also save taxpayer dollars spent by the City, County and State governments on emergency care for homeless people.

The Blueprint also recommends ways we can help families and individuals remain stable in housing so that they do not become homeless in the first place. And when people do become homeless, *The Blueprint* offers strategies to help them return to permanent housing as quickly as possible to minimize the disruption they experience. Once in permanent housing, they will have ready access to the supports and services they need to remain stably housed. All programs will affirm the value of education, employment and sobriety.

RECOMMENDATIONS

To accomplish the next steps in the evolution of our homeless service system, *The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years* offers a comprehensive plan that relies on four spheres of activity, each with its own recommended strategies and actions. All of these recommendations are based on the best practices of innovative programs across the nation that have demonstrated proven success achieving the goals of *The Blueprint*.¹ Briefly, the major recommendations of *The Blueprint* include:

A. Expand Permanent Housing Opportunities

- 1) **Create 1400 affordable housing units for homeless people by 2014**, through the provision of rent subsidies, new housing development and the preservation of affordable housing stock
- 2) **Facilitate housing placements, by:**
 - **Creating a centralized housing placement assistance office** that will assist homeless and at-risk individuals and families to conduct housing searches and secure affordable housing
 - **Developing a local program to provide a time-limited rental subsidy of four months to two years to homeless people** who are employable or receiving Supplemental Security Income (SSI), linked to intensive job search activities and supportive services for tenants, as needed
 - **Exploring ways to prioritize homeless people for placement into subsidized permanent housing**, including the possible establishment of a “preference” for homeless applicants for public housing and Housing Choice vouchers

¹ A growing body of best practices literature informs the ideas of this document. Many of these can be found at the National Alliance to End Homelessness at <http://www.endhomelessness.org/best/>

B. Increase Access to Services and Supports

- 3) **Reconfigure case management to be assertive, coordinated and focused on placing and maintaining homeless people in permanent housing.** Prioritize funding for both 1) case management to homeless people and 2) continuing case management and supportive services to formerly homeless people placed in permanent housing. Some of the strategies for accomplishing this include:
 - **Prioritize funding to expand the number of case managers and reduce their caseloads** so that they can offer long-term, goal-oriented case management services
 - **Establish a Case Management Coordinator position** that will oversee an expansion of coordination, training and technical assistance services
 - **Provide additional tools to help case managers place people into housing**, including rental subsidies, cash grants for household expenses and transitional placements for some specific subpopulations (such as youth and the medically frail)
 - **Review the region's capacity to provide substance abuse treatment and support**, and explore ways to make services related to substance abuse more accessible to homeless people
- 4) **Improve the effectiveness of outreach and engagement of homeless people living in public spaces, by:**
 - **Coordinating and reviewing all street outreach activities**
 - **Providing additional engagement tools to outreach workers, including access to an assessment shelter, drop-in center, and permanent housing**
 - **Working with the State to expedite access to entitlements and other supports**
- 5) **Link homeless and formerly homeless people to mainstream services and resources**, such as Workforce Investment Act programs, job opportunities, entitlements and substance abuse treatment.

C. Prevent Homelessness

- 6) **Establish a system for identifying people at risk of homelessness**
- 7) **Help at-risk households remain stably housed by providing emergency assistance, improving access to supportive services and maximizing their incomes**
- 8) **Prevent people from becoming homeless when they leave institutional care**, such as jail, prison, shelter, hospitalization, treatment and foster care, by:
 - **Developing permanent housing plans prior to release**
 - **Establishing clear responsibility for the implementation of discharge plans in the community**
 - **Working with State, County and private agencies and systems to improve coordination of institutional discharges and community placement activities**

D. Develop a Mechanism for Planning and Coordination

9) Establish the *Chattanooga Regional Interagency Council on Homelessness* to:

- **Enhance government and nonprofit capacity to raise federal and private funds and attract additional resources** to reduce and end homelessness
- **Expand capacity for data collection and analysis;** establish baseline statistics on the extent and nature of homelessness; and set clear policy goals, timeframes and numerical targets for homelessness reduction
- **Determine funding priorities for homelessness reduction and approve spending** for homeless reduction efforts across systems
- **Establish and maintain standards for service delivery and case management**
- **Increase collaboration between for-profit, governmental, nonprofit and faith-based agencies.**

A New Approach

Chattanooga's new approach reflects a national change in strategy now occurring in over 92 cities across the country. Supported by the federal government, these efforts build on what is often referred to as a "housing first" approach: the primary focus is to concentrate on returning homeless families and individuals to permanent housing as quickly as possible. In short, *The Blueprint* refocuses efforts away from mitigating the discomfort of homeless people and toward actually trying to end their homelessness.

The goals of *The Blueprint* are ambitious. It will take time to achieve them. Chattanooga will have to look beyond its traditional homeless services system to larger mainstream service systems and resources. Most important, ending chronic homelessness will require an expansion of resources for housing and services from the federal government.

With additional federal support, the governments, nonprofit organizations and faith-based communities can work together to implement the recommendations put forth in this document. If the sustained commitment and resolve that Chattanoogaans traditionally apply to major initiatives in their community is employed in the implementation of *The Blueprint*, together we can end chronic homelessness and significantly reduce all homelessness in the Chattanooga region in ten years.

THE BLUEPRINT TO END CHRONIC HOMELESSNESS IN THE CHATTANOOGA REGION IN TEN YEARS

I. Introduction

Homelessness is mostly hidden in Chattanooga and the counties that surround the city. The river, hills and open space that make Chattanooga and Southeast Tennessee a beautiful place to live also provide cover for homeless individuals and families residing in camps, caves and their cars, under bridges and in other out-of-the-way public spaces. More careful observation readily conveys the true extent of the problem.

Over 4,000 different people experience homelessness in the Chattanooga region during the course of each year. Homeless children comprise approximately one-quarter of this total. Each year, the Chattanooga region spends more than \$7.3 million on emergency and transitional services, shelter and housing for homeless people.

Every night, an average of 370 Chattanoogaans sleep in emergency shelters or transitional housing programs, while approximately 394 others bed down exposed to the elements. Thousands more live doubled up in the homes of family and friends, or are at imminent risk of homelessness, living in substandard or overcrowded housing they cannot afford. Homelessness in the counties surrounding Chattanooga and Hamilton County raise these numbers further. Some individuals remain homeless in Chattanooga and the Southeast Tennessee region for years at a time.²

The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years is a long-range, comprehensive plan to help homeless people in our area return to healthy and stable lives in permanent housing. It is the culmination of a seven-month planning effort by the Chattanooga region's homeless service providers, government administrators, housing developers, community leaders and homeless people themselves.

As its title clearly indicates, *The Blueprint* plan is intended to end long-term, or "chronic," homelessness.³ Because they typically have complex service needs and remain homeless for extended periods of time, chronically homeless people use a disproportionate share of scarce emergency resources like shelter, medical care and psychiatric services.⁴ In 2003, 670 different individuals served by the Chattanooga

² Statistical information about homelessness in the Chattanooga region is gathered from the following sources: the Service Point Homeless Management Information System operated by the Chattanooga Regional Homeless Coalition; the database maintained by the Hamilton County Department of Health's Homeless Health Care Center; a street count of homeless persons living in public spaces conducted in March 2003; the Chattanooga Continuum of Care and provider estimates.

³ The United States Department of Housing and Urban Development defines individuals or families as "chronically homeless" if they have a disabling condition and have either been continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years.

⁴ A 2001 study of New York City's shelter system found that the 16.8% of shelter residents identified as chronically homeless used more than 50% of all shelter resources available over the course of a year ("A Case Record Review of Long-Term and Short-Term Shelter Stayers in New York City," NYC Department of Homeless Services and the Corporation for Supportive Housing, 2001).

Homeless Health Care Center reported having been homeless for more than a year. A majority of these individuals can be considered chronically homeless.⁵

The emphasis on helping chronically homeless people reflects a new national consensus that this group is underserved by existing efforts. Under the leadership of the federal Interagency Council on Homelessness and its Executive Director Philip F. Mangano, 92 localities nationwide have now initiated or published blueprints to end chronic homelessness. Just as this document does for the Chattanooga region, these comprehensive plans outline region-specific policy changes and new initiatives that will improve the effectiveness of efforts to house the chronically homeless population.

The scope of *The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years* encompasses far more than chronic homelessness, however. When implemented over the next decade, *The Blueprint's* policy recommendations will also result in a significant reduction of all types of homelessness, including homelessness among families, youth and single adults who experience episodic homelessness.

The Blueprint will end chronic homelessness and reduce all types of homelessness over the next decade by investing our resources in a coordinated, sustained effort that addresses the underlying causes of homelessness. This effort will:

- Reduce the number of people who become homeless
- Increase the number of homeless people placed into permanent housing
- Decrease the length and disruption of homeless episodes
- Provide community-based services and supports that prevent homelessness before it happens and diminish opportunities for homelessness to recur.

To accomplish these goals, we will establish a new mechanism to coordinate our response to homelessness, the *Chattanooga Regional Interagency Council on Homelessness*. Rather than creating a new, separate bureaucracy to administer services to homeless people, the *Chattanooga Regional Interagency Council on Homelessness* will provide a mechanism for the many government, nonprofit and faith-based agencies serving homeless people to collaborate on a comprehensive regional response to homelessness.

Working together from a new, interagency perspective, the *Chattanooga Regional Interagency Council on Homelessness* will meld the Chattanooga region's many effective, but often isolated, service and housing programs for homeless people into a coordinated *system* of homeless services and housing. To guide this transformation, the *Council* will improve data collection and analysis, establish service standards, measure program performance, coordinate case management and establish annual numerical targets for the reduction of homelessness.

⁵ From 2003 Homeless Health Care Center data. Of the 670 individuals, 237 reported being homeless for more than five years.

II. A New Approach

A Tradition of Care

Over the past twenty years, the Chattanooga region has responded to the challenge of homelessness with care and concern. Chattanooga's faith-based community has established emergency shelters for families and individuals, as well as the Community Kitchen homeless services center on Eleventh Street. The Hamilton County Department of Health's Homeless Health Care Center, also on Eleventh Street, is a model for delivering primary health care services to homeless people. Collaborations with all levels of government have yielded transitional housing programs that help homeless people address mental health and substance abuse issues.

The efforts of the Chattanooga community have saved countless lives by providing basic emergency assistance to individuals and families when they become homeless – food, clothing, medical care and temporary shelter. They have also helped many homeless people overcome mental illness and addiction, gain employment and return to lives in permanent housing.

A New Focus: Reducing Homelessness

But as impressive as the many individual success stories have been, Chattanooga's network of homeless services has been unable to reduce the overall number of homeless people in the region. Chattanooga is hardly alone: most localities are experiencing increases in homelessness, the result of socio-economic factors largely beyond the control of local governments. These include: the disappearance of jobs for low-skilled workers; the growing disparity between rich and poor; the inadequacy and inaccessibility of entitlements for disabled people and families; increased incarcerations; and the lack of affordable housing, to name a few.

If we are to end homelessness, these larger, structural issues will have to be addressed at the federal level. There are, however, several reasons that Chattanooga's response to homelessness does not do more to reduce the problem. For example:

- Most services related to homelessness in the Chattanooga region focus on addressing the emergency needs of at-risk households only *after* they become homeless. Very little social service and financial support is available to prevent at-risk families and individuals from becoming homeless in the first place.
- Many homeless and at-risk individuals and families have difficulty gaining access to the services and supports they need to achieve or maintain stability. Mainstream medical care, mental health services, substance abuse treatment, employment programs and other supports are often unavailable, in short supply or ineffective at reaching many of the homeless people most in need. Demand is especially high for substance abuse treatment and support service slots that are more responsive to the needs of homeless people.

- When homeless people are re-housed, the level of support they need to remain stable and build on their success is unavailable to them in the community. This lack of community-based supports can often delay homeless people's return to permanent housing or allow them to become homeless again, sometimes repeatedly.
- Because there is a dearth of funding for community-based supportive services, the affordable housing that is developed fails to meet the permanent housing needs of homeless persons.

By addressing these and other gaps, the Chattanooga region can make its system of homeless services and housing more responsive to the needs of homeless people. Although currently homeless people must often wait for access to shelter and services, *The Blueprint* effort does not necessarily advocate or require an expansion of emergency shelter and transitional housing capacity. Instead, *The Blueprint* recommends strategies that will move homeless people through emergency and transitional programs more quickly. This will free up shelter and program space to allow transitional programs to serve a greater number of homeless people each year. In most cases, these families and individuals can be better served by investing in an expansion of ongoing, community-based supportive services delivered to them in permanent affordable housing. If these efforts are combined with additional resources for rent subsidies, supportive services and treatment from the federal government, we can end chronic homelessness in the Chattanooga region.

The Costs of Homelessness

The disruption caused by a homeless episode can have devastating and lasting repercussions for the individual and his or her family. Homelessness can depress people's health, educational achievement and employment opportunities over the long-term, especially for children who become homeless.⁶

Homelessness is not only a personal tragedy, however. It is expensive to the public as well. Research has clearly documented that homelessness increases people's use of costly emergency interventions, such as emergency medical care, psychiatric hospitalizations, shelter and incarceration. A 2001 study by the University of Pennsylvania of 4,679 homeless mentally ill individuals in New York City found that the average homeless individual with mental illness cost the public \$40,449 a year in emergency interventions.⁷

While New York City may spend more on these interventions than most municipalities, homelessness presents consistently high costs to the public in every American city. As

⁶ Margot B. Kushel, et al., "Emergency Department Use Among the Homeless and Marginally Housed: Results from a Community-Based Study," *American Journal of Public Health*, Vol. 92, #5, pp. 778-784, May 2002; "Report of the Kids Mobility Project," Family Housing Fund, Minnesota, 2002; "Housing and Schooling," Citizens Housing and Planning Council, *The Urban Prospect*, Vol. 7, #2, March/April 2001.

⁷ Culhane, Metraux and Hadley, "The Impact of Supportive Housing for Homeless Persons with Severe Mental Illness on the Utilization of the Public Health, Corrections and Emergency Shelter Systems: The New York/New York Initiative," *Housing Policy Debate*, 2001.

much as 70% of these costs are borne by states, for psychiatric hospitalizations and additional Medicaid spending. Counties also spend substantial sums in unreimbursed medical costs and incarceration expenses related to homelessness, while localities providing shelter and other emergency assistance pay for homelessness as well.⁸

The Cost Savings of Supportive Housing

The costs of homelessness are daunting. But the University of Pennsylvania study also pointed the way to a solution: supportive housing – affordable housing linked to on-site or visiting supportive social services.⁹ When the individuals in the study were placed into supportive housing, their use of emergency interventions decreased, reducing public costs by 40%. For every unit of supportive housing developed, the public saved \$16,282 per year in reduced emergency service costs. This paid for all but \$995 of the annual cost of building, operating and providing services in the housing.

In the study, the majority of the service use reductions (and cost savings) achieved by placing homeless individuals with mental illness into supportive housing occurred in health services, including an average reduction of 27 days of psychiatric and medical inpatient hospital care per unit constructed. The New York State Office of Mental Health benefited most from the reduced number and length of hospitalizations made possible by the creation of supportive housing, saving \$8,260 per unit constructed. Because both hospitalization costs and housing development costs reside in the Office of Mental Health’s budget, much of these savings could be applied directly to additional supportive housing development by the agency.

The study also found that the costs of incarcerating homeless people with mental illness were greatly reduced by their placement into supportive housing. While comparatively small when measured against the substantial health care savings, placement into supportive housing reduced the number of individuals with mental illness entering jail each year by 26%. The number entering State prisons was reduced by a striking 63%. In addition, jail days consumed fell by 38% and prison days consumed fell by 85%.¹⁰

Prevention, Rapid Intervention and Community-based Supportive Services

The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years bases some of its recommendations on the research showing the cost-effectiveness of supportive housing. It will greatly expand the availability of supportive services and case management in the community, and link these services to affordable permanent housing units. Following these strategies will not only house chronically homeless people who have been previously unserved, but also save taxpayer dollars spent by the City, County and State governments on emergency care for homeless people.

⁸ Sharon A. Salit, M.A., Evelyn M. Kuhn, Ph.D., Arthur J. Hartz, M.D., Ph.D., Jade M. Vu, M.P.H., and Andrew L. Mosso, B.A., “Hospitalization Costs Associated with Homelessness in New York City,” *New England Journal of Medicine*, Vol. 338:1734-1740, #24, June 1998; Proscio, “Supportive Housing and Its Impact on the Public Health Crisis of Homelessness,” Corporation for Supportive Housing, 2000. Culhane et al., 2001.

⁹ See Appendix B for more on supportive housing.

¹⁰ Culhane et al, 2001.

The Blueprint also recommends ways we can help families and individuals remain stable in housing so that they do not become homeless in the first place. And when people do become homeless, *The Blueprint* offers strategies to help them return to permanent housing as quickly as possible to minimize the disruption they experience. Once in permanent housing, they will have ready access to the supports and services they need to remain stably housed.

It will take time to achieve these goals. Chattanooga will have to look beyond its traditional homeless services system to larger mainstream service systems and resources. Mainstream employment programs, entitlements, mental health and medical care systems will be helped to better engage and serve homeless and at-risk people with their existing programs.

Chattanooga's new approach reflects a national change in strategy now occurring across the country. Supported by the federal government, these efforts build on what is often referred to as a "housing first" approach: the primary focus is to concentrate on returning homeless families and individuals to permanent housing as quickly as possible. In short, *The Blueprint* refocuses efforts away from mitigating the discomfort of homeless people and toward actually trying to end their homelessness.

III. Guiding Principles

The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years offers specific recommendations, policies and investments. Together, these will accomplish its ambitious, but wholly achievable, goals. The change in approach can best be summed up by the following eight principles:

1. Every effort will be made to prevent homelessness before it happens.
2. The ultimate goal of all efforts to address homelessness is to help each homeless person quickly secure and then maintain a place in permanent housing.
3. Whenever possible, services and supports will be community-based and delivered to people in permanent housing.
4. Service delivery must be coordinated among nonprofit and public service providers and across different systems of care, with an emphasis on increasing homeless people's access to mainstream service systems.
5. Homeless and formerly homeless people will be offered choices in service and housing provision and consulted in all planning and implementation efforts.
6. The effort to reduce and end homelessness must be adequately funded and sustained for a long-term period, and made a priority for all levels of government and community organizations.
7. The effort to reduce and end homelessness must have clearly defined targets and measurable outcomes, with regular public reports that monitor its effectiveness.
8. Programs and initiatives will be based on "best practices" and guided by proven research and periodic evaluation.

IV. Strategies for Success

To accomplish the next steps in the evolution of our homeless service system, *The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years* offers a comprehensive plan that relies on four spheres of activity:

- A. Expand permanent housing opportunities**
- B. Increase access to services and supports**
- C. Prevent homelessness**
- D. Develop a mechanism for planning and coordination**

A more detailed review of these four elements of the plan comprises the bulk of this document. Briefly, they include the following strategies and actions:

A. Expand Permanent Housing Opportunities

- 1) Create 1,400 affordable housing units for homeless people over the next ten years, through the provision of rent subsidies, new housing development and the preservation of affordable housing stock
- 2) Facilitate housing placements

B. Increase Access to Services and Supports

- 3) Reconfigure case management to be assertive, coordinated and focused on placing and maintaining homeless people in permanent housing. Prioritize funding for both 1) case management to homeless people and 2) continuing case management and supportive services to formerly homeless people placed in permanent housing.
- 4) Improve the effectiveness of outreach and engagement of homeless people living in public spaces
- 5) Link homeless and formerly homeless people to mainstream services and resources

C. Prevent Homelessness

- 6) Establish a system for identifying people at risk of homelessness
- 7) Help at-risk households remain stably housed by providing emergency assistance, improving access to supportive services and maximizing their incomes
- 8) Prevent people from becoming homeless when they leave institutional care, such as jail, prison, shelter, hospitalization, treatment and foster care, by developing permanent housing plans prior to release and establishing clear responsibility for their implementation in the community

D. Develop a Mechanism for Planning and Coordination

- 9) Establish the *Chattanooga Regional Interagency Council on Homelessness* to:

- Enhance government and nonprofit capacity to raise federal and private funds and attract additional resources to reduce and end homelessness
- Expand capacity for data collection and analysis; establish baseline statistics on the extent and nature of homelessness; and set clear policy goals, timeframes and numerical targets for homelessness reduction
- Determine funding priorities for homelessness reduction and approve spending for homeless reduction efforts across agencies and systems
- Establish and maintain standards for service delivery and case management
- Increase collaboration between for-profit, governmental, nonprofit and faith-based agencies.

The Blueprint plan includes a specific emphasis on people experiencing “chronic homelessness,” defined as extended and/or repeated episodes of homelessness of a year or more, complicated by major disabilities. As in other cities, chronically homeless Chattanoogaans have not been served effectively by existing efforts to help homeless people. Though this document attempts to look at all efforts in the area of homelessness, it is essential that we address this gap in services. Chronically homeless people often experience the most hardship of all homeless people. Typically, they are also the heaviest users of emergency services and our limited funding resources.

The changes outlined in this document are significant and far-reaching. But they build on the many strong programs and good works that already exist in Chattanooga. Much of what needs to be accomplished can be done with the resources we already have. However, homelessness is the result of large socioeconomic forces: the disappearance of jobs for people with low skills, the shortage of affordable housing, the eroding buying power of disability and other entitlements, inadequate treatment options and limited community-based supports and services, to name some of the most important. To succeed, we will need to use local resources judiciously while obtaining additional administrative and funding support from the state and federal government. These investments will in turn produce substantial public savings in spending on emergency services.

V. The Blueprint Planning Process

In September 2003, Mayor Bob Corker of Chattanooga joined with the Chattanooga Regional Homeless Coalition to initiate a planning process that would, for the first time, create a comprehensive vision for the Chattanooga region’s response to homelessness.

Both the Mayor and the Coalition began with a strongly-held conviction that Chattanooga, Hamilton County and the Southeast Tennessee region has a wealth of good programs and effective providers serving homeless people today. By improving coordination of these efforts and identifying missing elements in the homeless services continuum, Chattanooga would build upon the strong foundation that already exists. And by specifically expanding homeless families’ and individuals’ access to affordable

housing, the Mayor and the Coalition hoped to establish a comprehensive homeless services system that would serve as a model for serving and housing homeless people in mid-sized cities across the nation.

Chattanooga was able to embark on this planning process thanks to the generous assistance of the Butler Family Fund, which provided a \$20,000 grant toward the effort. The City of Chattanooga provided additional funding. Funds were used to pay for public planning events, administrative support and for the services of a policy consultant.

Early on in the process, the Mayor and the Coalition agreed to coordinate this planning process with the present federal administration's efforts to end chronic homelessness. They adopted a format being used by over 60 municipalities around the country, "*The Blueprint to End Chronic Homelessness in Ten Years.*"¹¹

The Mayor and the Coalition announced the commencement of *The Blueprint* planning process on September 18, 2003. They were joined by Philip F. Mangano, the Executive Director of the United States Interagency Council on Homelessness, the White House office charged with coordinating the federal response to homelessness. At the announcement, the Mayor named fourteen Chattanoogaans with extensive experience and expertise in homelessness, housing, mental health and emergency services to lead the effort by serving on a Blueprint Steering Committee.¹²

The Mayor and the Coalition realized from the start that, to be successful, the plan would have to address not just the homeless service and housing needs of Chattanooga, but those of Hamilton County and Southeast Tennessee as well. Accordingly, Mayor Corker requested and received the assistance of Hamilton County Mayor Claude T. Ramsey and his administration, as well as the participation of the Southeast Tennessee Development District and the Southeast Tennessee Regional Representative of the State Department of Mental Health and Developmental Disabilities' Creating Homes Initiative.¹³

Even before the official announcement, the City and the Coalition had begun gathering information about homelessness in Chattanooga. Information that formed the basis of the recommendations included in *The Blueprint* came from a number of sources, including local service providers, housing developers, government administrators, foundation executives, business and community leaders, national experts and homeless people themselves.

¹¹ More information on efforts to end homelessness nationally and in other localities can be found at www.endhomelessness.org.

¹² See Appendix A for a list of the members of The Blueprint Steering Committee.

¹³ An initiative of the Tennessee Department of Mental Health and Developmental Disabilities, the Creating Homes Initiative (CHI) created and expanded affordable, safe, permanent and quality housing options in local communities for people with mental illness in Tennessee. In three years that began in August 2000, CHI subsidized, developed and funded supportive services for 3,329 housing units for people with serious and persistent mental illness.

To ensure that all of the voices of the community were heard, and the full extent of national knowledge and expertise were utilized, *The Blueprint Steering Committee* gathered information in a number of ways, including:

- A public forum where nationally-known providers of innovative programs for homeless people spoke and over 100 participants traded information about the present system of homeless services in Chattanooga. Participants came from all walks of life and levels of expertise. They spent the day identifying the strengths and needs of the present system of services and envisioned what a transformed system would look like.
- A public forum where 35 homeless people and front line providers shared their experiences with homelessness in Chattanooga.
- A multi-media interview project that allowed homeless people to talk about their lives in Chattanooga.
- A series of focus groups with executive directors, program directors, administrators, case managers and front line workers of nonprofit, faith-based and government programs serving homeless people. These focus groups concentrated on specific aspects of homeless services, such as prevention, outreach and engagement, emergency shelter, transitional housing and permanent housing.
- Regular steering committee meetings where members discussed issues facing homeless people, government and the provider community, as well as policy options to improve services and access to housing.
- An extensive series of phone and in-person interviews with government and nonprofit administrators, front line workers and other stakeholders.
- An analysis of all existing local data gathered through the Coalition's Service Point homeless management information system and the Chattanooga Homeless Health Care Center's database, as well as other local data collection systems, surveys, planning documents and a review of local and national policy reports on homelessness.
- A series of drafts of *The Blueprint* were reviewed by a variety of stakeholders.

VI. Homelessness in Chattanooga Today

The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years envisions a new approach to delivering services and housing to homeless people. One strategy of this new approach will be to employ statistical analyses to track homeless people's use of emergency shelter and services and other publicly-funded systems. By collecting and analyzing just slightly more homeless data than we do now, and matching it with data from psychiatric centers, prisons and other systems, we can ascertain when and where people are most at risk to become homeless, who is not being served and what programs show the most success in returning homeless people to permanent housing.

Much of this data is collected at present: between the Hamilton County Department of Health's 15-year database of Chattanooga Homeless Health Care Center users and the Coalition's three year-old Service Point Homeless Management Information System, the

Chattanooga region has considerably more advanced and reliable data collection and analysis capacity than most localities of its size. These data systems already provide a solid foundation for future planning needs, and they continue to evolve and expand: every month, new providers join the Service Point reporting system, new data fields are added and the information collected becomes more accurate.¹⁴

There are limits, however, to what we know about homelessness in Chattanooga today. For example: there are still some shelter and service providers that do not report to Service Point; without data matches with other systems of care, it is difficult to confirm much self-reported data; and some crucial information, such as who occupies shelter beds each night, is not yet collected.

The Blueprint has begun a process of reviewing data collection and analysis activities that will continue in the coming months. This review will help establish baseline data that will enable the Chattanooga region to set goals for, and then accurately measure, program performance improvements and homelessness reduction. Of course, an increase in the number of providers reporting to Service Point over the next few years may create the appearance that homelessness itself is increasing, whether or not such a rise actually occurs. As Service Point use grows, system administrators will have to take this statistical distortion into account when doing their analyses.

With the cooperation and commitment of providers, efforts begun during *The Blueprint* process will soon transform Chattanooga's data systems from first-rate to world class. Until that time, the following overview consolidates the most accurate information we have to date of homelessness and the services available to homeless people in the Chattanooga region today.

Homelessness over the Course of One Year

Over the course of a year, more than 4,000 discrete individuals experienced homelessness in the Chattanooga region, including almost 1,000 children. The total figure includes 3,077 different homeless individuals who received services in fiscal year 2003 from nonprofit, faith-based and government agencies and organizations reporting to the Service Point database.¹⁵ It also includes an estimated 500-600 homeless people in Hamilton County who in FY2003 utilized shelter and service programs that do not report

¹⁴ The Service Point Homeless Management Information System is an integrated database system that collects information from a majority of Hamilton County's nonprofit, governmental and faith-based providers serving homeless people. The Chattanooga Regional Homeless Coalition has operated the Service Point homeless management information system for three years. At this time, Service Point does not collect data from youth shelters, some domestic violence shelters and four relatively large faith-based shelters. It is anticipated that additional providers will join the Service Point system in 2004. The Hamilton County Department of Health's Homeless Health Care Center has collected data since 1988. This data is especially useful for longitudinal trends and analyzing the characteristics of the single adult homeless population that depends on the Homeless Health Care Center and the co-located Community Kitchen.

¹⁵ The Coalition's fiscal year extends from July 1st to June 30th.

to Service Point, as well as another estimated 500-700 individuals who experienced homelessness in the surrounding region at some point during the year.¹⁶

These numbers include only single adults and individual family members who experienced actual homelessness – at one time during the year, they resided in an emergency shelter, a transitional housing program and/or in public spaces. It does not include thousands of other Chattanoogaans who live doubled up with relatives and friends, reside in substandard or overcrowded housing, or face other housing-related problems.

In all, 777 different homeless individuals (427 single adults and 350 members of families) spent at least one night in emergency shelter or transitional housing in Hamilton County during FY2003. An estimated 600 to 900 others utilized Hamilton County shelters not reporting to Service Point at some point during the year. The remaining 1,500 or so – most, but not all of them, single adults – resided in camps, caves, cars and other public spaces, although this number may inadvertently include some doubled-up families receiving services who are wrongly reported as homeless. A significant portion of the homeless population alternated between both shelter and outdoor living.¹⁷

Homelessness in One Night

When measured in a single night, rather than over the entire year, the number of homeless people in Chattanooga is, of course, smaller: while some people are homeless for years at a time (people often described as “chronically homeless”), most people experience episodes of homelessness alternated with periods in which they are housed.

On March 25, 2003, the Chattanooga Regional Homeless Coalition collaborated with service providers and volunteers to conduct a point-in-time “street count” of homeless people living in public spaces. Combining the results of this street count with data from Service Point and information about shelters not reporting to Service Point, we know that on any given night, approximately 758 unduplicated homeless individuals reside in shelters, transitional housing programs and public spaces in Chattanooga. These include 562 unaccompanied single adults, among them:

- Approximately 162 homeless single adults in 5 emergency shelters and 3 transitional housing programs reporting to Service Point
- Approximately 88 homeless single adults in 5 faith-based emergency shelters that do not report to Service Point
- Approximately 312 homeless single adults on the streets, in camps and in other public spaces.

Every night, approximately 202 family members in 75 families are homeless in Chattanooga, including:

¹⁶Service Point data and Coalition and provider extrapolations and estimates, 2003.

¹⁷ Service Point data, FY2003.

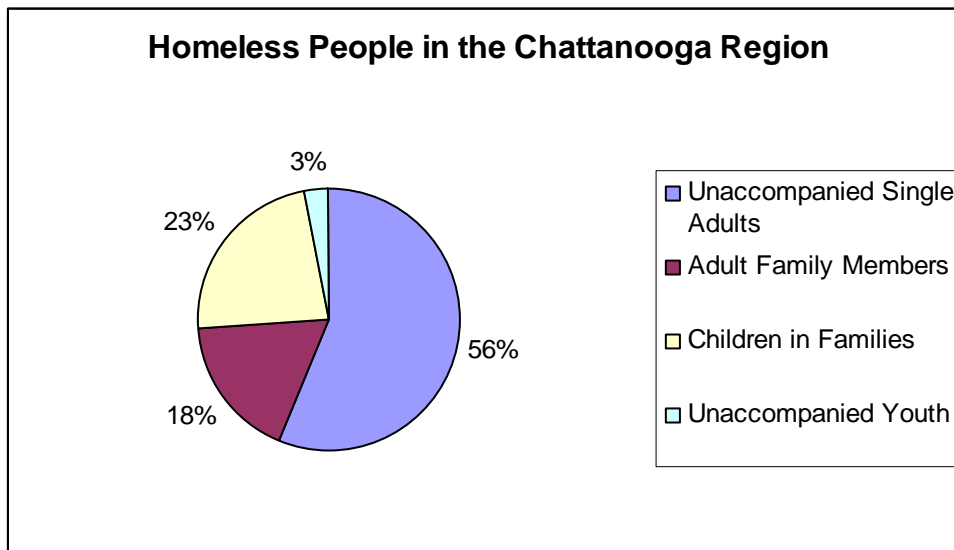
- Approximately 120 family members in 5 emergency shelters and 3 transitional housing programs.
- An estimated 82 family members in public spaces, mostly in local campgrounds.

These totals do not include homeless people from the surrounding region, including those in emergency shelters in Dayton, Cleveland and other neighboring towns.

Demographic Information

The Chattanooga region’s homeless population can be divided into four major subgroups: unaccompanied single adults, adults in families, children in families and unaccompanied youth under age 18. Chart 1 breaks down the population between these four groups, using data both from the Homeless Health Care Center and Service Point:¹⁸

Chart 1



These percentages vary slightly from the national averages. Chattanooga’s homeless population has a smaller percentage of children and a higher representation of single adults than the nation as a whole. This may be because housing is less expensive than in many other parts of the United States. A mother who works at a low-wage job or receives entitlements is more likely to be able to break into the housing market in Chattanooga than in cities with high housing costs.

At the same time, single adults in the Chattanooga region are more likely to be among those most vulnerable to homelessness because, unlike a number of states, Tennessee does not offer public assistance to single adults. Without this safety net, single adults

¹⁸ These estimates combine data from the Homeless Health Care Center (which serves a clientele that is 66% unaccompanied single adults) and Service Point shelter and transitional housing use data (which is skewed 55% to family members because only three of the reporting facilities accept single men). Using additional information gathered from the street count and knowledge of non-reporting shelters capacity produced the estimates above.

who cannot maintain full-time employment and do not qualify for disability entitlements are more likely to experience a housing emergency.

Further analysis of the Homeless Health Care Center and Service Point data shows that the homeless population in the Chattanooga region has the following characteristics:

- The Chattanooga region’s homeless population is split fairly evenly by gender, with men slightly outnumbering women.
- The Chattanooga region’s homeless population is 48% white, 50% African-American and 2% Latino.
- Most homeless people in the Chattanooga region (61%) are between the ages of 30 and 54 years old; 3% of the homeless population is 60 years old or older and 24% consists of children 18 years of age or younger.
- Approximately 34% of homeless people served by the Homeless Health Care Center report having been “treated for nerves,” indicating a serious and persistent mental illness. Approximately 29% of homeless people known to Service Point self-report having mental illness. Providers estimate that the percentage of unaccompanied homeless single adults with serious mental illness is higher, in the 40-45% range. Very few adult members of homeless families have mental illness.
- Approximately one-third of homeless people known to Service Point self-reported having abused drugs or alcohol. Providers estimate that the incidence of substance abuse is closer to 50% among unaccompanied homeless single adults, and less than 15% among adult members of families.
- Providers estimate that about half of the homeless mentally ill population also has a secondary diagnosis of drug or alcohol addiction.
- Providers estimate that 5-10% of the unaccompanied homeless single adult population is employed.
- Approximately 15-25% of homeless single adults are veterans of the armed forces.
- As much as 40% of the homeless family population has experienced recent domestic violence. Many more have histories of domestic violence victimization.
- Providers estimate that approximately 80% of all homeless people in Chattanooga grew up or have family ties in Hamilton County.¹⁹

Homelessness Trends

After appearing to decrease during the height of the economic boom of the late 1990s, homelessness in the Chattanooga region rose in 2000 to a level that has remained relatively stable over the last four years.²⁰ Outreach and shelter providers report some periods of higher demand for emergency shelter among unaccompanied single adults this winter. Faith-based and nonprofit organizations report that the number of households

¹⁹ All ethnographic statistics extrapolated from the Homeless Health Care Center 2003 data, Service Point, provider interviews and program observation.

²⁰ From a review of the number of people served annually by the Homeless Health Care Center (the only longitudinal data available that measures homelessness in Chattanooga over the last decade). After dropping from 2,328 people served in 1996 to 2,091 in 1997, the number served in 2000 rose to 2,508 and remained within 100 of that number for the past three years.

requesting emergency assistance for food or housing has risen. Demand is high enough that the Chattanooga region's allocation of pantry packages is now totally distributed to needy households within the first two days of the week. Previously, demand was such that emergency food supplies lasted at least five days.

Chattanooga's homelessness roughly reflects the national experience. Some larger cities have seen substantial increases in homelessness, while smaller cities have noticed less extreme, but still significant, increases in homelessness and housing instability. Overall, the December 2003 Hunger and Homelessness Survey by the United States Conference of Mayors found that requests for emergency shelter rose by an average of 13% in the last year. Four out of five cities reported that emergency shelters have turned away homeless families due to lack of resources. Sixty percent say that the length of homeless episodes has also increased, to an average of five months.²¹

Causes of Homelessness in the Chattanooga Region

Widespread homelessness is caused by a combination of factors. In many parts of the country, housing development has not kept pace with population growth. In most communities, improvements in housing quality, the growing scarcity of land and increasing administrative barriers to development have combined to increase housing costs, making most unsubsidized housing unaffordable to people with very low incomes. The sharp rise in the cost of housing has far outpaced the modest growth of employment and entitlements income, especially for people with disabilities or low job skills. By conservative estimates, nationwide the number of low-income renters exceeds the number of affordable units by more than 5 million.²²

Like a game of musical chairs, the shortage of affordable housing means some low-income households will become homeless. Those most at risk are people with disabilities, poor work histories, mental illness and/or addictions. These individuals and families can benefit from services and supports to overcome these barriers. But a successful intervention must also include decent and safe housing affordable to their incomes.

Housing Supply: Housing in the Chattanooga region is more abundant than in many areas of the United States. The vacancy rate for rental housing in Hamilton County was 8.6% in 2000, compared to 2-5% in the most crowded cities.²³ As a result, housing here is also relatively inexpensive. A recent report calculates that an American family must, on average, earn at least \$15.21 an hour to afford to rent a two-bedroom apartment. In some cities with high housing costs, such as San Jose, California or New York City, this "housing wage" rises to \$28 to \$35 an hour. By comparison, Hamilton County's housing wage is \$10.62 per hour.²⁴

²¹ U.S. Conference of Mayors – Sodexo Hunger and Homelessness Survey 2003, December 18, 2003.

²² National Alliance to End Homelessness, "A Plan, Not a Dream," 2000, p. 13.

²³ Chattanooga Community Research Council, Quick Table DP-1: Profile of General Demographic Characteristics: 2000 U. S. Census.

²⁴ "Out of Reach, 2003: America's Housing Wage Climbs," National Low Income Housing Coalition, 2003. The report uses the federal government's Fair Market Rent (FMR) standard and defines rents as "affordable" when they cost no more than 30% of total household income.

Some types of housing may be in short supply in Chattanooga, most significantly, housing for single adults and people with special needs. This is especially true in rural areas. In addition, 738 public housing units have been or will soon be lost in Chattanooga within a period of five years, as the Chattanooga Housing Authority demolishes substandard housing stock and downsizes concentrated clusters of public housing.²⁵

Further exacerbating the loss of affordable housing units is the fact that 598 public housing units are not available because they are being modernized in the near future or they are being used to house services for the residents. Some of the privately-owned affordable housing stock is also in substandard condition.

Income: A more important factor in local homelessness is income. The Chattanooga region's unemployment rate is relatively low, but so are wages. Most entry-level jobs for people with few or no skills pay close to minimum wage. Many offer only temporary or inconsistent employment. Homeless people face additional barriers because of the stigma of homelessness, and because many available jobs are not accessible by public transportation or are second or third shift, the only times shelter beds are available.

With steady employment, most homeless people can eventually earn enough to move back into permanent housing. But the struggle to find and retain a job while homeless usually delays most people's housing placements. Many of the jobs available to workers with low skills are seasonal or offer only intermittent hours. The lack of a steady income regularly threatens the stability of formerly homeless persons once they are housed.

Chronic unemployment and/or underemployment are particularly significant risk factors for homelessness in Tennessee because Tennessee does not offer public cash assistance to single adults without children. Also, single adults are limited to no more than five months of federally-funded Food Stamps per year in Tennessee. As a result, any interruption in employment income can instigate a housing emergency for a single adult.

For people unable to secure employment due to a disability, affording housing is a considerable challenge. A physically or psychiatrically disabled individual eligible for Supplemental Security Income (SSI) receives \$552 per month, while the fair market rent for a one-bedroom apartment is \$442 per month.²⁶ In addition, many disabled individuals are unable to meet the stringent eligibility requirements or complete the lengthy application process for SSI.

A single mother may qualify for Families First, Tennessee's name for the federal Temporary Aid to Needy Families (TANF) entitlement. For a family of three, this will amount to approximately \$185 in cash per month, supplemented with up to \$371 a month

²⁵ Chattanooga Housing Authority.

²⁶ Out of Reach 2003.

in Food Stamps.²⁷ Tennessee families receiving TANF now face a federally-mandated five-year time limit on eligibility. These families will be at high risk for homelessness.

Both SSI and welfare recipients usually need supplemental housing assistance to prevent homelessness. They may receive this assistance through public housing, a federal Section 8/Housing Choice rent subsidy or placement in a group home. Currently, there are waiting lists of 255 households for public housing and 1,438 households waiting for Housing Choice vouchers. The Housing Choice voucher waiting list is currently closed; families already in line must wait at least a year for a housing subsidy. Placement into a group home for disabled residents takes an average of two to four weeks.²⁸

Other Contributing Factors to Homelessness: Of course, many other factors combine with low incomes and high housing costs to cause people to become homeless. In addition to the loss of employment or entitlement income, people most often become vulnerable to homelessness because they also have substance abuse or mental illness issues, physical disabilities or poor health, inadequate education, limited work experience, criminal histories and domestic violence. Once they become homeless, the limited availability of treatment slots – particularly for substance abuse – makes it difficult for them to get access to assistance.

VII. Shelters and Services for Homeless People in Chattanooga

Without employment or entitlement income, it is very difficult for homeless people to afford housing. And, of course, it is very difficult to find employment or apply for entitlements when homeless. When homeless people must also overcome other barriers to housing stability, such as mental illness or addiction, housing placement becomes even more challenging.

Chattanooga's present response to homelessness acknowledges these challenges by reserving scarce resources primarily for those individuals and families who demonstrate motivation to address employment, mental health and addiction issues. As a result, transitional housing programs and other homeless service providers may achieve a higher percentage of positive outcomes than they would if they accepted homeless individuals and families into their programs regardless of their level of motivation. But this informal policy can also have the effect of directing limited shelter, program and housing slots away from those lower-functioning homeless people least able to advocate for themselves

²⁷ Tennessee Department of Human Services Rate Sheet, Rev. 11/7/03.

²⁸ The federal Section 8/Housing Choice program administered by the Department of Housing and Urban Development is the most important tool for reducing and ending homelessness. It provides an annual allocation of ongoing, renewable rental subsidies to states and local housing authorities. These "Housing Choice" vouchers pay private landlords approximately \$550 per month for a one-bedroom apartment in Tennessee, while also requiring tenants to contribute 30% of their incomes toward rent. At present, there are 24,806 Housing Choice vouchers in use in Tennessee. The Chattanooga Housing Authority manages 3,012 of these, while the counties surrounding Chattanooga control approximately 1,127 additional vouchers. Private organizations manage 148 HUD-controlled Vouchers, 796 rental assistance 202/811 program vouchers, and 2,437 project-based vouchers in the region. Source: Chattanooga Housing Authority, 2004.

and most in need of assistance. Members of the more resourceful, higher-functioning group are more likely to secure available assistance, even though they may have eventually returned to permanent housing with or without that assistance. Members of the second, less able group cannot compete with the first for the limited amount of services, shelter and housing assistance available, even though that assistance is absolutely necessary if they are to be re-housed.

Today, all homeless people in Chattanooga can get meals, clothing and showers, as well as appointments for primary medical care and some social services at the Community Kitchen and Homeless Health Care Center located on 11th Street. But emergency shelter is considerably less available, particularly for those who exhibit barriers to independent living. Transitional housing and treatment beds and permanent housing subsidies are similarly difficult to secure, with even motivated families and individuals often waiting months to get accepted into programs and housing.

The following is a brief overview of homeless services in the Chattanooga region:

Emergency Services: Homeless people in Chattanooga typically first turn for help to the multi-service complex of programs for homeless people located on East 11th Street, just a few blocks from the Chattanooga city center. The co-located Chattanooga Community Kitchen, Homeless Health Care Center and the Interfaith Hospitality Network collaborate to address the varied and often complicated needs of homeless people.

The Community Kitchen provides over 100,000 meals a year to homeless people in four sittings each day. It also meets many other immediate needs of homeless people, such as clothing, showers and laundry facilities. In addition, both the Community Kitchen and the Homeless Health Care Center employ case managers who work together to begin to address the most urgent needs of the people they serve. The Interfaith Hospitality Network also provides limited case management services to up to 28 family members residing in the Network's shelters at any one time.

The volume of requests for assistance at the complex has become so large that case managers' time and resources are limited. They make referrals to other agencies, programs and shelters, including the HELP II job training program and the VIP intensive outpatient substance abuse recovery program, both located on-site at the complex. The case managers also act as gatekeepers for the St. Matthew's and St. Catherine's shelters and the Interfaith Hospitality Network. Finally, they help homeless people secure entitlements and resolve a host of other personal, economic and bureaucratic issues they face each day.

In addition to case management and service programs, the Chattanooga Homeless Health Care Center provides primary medical care to homeless people of all ages. Funded predominantly by the county and federal governments, with some crucial additional assistance from the State and City, the Homeless Health Care Center offers a full-service on-site clinic as well as outreach teams that provide medical services in area shelters. The health care services offered by the center are comprehensive and easily accessible to homeless people. Often, the center's provision of health care services presents a vital

opportunity to engage otherwise distrustful clients into services. Demand greatly exceeds capacity for some services, such as dentistry, optometry and psychiatric evaluations and care.

Outreach and Case Management: There is some limited street outreach services to homeless people living in public spaces, but they have little shelter or housing to offer. There is no shelter available in which homeless people with active substance abuse issues can be engaged and convinced to enter treatment. Without this crucial step, it is difficult to draw homeless people into treatment.

Homeless people with mental illness face a more daunting challenge in that they must often wait weeks for TennCare²⁹ approval in order to receive prescribed psychotropic medication before they can gain access to shelter. Some homeless individuals with mental illness can obtain a few weeks' medication and psychiatric care from programs operated by Volunteer's Joe Johnson Mental Health Center and the Fortwood Mental Health Center. But these programs' resources are limited and not universally available, leaving many unable to secure the clinical help and medication they need.

Case management services that help people with psychiatric disabilities remain stable are mostly directed to people who are already housed. The intensive level of day-to-day assistance required by many homeless people to become housed and address addictions, mental illness and other issues makes it difficult for most providers to offer case management to the homeless population. The few case managers specifically serving homeless people are often overwhelmed by the demand for their services. Without the time to develop and then implement ongoing, comprehensive service plans with clients, they mainly offer what is better described as crisis intervention rather than ongoing case management.

Emergency Shelter: Homeless single adults can line up for one of twelve beds at the Salvation Army shelter. If they are lucky or enterprising enough to get one, they must pay \$8 per night, although stays are limited to a week or two to 30 days at the most. About one hundred additional free emergency shelter beds are also available in various other faith-based shelters. These are also in high demand; many require attendance at religious services. No shelter is available for single adults who do not have proper identification, are inebriated, have serious mental illness that affects their behavior or who are employed on night shifts.

Homeless families who are victims of domestic violence may gain access to 96 beds in emergency shelters set aside for the domestic violence population. If there is no domestic violence involved, families must compete for 159 beds at 7 emergency shelters and the Interfaith Hospitality Network, a system of rotating church and synagogue-based shelters administered by volunteers.

²⁹ TennCare is the Tennessee State-administered medical insurance program that operates under a federal waiver to fulfill the role of Medicaid.

Transitional Housing: Most transitional housing programs in the Chattanooga region have relatively high eligibility standards, making it difficult for many homeless people to get the help they need. Many transitional housing programs only accept homeless families and individuals who are employed, looking for work, or enrolled in mental health or substance abuse treatment. Some transitional housing programs require family heads of households to be employed before they will be accepted, a difficult task for someone who has just lost her housing.

Often, residents of a transitional housing program “graduate” not to permanent housing, but to another transitional housing program where they may stay for many more months. While this ensures that they continue to receive a more intense level of services than they could otherwise receive in the community, it also prolongs their homelessness. Homeless families and individuals with service needs tend to stay longer in transitional housing in the Chattanooga region than in most other localities.

Three transitional housing programs offer substance abuse treatment to homeless persons; another is for homeless individuals with mental health issues. These require demonstrated sobriety at all times and consistent program attendance. They enforce a “zero tolerance policy” for those who relapse, discharging them from the programs. Another transitional housing program serves homeless youth in State custody. Four other transitional housing programs serve homeless families, including one that offers counseling and support in apartments to families and single women who are victims of domestic violence. These programs also enforce firm eligibility standards and require a high level of participation and program compliance.

There is high demand for transitional housing programs and entry can take weeks or months. This is especially true for substance abuse treatment beds. Existing residential substance abuse treatment programs cannot meet the current demand among homeless people. In addition, despite these programs’ success helping many members of this population, there are many more homeless individuals with substance abuse issues who do not respond well to treatment modalities currently available in the Chattanooga region. An expansion of treatment options would increase the number and types of homeless people who could receive treatment.

Community-based Supportive Services: Formerly homeless people with psychiatric disabilities can receive case management services from case managers funded through TennCare. These case managers provide effective support to hundreds of people with disabilities housed in the community. However, TennCare pays for only three visits per month per client, making it difficult to provide an adequate amount of support for formerly homeless people with intensive service needs. TennCare will pay a higher reimbursement rate if the individual with mental illness has been hospitalized for more than 30 days in the past year. This more intensive level of case management allows ten visits per month, and is focused on providing the support and stability necessary to reduce the individual’s heavy use of hospitalization and other publicly-funded services.

People living with HIV/AIDS can receive comprehensive case management services, rent subsidies and specialized medical care from Chattanooga Cares, a nonprofit serving people with HIV/AIDS in the Chattanooga region. The wrap-around nature of the services offered by Chattanooga Cares can serve as a model for future expansions of case management capacity.

Placement into Permanent Housing: The limited availability of rent subsidies and support services for people living in permanent housing is the primary barrier preventing homeless people from returning to permanent housing. The Chattanooga Housing Authority (CHA) and other authorities in the region administer over 4,000 Section 8/Housing Choice vouchers. But the program is oversubscribed at the local level and the CHA's 1,438-person waiting list is closed at present. Public housing also has a waiting list, though it is somewhat more accessible. However, strict eligibility requirements prevent most homeless people with criminal or substance abuse histories from gaining access to either of these resources.³⁰

With few housing subsidies available, transitional housing residents must be employed or receiving full entitlements and have accumulated savings in order to move into permanent housing. This greatly delays their stays in transitional housing programs.

The dearth of vacancies in transitional housing programs in turn reduces movement out of the emergency shelters and reduces programs' ability to help people off of the streets. Usually, those homeless people with the greatest barriers to returning to permanent housing – untreated mental illness and active substance abuse – are the ones left unserved. In 2002, 624 individuals served by the Homeless Health Care Center reported being homeless for more than one year; in 2003, the number was 670.

VIII. Spending on Homelessness in the Chattanooga Region

An initial review of the costs of the services for homeless people described above finds that, all told, over \$7.3 million is spent each year responding to homelessness in Chattanooga and Hamilton County (*see chart 2*).³¹ This includes \$3.3 million in annual funding for emergency shelters and transitional housing programs for homeless people. It also includes approximately \$1.4 million spent annually on other non-medical emergency services delivered to people while they are homeless, such as food, clothing, engagement activities and referrals to programs.

³⁰ Until a few years ago, the Chattanooga Housing Authority gave homeless families priority for housing placements and subsidies. While this allowed some homeless families to move more quickly into public housing, it also inadvertently encouraged ill-housed (but not yet homeless) families to declare themselves homeless and enter shelter in order to gain access to affordable housing. To be sure, many of these families had serious housing needs; in some cases, placement into subsidized housing was the correct answer. But it is important not to create incentives that encourage people to become homeless to gain access to housing and services

³¹ Chattanooga/Hamilton County Regional Homeless Services Funding for 2004, Chattanooga Regional Homeless Coalition.

The figure for total spending on homelessness does not include spending on persons with mental illness who receive case management services funded through TennCare and also happen to be homeless or formerly homeless. Spending on permanent housing for formerly homeless people is similarly underreported: these figures include only housing programs that specifically target homeless people and have a service component attached to the housing. In addition, the chart does not include some spending on homelessness in the counties surrounding Hamilton County because it was unverifiable at the time this report was published.

Chart 2: Spending on Homelessness in the Chattanooga Region

Type of Program	Total Spending
Transitional Housing	\$1,827,000
Emergency Shelter	1,511,000
Primary Health Care & Clinical Services	1,122,000
Emergency Services	998,000
Permanent Housing & Supportive Services	995,800
Outreach & Case Management	295,000
Coordination, Planning & Advocacy ³²	287,000
Re-housing Assistance	152,500
Employment Services	135,500
TOTAL	\$7,324,000

Funding Sources

Approximately 40% of all spending on homelessness in the Chattanooga region is funded by the federal government (although many of these federal funds are passed through or managed by the State or local governments). This is matched by an even greater amount of funding (43% of the total) donated by faith-based communities, private philanthropy, foundations and the United Way of Greater Chattanooga. Hamilton County also makes a significant contribution towards homeless services, mostly on primary healthcare delivered by the Homeless Health Care Center.

Chart 3: Regional Funding Sources for Homeless Services

Funding Source	Spending
Federal	\$2,905,000
State	481,000
County & City	691,500
Program Income ³³	64,500
Philanthropy	\$3,182,000
Total	\$7,324,000

³² “Coordination, Planning and Advocacy” includes the Chattanooga Regional Homeless Coalition budget for managing the Continuum of Care federal funding application process, operating the Service Point database and other planning and advocacy efforts.

³³ “Program Income” is predominantly cash contributions from homeless people themselves to defray the costs of some emergency shelter and transitional housing programs.

Investments in Affordable Housing

In addition to spending on emergency services, the City of Chattanooga's sustained commitment to affordable housing development and preservation continues to be a major factor in mitigating and preventing homelessness in the Chattanooga region. This funding is primarily used to assist low and moderate income households to purchase or repair and preserve affordable housing, although some of it has been used to help build transitional and permanent housing for homeless and formerly homeless people.

In FY2003, the City spent \$4.9 million on affordable housing development in Hamilton County; in the previous year, \$4.5 million was allocated to affordable housing. The City's spending on affordable housing development is expected to remain at this level or rise in future years. Approximately \$2.9 million of this spending comes from Chattanooga's allocation of federal HOME and Community Development Block Grant (CDBG) funds, as well as income derived from prior investments of these funds. The City consistently allocates 65% of its HOME and CDBG budget to affordable housing. The City also contributes \$2 million per year in City tax levy dollars to affordable housing development.³⁴

In addition, the Chattanooga Housing Authority manages over 3,000 units of publicly subsidized housing, funded with \$8.85 million in federal funds. An additional \$15 million in federal funds pays for Section 8/Housing Choice rental subsidy vouchers in Hamilton County. In Fiscal Year 2003, the Chattanooga Housing Authority also spent \$15 million developing and rehabilitating public housing units under the federal HOPE VI program.³⁵

³⁴ City of Chattanooga Office of Economic and Community Development, 2003.

³⁵ United States Department of Housing and Urban Development FY2003 budget.

RECOMMENDATIONS

Toward a New System of Homeless Services

The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years will help transform our response to homelessness by building on the effective services, shelter and transitional housing programs that already exist. Using these as a foundation, *The Blueprint* organizes its recommendations into four spheres of activity:

- A. Expand permanent housing opportunities**
- B. Increase access to services and supports**
- C. Prevent homelessness**
- D. Establish a mechanism for planning and coordination**

The first, expanding permanent housing opportunities, is the most important. If we are to expand outreach to homeless people living in public spaces, engage more people into shelter and services and quickly place them into permanent housing, the Chattanooga region will need to ensure that there is an adequate number of appropriate and affordable permanent housing units available. Our success increasing the amount of permanent housing available to homeless people – in short, giving homeless people a place to live – will in large part determine the success of our other efforts at meeting their needs.

Jack Webster³⁶ is seventy years old and his health is failing. Living on coffee and cigarettes and the occasional hot dog, he often gets dizzy and weak. Though he receives a modest Social Security check each month, it is not enough to allow him to afford an apartment, or even a room, in Chattanooga. Too old to work and with no way to increase his fixed income, he has been homeless for years.

It wasn't always this way. Jack's life reads like an epic tale of the 20th century. As a runaway kid in the late 1940s, he toured the South in a carnival playing "The Mysterious Alligator Boy." "They used to cover me with this concoction of mud and oatmeal, so I looked all scaly. They claimed I was 'the sad product of the most unholy union of a fallen woman and a bull alligator, conceived one moonlight night in the swamps of Louisiana.' It was quite a show."

As an adult, Jack's personal drive and ambition helped him beat the odds, and he realized great success as a contractor in Virginia and North Carolina. "I was making a lot of money. I'd fly from one construction site to another in my own Piper-Cherokee." But when his wife died, he began losing his battle with alcohol abuse and depression. Eventually he lost his business. Later, age, depression and his constant drinking rendered him homeless.

After years on the streets of various cities in the South, he sought assistance at the Chattanooga Community Kitchen on East 11th Street. The case managers there hooked him up to the VIP outpatient substance abuse program co-located at the East 11th Street complex and helped him find refuge in the basement shelter of St. Matthew's Church. With the support of the program and his shelter mates, he has been clean and sober for more than a month.

But without increasing his income, Jack has not been able to secure an apartment. As he ages and grows weaker, he is less and less able to fend for himself. He's scared of what will happen to him if he loses his bed at the shelter.

What Jack needs is supportive housing – affordable housing linked to flexible and effective supportive services. With the stability of a permanent apartment, the services will not only help him maintain his sobriety, but also assist him with all his household needs and keep him as healthy as possible. With his history of alcohol abuse, the case managers at the Community Kitchen know that Jack would be a perfect candidate for supportive housing, if only there were units available. But the supportive housing that does exist in Chattanooga only serves people with serious mental illnesses. "I don't know what I'll do next month," Jack says bravely. "But I'll survive. I always do."

³⁶ The names and some identifying details of the individuals profiled in *The Blueprint* have been changed to protect their identities.

A. Expand Permanent Housing Opportunities

Placement into permanent housing is the primary goal of all efforts to assist homeless people. Of course, treating mental illness, substance abuse and other problems that may have contributed to a person's homelessness is critical. But addressing these issues should not unnecessarily delay placement into permanent housing in anticipation of the individual achieving some future state of "housing readiness."

Addressing people's barriers to independent living while they reside in permanent housing is often characterized as a "housing first" methodology. Research shows that "housing first" programs that address such problems while the individual or family is in permanent housing can have better long-term success than programs that attempt to treat or mitigate these problems in a transitional setting before permanent housing placement.³⁷

Barriers to Permanent Housing Placement

Despite this research – and indications that a "housing first" approach is also more cost effective – Chattanooga (like most other municipalities) currently has few "housing first" programs for homeless people. For a variety of reasons, many homeless families and individuals living in Chattanooga's transitional housing programs now remain in those programs longer than necessary. Though they demonstrate the stability necessary to maintain a place in permanent housing, they may remain in transitional housing while they participate in job training or search for employment. Or they may stay additional months in a transitional setting while amassing the funds necessary to pay for rental deposits and other expenses associated with moving into permanent housing.

Often, transitional housing providers and residents alike delay the move into permanent housing because they are concerned that, once they are placed in permanent housing, the residents will continue to need some level of ongoing supportive services for some period of time. At present, these services are unavailable to most formerly homeless people placed in the community. As a result, some homeless people in Chattanooga graduate from one transitional housing program only to enter another less intensive one, sometimes moving on to a third transitional program before they are deemed capable of living in permanent housing.

Some more independent homeless individuals and families would be able to secure and maintain themselves in permanent housing, if they were able to raise their income or lower their housing costs only slightly. For example, a recipient of SSI disability entitlements can afford to pay up to \$160 per month toward rent.³⁸ A supplemental rental

³⁷ Rog, D. J. and Gutman, M. (1997), "Homeless families program: A summary of key findings." and Shinn, M., Weitzman, B. C., Stojanovic, D., Knickman, J. R. Jimenez, L. Duchon, L. and Krantz, D. H. (1998). "Predictors of homelessness among families in New York City: From shelter request to housing stability."

³⁸ Federal housing affordability guidelines consider housing affordable when it costs 30% or less of a tenant or owner's income.

subsidy of \$282 per month would allow this individual to afford the Chattanooga region's average median rent of \$442 per month. But there are few rent subsidies available to allow them to do this.

Finally, many homeless people in the Chattanooga region who have mental illnesses and other barriers to independent living will definitely need to receive ongoing, sometimes intensive, supportive services to succeed in permanent housing. Most will also require additional rental and financial subsidies to remain housed. Currently, these services and subsidies are not available for many persons in this group.

Expanding Opportunities for Housing Placements

To help address all of these issues, *The Blueprint* focuses on expanding opportunities for homeless people to gain access to safe, decent, affordable and appropriate permanent housing, including housing linked to ongoing supportive services. This can be accomplished through two main strategies: 1) creating affordable and appropriate housing units for homeless individuals and families, and 2) facilitating their access to these and other existing units of affordable housing.

Additional recommendations for expanding access to and funding for supportive services linked to housing are discussed in Parts B and C of this report.

RECOMMENDATION #1:

Create 1,400 affordable housing units for homeless people over the next ten years, through the provision of rent subsidies, new housing development and the preservation of affordable housing stock. A majority of the units will be linked to supportive services.

The Chattanooga region's overall shortage of housing is not as severe as in many areas of the United States. Homelessness in the region is instead more often a result of people having incomes inadequate to break into the housing market (though inadequate income may in itself be caused by mental illness, substance abuse, lack of employment skills and other barriers). There are vacant units available, but their rents are too high for very low-income area residents to afford.

Creating fourteen hundred permanent housing units affordable to homeless people by 2014 is the linchpin of *The Blueprint* plan. This new affordable housing resource will allow transitional housing programs and emergency shelters to return homeless people to permanent housing more quickly, which will, in turn, free up space to allow street outreach workers to engage and swiftly place homeless people into transitional programs.

The 1,400 unit target was derived from a preliminary analysis of the need conducted by *The Blueprint* Steering Committee. This analysis looked at the number of homeless

people who meet the criteria for chronic homelessness over the past few years, as well as the number of individuals who have been homeless for periods longer than that. It also evaluated the number of people who become newly homeless each year, and the number of people who are re-housed or move on to other localities. While the overall need for permanent housing units affordable to very low income people in the Chattanooga region is most likely higher, the 1,400 unit target is expected to meet the twin goals of ending chronic homelessness and sharply reducing all types of homelessness.

It will be necessary to build some new permanent housing units for homeless people with special needs, particularly in the rural areas surrounding Chattanooga. New affordable housing construction can also help to ensure that formerly homeless tenants are not concentrated in impoverished neighborhoods that lack access to services and employment opportunities.

Increased efforts to preserve or replace affordable housing units at risk of demolition or redevelopment will also be required. Without a concerted effort to preserve or replace these vulnerable affordable housing units, it will be increasingly difficult to meet the housing needs of homeless people in the Chattanooga region.

If affordable housing in the region is successfully preserved, however, the housing needs of most homeless Chattanoogaans can be met by providing rent subsidies for use in existing housing units. To ensure that formerly homeless people remain stably housed, supportive services will be linked to a majority of the affordable units created.

The Blueprint's affordable housing creation program will be partly modeled on the successful Tennessee Department of Mental Health and Developmental Disabilities' *Creating Homes Initiative (CHI)*. Designed and implemented by Marie Williams, Director of the Department's Office of Housing Planning and Development, CHI has made safe, decent affordable housing units available and accessible to 3,329 Tennesseans with mental illness in just over three years, including 1,009 in the Southeast Tennessee region.

As in CHI, housing units under *The Blueprint* initiative will be created by marshaling as many different resources as possible. Looking beyond funding streams traditionally used to fund housing for homeless people, such as the McKinney-Vento Homeless Assistance Act (the primary federal funding stream for homeless services and housing), *The Blueprint* will create housing through a combination of three strategies: rental subsidies, preservation and new construction.

Rental Subsidies - Rental subsidies will be provided through these strategies:

a. Increase the number of federally-funded Section 8/Housing Choice rental subsidy³⁹ vouchers available to people who are homeless or have special needs in the Chattanooga region, from the following sources:

- 50 vouchers recently awarded to a collaboration of providers and government agencies through the federal Collaborative Grant to Help End Chronic Homelessness⁴⁰
- 35 tenant-based vouchers recently awarded to rural counties in Southeast Tennessee through the federal Continuum of Care process
- Additional Shelter Plus Care vouchers awarded annually through the federal Continuum of Care process
- Additional Mainstream Housing Choice Vouchers for Persons with Disabilities annually allocated to the Chattanooga Housing Authority (CHA)⁴¹
- Additional Housing Choice vouchers allocated on a competitive basis
- Other vouchers annually allocated to the Chattanooga Housing Authority (CHA), the Tennessee Housing Development Agency (THDA) and other regional housing departments, including Fair Share and other special voucher allocations.⁴²

b. Develop a local program to provide a time-limited rental subsidy of four months to two years to homeless people. Subsidies will be primarily directed to employable individuals and individuals receiving Supplemental Security Income (SSI). This cost-effective program will affirm the value of work and will be linked to intensive job search activities and supportive services for tenants, as needed. This subsidy builds on the proven success of such similar efforts as the Individual Self-Sufficiency Initiative (ISSI) in Massachusetts.⁴³ By the end of the local subsidy's time limit, recipients will

³⁹ The federal Section 8/Housing Choice voucher program is administered by the United States Department of Housing and Urban Development (HUD), as are the similar Shelter Plus Care, Mainstream, Special Needs and Fair Share vouchers allocated to specific populations. Section 8/Housing Choice vouchers provide ongoing rental subsidies to low-income tenants in permanent housing. The subsidy pays for the difference between 30% of the tenant's monthly income (the tenant's contribution) and the monthly rent.

⁴⁰ For more on Chattanooga's collaborative grant, see Appendix C.

⁴¹ In 2002, the federal Department of Housing and Urban Development (HUD) allocated 260 vouchers to the CHA for people with special needs. The demand for such vouchers is considerably higher and the allocation should be increased to meet demand.

⁴² At present, CHA's Section 8/Housing Choice voucher program is oversubscribed. It is unclear whether and when the federal government will make new vouchers available. The Administration's recently released 2005 budget proposal cuts funding for the Section 8/Housing Choice program by \$1.7 billion per year nationwide. If adopted, this could cause 250,000 poor households to lose their housing subsidies and be threatened with homelessness. As ending chronic homelessness has been identified as a federal priority, it is anticipated that in the near future the federal government will reverse this proposal and will instead provide states and localities with additional Section 8/Housing Choice vouchers, the most essential and effective tool for ending homelessness.

⁴³ For more information on the Massachusetts ISSI and other similar programs, go to http://www.state.ma.us/dhcd/publications/HOW_TO2K2.HTM#ISSI

either earn adequate income to remain housed or be provided a Section 8/Housing Choice voucher.

Housing Preservation - Affordable housing will be preserved through two new efforts:

- c. **Monitor the stock of all existing affordable housing units to encourage one-for-one replacement of any publicly-subsidized housing units that are lost to demolition or redevelopment.**
- d. **Prioritize funding for small cash grants or loans to private landlords to pay for minor repairs in return for making housing units available and affordable to homeless or at-risk households.** Link to a new employment training program that teaches construction skills to homeless and formerly homeless people.⁴⁴

New Housing Development - New affordable units will be developed as needed:

- e. **Develop new affordable housing units through new construction, acquisition and major rehabilitation,** using the following resources:
 - The 10% of Tennessee’s allocation of the federal Low Income Housing Tax Credit earmarked for people with special needs
 - The 10% of Tennessee’s allocation of federal HOME dollars earmarked for people with special needs
 - The 15% of Tennessee’s allocation of federal HOME dollars earmarked for Community Housing Development Organizations
 - The federal 811, 202, 221(d) and 236 housing development programs
 - The federal Community Development Block Grant (CDBG) allocation to the Chattanooga region
 - Grants and discounted loans from the Federal Home Loan Bank of Cincinnati⁴⁵
 - Federal HOME and CDBG funding allocated to the City of Chattanooga, as well as annual program income from prior investments of these funds. In addition, the Chattanooga Housing Authority has bonding authority and the City will soon establish a \$1 million Community Development Loan Pool for housing and economic development. These resources fund an array of important affordable housing programs; the City will continue to invest these funds in affordable housing, while exploring the creation of a preference for projects that include supportive housing units.

⁴⁴ The associated training program will be modeled on the successful “Youthbuild” employment training program for youth managed by the Chattanooga Housing Authority.

⁴⁵ Annually, 10% of Federal Home Loan Bank profits are allocated to loans and grants for affordable housing development for low-income and special needs populations. This funding amounts to about \$20 million per year invested in affordable housing in the Federal Home Loan Bank region that includes Tennessee and neighboring states.

RECOMMENDATION #2:
Facilitate housing placements

Even when homeless people are able to earn or otherwise secure an adequate income, they still encounter barriers to obtaining appropriate housing. Inconsistent rental histories, bad credit, criminal backgrounds, unattractive personal appearance, the stigma of homelessness, HIV/AIDS and physical disabilities, and other associated issues can dissuade prospective landlords from renting to homeless, at-risk and formerly homeless people. Many of these barriers also hinder homeless and formerly homeless people's efforts to secure employment.

Discrimination against individuals and families solely because they are homeless or formerly homeless must be vigorously opposed. Homelessness is a temporary (if sometimes persistent) condition, not a defining trait. Similarly, the population of homeless, formerly homeless and at-risk people contains a high percentage of persons who belong to other marginalized groups. They sometimes encounter discrimination based on race, HIV/AIDS status, age, mental illness and physical disabilities. This discrimination can prevent homeless people from renting permanent housing or obtaining employment, and makes at-risk households vulnerable to losing the housing or employment they currently have.

In some cases, however, landlords' reservations are not discriminatory and are sometimes well-founded: many homeless people need ongoing supportive services in addition to rental subsidies to succeed in permanent housing. Without these services, homeless individuals and families placed into permanent housing are much more likely to miss rent payments, damage apartments, disturb neighbors or resume behaviors that can cause them to become homeless again. Certainly, without the promise of ongoing social and financial support, few landlords will take a chance on renting their housing to homeless people.

Placements of homeless families and individuals into permanent housing will be facilitated through the following strategies:

- a. **Establish a centralized housing assistance office that will locate vacant housing units, identify prospective tenants and coordinate placements into permanent housing.** This office will be administered by the Chattanooga Housing Authority (CHA), overseen by a paid full-time supervisor and staffed by volunteers recruited from faith-based communities, housing authority residents and senior citizens, as well as homeless and formerly homeless interns receiving stipends.⁴⁶

Services provided by the office will include:

⁴⁶ The proposed housing assistance office will be informed by other similar, successful efforts such as the Housing Support Center in Philadelphia, Pennsylvania and the HomeStart program in Boston, Massachusetts.

- A housing locator and listing service to help homeless and at-risk individuals and families find affordable and appropriate housing units from private landlords, affordable housing developers and public housing
- The use of case management assessments of prospective tenants to ensure that housing is appropriate to the needs of the tenant and the landlord
- The ability to refer clients for cash grants for utility and rent deposits, first months' rent and moving expenses
- Access to other available subsidies and supportive services
- Formal linkages with State and local agencies that administer entitlements and other assistance in order to expedite placements
- Personal advocacy with landlords to expand homeless people's access to housing and protect them from discrimination based on their homelessness, mental and physical disabilities, HIV/AIDS status, race and other prejudice
- Follow-up with landlords and tenants to ensure that both are meeting terms of lease, as well as mediation services to resolve problems.

b. Explore ways to prioritize homeless people for placement into subsidized permanent housing, including the possible establishment of a “preference” for homeless applicants for public housing and Housing Choice vouchers. Populations that could be prioritized include homeless people who have successfully completed substance abuse treatment or who are discharged to homelessness from institutional care. Recipients of these vouchers would be linked to appropriate, ongoing supportive services.

Five years ago, **Bobby Slocumb's** life hung in the balance. He was smoking crack when the police raided the house he was in. "I was staring right into the barrel of a policeman's gun. I thought, I'm going to die in a crackhouse. And all my family is going to go to my funeral, knowing I died in a crackhouse."

Bobby didn't die that night. Instead he went to prison for a year. Upon release, he swore he wouldn't go back to a life of addiction. But it wasn't so easy. Homeless, with no job prospects and a lengthy criminal record related to his longtime drug abuse, Bobby started to think it was just a matter of time before he ended back in prison. That was when he was approached by a worker from the Victory In Progress (VIP) outpatient substance abuse treatment program located at the East 11th Street multi-service complex.

Bobby signed up for VIP, and soon he was living at St. Matthew's shelter, clean and sober. Upon graduation from VIP, he enrolled in the co-located Homeless Employment Life Skills II (HELP II) program, a job training and supportive service program for homeless people. With HELP II, Bobby began working at the Chattanooga Community Kitchen's recycling department 20 hours a week. "Now THAT was a crappy job," he smiles. "But I knew if I could just keep doing it, one day at a time, I could crawl back out of this hole I was in."

And crawl back he did. After a few months, Bobby was promoted to a full-time warehouse job at the Kitchen. In 2002, he graduated from HELP II and moved into his own apartment. HELP II assisted Bobby with the rent deposit, household furnishings and furniture, but his move was delayed while he saved up enough money to pay for the required utility deposits.

Soon, he was promoted again to Assistance Maintenance person. Within a year, he had become the Maintenance Supervisor at the Kitchen. He is planning to get married and, with the help of a subsidized mortgage for first-time homeowners, he and his future wife have just bought a house.

After a life of drugs and crime, Bobby is extremely proud of his accomplishments over the last five years. He'll share his story with any of the Kitchen's homeless clients he thinks can benefit from hearing it. In his mind, his success is due to his own determination, but also because the service programs and supports were available to him right when he needed them most. He knows he now stands as a symbol of what can be achieved, even as he realizes there aren't enough treatment slots or jobs at the Kitchen available to everyone who needs one. But he'll soldier on. His favorite reply to any problem can be heard most every day around the Kitchen, "No excuses, buddy, it can be done."

B. Increase Access to Services and Supports

Chattanooga's present system of homeless services and shelters has had great success assisting motivated homeless people to get the help they need to return to permanent housing. But many homeless people are not "motivated." They are often distrusting, depressed and discouraged. They may require more social service support before they are motivated to work toward housing, sobriety, employment and other hallmarks of social stability. They have been promised help many times before, and have often failed or been failed. They require a more intense level of engagement.

The current structure of services has little capacity to engage and serve homeless people with more complicated service needs. For a number of reasons, the outreach, case management and other supports necessary to reach them are not currently available:

- The high caseloads of case managers and outreach workers make it difficult to spend the time necessary to engage members of this group.
- There are few places or opportunities for developing in-depth, lasting therapeutic relationships.
- Case managers have little access to the subsidies and community-based services and supports necessary for difficult-to-reach homeless people to succeed in housing.
- Many workers serving homeless people struggle to keep informed and up to date on resources and procedures.

All too often, workers on the front lines are reduced to helping people survive homeless, rather than helping them to become housed once again. To assist homeless people with more complicated service needs to return to housing, we will need to make an investment in case management: to increase coverage, reduce caseloads, improve training and supervision. Investments in the tools case managers need to operate effectively – access to shelter beds, transportation, psychiatric evaluations, rent subsidies and petty cash, to name just a few – will also be required.

Increasing Residential Stability is Cost-Effective

This investment will pay off for Chattanooga. The homeless people who are not receiving the services they need are precisely those who cost the public the most in emergency spending, whether for medical or psychiatric care, or incarceration and other emergency expenses. They need to be prioritized for services. For this group, engagement and transitional services alone will not be enough. Permanent housing that will accept them must be more readily available as well. In addition, they will require community-based services and financial supports to ensure that they remain stably housed.

At the same time, homeless people who are already motivated to address their mental health and substance abuse issues must continue to be served. They must be assisted to move to permanent housing more quickly, in order to free up precious space in

transitional housing programs. Once there, they too must be able to gain access to the supportive services they need to remain housed, employed and stable.

Homeless people's access to services and supports can be increased by investing in and reconfiguring case management to emphasize individuals' participation in service plans and rapid placement into permanent housing. Coordinating street outreach efforts with case management will also help move people into housing more quickly. Improved case management will also facilitate formerly homeless people's linkages to mainstream resources like day care, medical care, job training and placement and other activities. The provision of ongoing, community-based supportive services to formerly homeless people in permanent housing will help expedite placements and increase their chances for success.

RECOMMENDATION #3:

Reconfigure case management to be assertive, coordinated and focused on placing and maintaining homeless people in permanent housing. Prioritize funding both for 1) case management to homeless people and 2) continuing case management and supportive services to formerly homeless people placed in permanent housing.

Case management services help people who are homeless or disabled get access to the services and supports they need to live fulfilling lives in the community. It is the cornerstone of any effort to end, reduce or prevent the recurrence of homelessness.

Case managers work on an ongoing, regular basis with clients in their homes and neighborhoods to develop and implement individualized service plans. Service plans for homeless people usually focus on obtaining housing, treatment and employment. Case management of formerly homeless people who have been housed typically focuses on maintaining sobriety and psychiatric, social and economic stability, with an emphasis on employment and other meaningful activities.

The case manager helps clients accomplish the steps necessary to achieve their goals, advocating on their behalf to various systems, providing advice and offering personalized, flexible support. Often, case management is accompanied by a seamless array of other services, such as money management, job training, instruction in the skills of daily living, counseling and other financial and social service supports. Good case management ensures that people are linked to the programs they need, when they need them.

There are a number of case managers serving homeless and disabled people in the Chattanooga region. Some, paid through TennCare, provide an average of three contacts a month. This level of supportive services is adequate for many stably housed people with disabilities. But many agencies find it a challenge to serve people destabilized by homelessness without providing more intensive care at more frequent intervals.

Other case managers focus specifically on serving homeless people. Transitional housing programs provide case management as part of a menu of services and supports focused on employment and housing. Volunteers in faith-based programs often perform many of the same duties as case managers. Case managers at the Homeless Health Care Center and Community Kitchen are forced to spend most of their time on crisis intervention. They must contend with so many requests for assistance that it is difficult to provide ongoing case management with clear service plans and manageable caseloads.

Most case managers are energetic, resourceful and knowledgeable about the local services and supports available to their clients. But every case manager has gaps in expertise, and many work without knowledge of other systems, agencies and services that could help their clients. Other case managers need additional training on counseling homeless people and on issues of housing and employment.

Case management can be reconfigured and coordinated to be more responsive to homeless people by taking steps to improve and expand coverage, and by providing additional tools and resources to support case managers' activities. Recommendations include:

Improve and Expand Case Management

- a. Prioritize funding for case management and supportive services to homeless and formerly homeless people.** A variety of existing funding sources will prioritize case management activities, supplemented by TennCare and additional funding as it becomes available. This will allow nonprofit and faith-based agencies serving homeless people to choose to hire more case managers, lower caseloads, provide additional supervision and/or increase salaries to attract and retain effective employees. Agencies can also use funds to provide case management and supportive services to formerly homeless people placed into permanent housing. Some agencies may choose to assign the same case manager to continue providing services and supports before and after placement into housing.

- b. Appoint a Case Management Coordinator and establish a Training, Resources and Practices committee for guiding and coordinating case management provision.** The committee will be comprised of representatives from nonprofit and faith-based case management providers, including supervisors and frontline case managers, as well as representatives from government agencies serving homeless and formerly homeless people. A full-time Case Management Coordinator will lead the committee. Under the Coordinator's leadership, the committee will oversee the coordination of case management activities for homeless people. The Committee will review standards, share best practices, oversee training activities, identify new resources and jointly review model cases. The Committee will also provide a forum for establishing confidentiality standards, operating procedures and safeguards to maximize use of the Service

Point homeless management information system. The Committee will advocate as a group for the interests of case managers and their clients.

- c. **Develop and implement a system-wide standards and training program for case management to homeless and formerly homeless people.** Link to other training and licensing programs. Include training in local resources and procedures, including expedited entitlements application procedures. Establish clear guidelines for designing case management service plans with measurable milestones.
- d. **Reduce average length of stay: use increased case management capacity to move homeless families and individuals through emergency shelter and transitional housing programs more quickly.** With additional case management support, transitional housing programs can accept more challenging residents from emergency shelters. With more affordable housing units available to homeless people, residents of transitional housing programs can move into permanent housing more quickly, as long as they continue to receive the support they need. This support can be delivered either by a new case manager or by allowing the transitional housing program to fund their case managers to follow up with the formerly homeless households they placed. Formerly homeless clients may receive financial and other incentives to maintain regular contact with case managers.

Create Additional Tools and Resources for Case Managers

- e. **Establish a four-month to two-year rental subsidy that will help employable homeless people to move into permanent housing immediately.** The rental subsidy will be linked with intensive job search activities, relapse-tolerant outpatient treatment (if necessary) and other case management supports. In some cases, the subsidy, or some part of it, will take the form of a loan, in order to stretch scarce dollars further.
- f. **Create permanent supportive housing for formerly homeless or at-risk youth.** This program will provide case management and supportive services focused on employment and independent living skills. The services will be more intensive and comprehensive than in most case management models. They will offer supportive services designed to address issues facing youth and delivered on-site in the housing. These will include money management, household management, cooking and shopping, job training, educational support, counseling and other services.
- g. **Solicit additional private funding and in-kind donations for flexible use by case managers for client moving costs, rents and deposits, back rent and other expenses associated with moving into permanent housing and other goals of case management service plans.** They will be made available to clients

of approved nonprofit and faith-based agencies for any use that expedites placement into permanent housing.

- h. Support case management with links to other specialized services, such as money management, representative payee arrangements, credit counseling and budgeting assistance, medication management, legal services, job development and placement, and other programs.** Nonprofit, faith-based and government agencies alike, from the Partnership for Families, Children and Adults to the Chattanooga Housing Authority, offer a range of supportive and specialized services that promote household stability among a variety of populations. Some of these services may need to be expanded to meet increased demand.

RECOMMENDATION #4:

Improve the effectiveness of outreach and engagement of homeless people living in public spaces.

Most homeless people who reside in public spaces have mental illness, substance abuse and other barriers to living independently in housing. They have rejected or have been failed by the systems of care intended to assist them. To help members of this group get off the streets and back into permanent housing, it is usually necessary first for outreach workers to reach out and engage them into trusting relationships. Outreach workers must be willing to meet homeless individuals where they live and on terms in which the clients have some control.

Outreach workers' success in engaging homeless individuals in public spaces depends on two things: 1) having the time to build trust and continuity with their clients; and 2) being able to respond quickly to the needs identified by clients. Once the outreach worker can prove that he or she will advocate for the client and can produce results, the homeless individual usually becomes more willing to cooperate with more ambitious goals, such as entry into shelter, treatment and ultimately, permanent housing.

Chattanooga has a handful of outreach workers working out of different programs who are charged with engaging homeless people in public spaces. Despite their dedication and considerable skills, these outreach workers currently have little to offer their clients that will encourage and allow them to move toward treatment and housing. For example:

- There are few emergency shelter beds available to homeless people coming right off the streets; none if the individual is mentally ill and unmedicated, or actively abusing alcohol or drugs.
- Direct placement directly into permanent housing with supportive services is similarly unavailable.
- There are no places for homeless people to go during the day where they can feel safe and be engaged into conversation and service plans.

- Even compliant individuals can wait days or weeks before they can get a shelter bed, and weeks or months for placement into a transitional housing program.

The delays caused by these issues regularly frustrate outreach efforts, as already reluctant or skeptical clients change their minds about entering treatment or shelter while waiting for program space to become available.

As a result, outreach workers are limited predominantly to providing food, clothing, blankets and referrals to medical and, sometimes, psychiatric care. This assistance addresses real emergencies and allows outreach workers to engage homeless individuals into therapeutic relationships. But with no shelter beds, treatment slots or housing immediately available, this assistance often does little more than facilitate homeless people’s ability to continue living on the streets.

Outreach and engagement of homeless people living in Chattanooga’s public spaces can be improved by reconfiguring existing outreach efforts into an integrated, client-centered system that focuses on placing homeless people into treatment and housing. To be successful, outreach activities must be seamlessly coordinated with case management, so that homeless people are not handed off from one worker to another and forced to endure repeated assessments. By providing outreach workers with a few additional tools and housing options, they can become much more effective at realizing their original goal: to reduce street homelessness.

Improving the effectiveness of outreach and engagement will require improved coordination and training. More importantly, outreach workers need to have quick access to shelters and housing in which they can place newly engaged homeless people. Finally, outreach workers need new tools that will expedite the placement process. These three strategies can be implemented through the following recommendations:

Coordinate Outreach

- Redeploy and coordinate existing outreach staff to focus outreach and case management activities on helping homeless people living in public spaces gain quick access to treatment, housing and employment.** While additional case management staff is desperately needed, there are probably enough outreach workers to meet current street outreach needs in Chattanooga (outreach needs in other areas in the region will be studied). But to be effective, street outreach must be backed up by a swift and seamless intake procedure, with immediate access to crisis intervention services and psychiatric evaluations. Outreach workers will continue to provide crisis intervention services and carry small caseloads (no more than five to ten clients per worker) of engaged clients who are attempting to follow treatment and housing service plans. Outreach will be closely coordinated with additional case management staff, allowing outreach workers to “hand off” engaged clients to case managers who will provide ongoing support.
- Evaluate outreach staff’s training and supervision needs, hours of employment and pay scales.** Ensure that outreach staff is familiar with all

available service and housing resources and applications procedures. Train staff on outreach techniques for engaging different homeless populations, including runaway youth and people with substance abuse and mental health issues.

- c. **Coordinate outreach efforts with police.** Build on the successful HELP III (Homeless Educating Local Police) cross-training modules, which train police officers on how to work with homeless people and providers. Provide police with information on available resources so that they can make referrals to appropriate services and shelter. Outreach workers will work with police to ensure that residents of disrupted encampments receive priority placements into shelter, treatment or housing. Abandoned encampments will be cleaned up and monitored so that they are not re-inhabited.
- d. **Redirect mobile soup kitchen programs so that they do not further enable homeless people to remain living on the streets or public spaces.** While distributing food to homeless people living in public spaces meets an immediate need and may help to engage individuals, it also can form part of a network of supports that makes it easier for people to continue being homeless. Food distribution will be redirected to shelter populations or linked to outreach efforts focused on helping people move into shelter and housing.

Improve Access to Shelter and Housing

- e. **Establish a drop-in center that provides a safe place for homeless people to go during the day.** Outreach workers will have a place they can bring homeless people to continue the engagement and placement process. The drop-in center can provide a base for case management services, counseling, psychiatric evaluation and care, medication and money management, as well as recreational activities and other forums for engaging homeless people into services and housing.
- f. **Prioritize funding for security and additional social services staff to allow two existing emergency shelters to accept unaccompanied homeless single adults directly from the streets.** With these additional resources, two shelters will be able to accept more readily individuals living in public spaces who are engaged by outreach workers. The shelters will have the capacity to serve a clientele with a wider variety of needs, including individuals with active substance abuse and mental health issues. The shelter social service staff will immediately assess new referrals, provide days or weeks of shelter, then quickly place them into appropriate transitional or permanent housing.
- g. **Seek federal funding to re-establish a Transitional Living Program (TLP) for homeless and runaway youth.** A successful transitional living program that provided shelter and flexible supportive services for homeless and runaway youth was closed in 2002 when it lost federal funding to other priorities. This program filled a critical gap for a vulnerable population by providing a readily accessible

safe haven for homeless and runaway youth. Funding will be sought to create a transitional living program that will once again fill this need. A new program will replicate evidence-based practices identified by the federal Interagency Council on Homelessness and the Department of Health and Human Services in an upcoming joint report on promising strategies to end youth homelessness

- h. **Increase access to permanent housing for homeless people living in public spaces.** Through a new program begun in March 2004 and funded through the federal Collaborative Grant to Help End Chronic Homelessness, chronically homeless people with disabilities will soon have access to 50 permanent housing units supported with intensive case management and wrap-around medical, psychiatric and social services. Additional permanent housing units supported with services will need to be made available to this population to meet future needs. *For more on Chattanooga's Collaborative Grant, see Appendix C.*

Expedite Placements

- i. **Expand and expedite homeless people's access to psychiatric evaluations, prescription medications and dentistry.** Homeless people need better access to psychiatric evaluations (including evaluations for substance abuse), medication (especially psychotropic drugs) and dental care. Some of these services may be supplemented with volunteer efforts and philanthropy. Psychiatric services need to be particularly responsive to outreach workers, case managers and homeless people living in public spaces.
- j. **Work with the Tennessee Department of Human Services to expedite the entitlement applications of homeless people, especially those living in public spaces.** This may include the creation of a temporary identification card or computer ID file accessible through Service Point. Obtaining TennCare medical insurance quickly is especially important for homeless people with disabilities.
- k. **Create a fund to help transient homeless people from outside the Southeast Tennessee region return to stable placements in their home communities.** Outreach workers and case managers will have access to the fund to pay transportation costs for people who can prove they have an appropriate place in transitional or permanent housing waiting for them.

RECOMMENDATION #5:

Link homeless and formerly homeless people to mainstream services and resources.

Homelessness first became commonplace in the 1980s because low-income people with mental illness were no longer able to get access to the care and support they needed from the mainstream mental health system that had formerly served them. As the mental health system was transformed from a system primarily based in institutions to one based

in the community, some former inpatients who needed additional financial and social services support “fell through the cracks” and became homeless.

During the rush to respond to the new homeless crisis, the fiscally-strapped mental health system (still struggling to learn how to deliver services in the community) ceded responsibility to more responsive nonprofit organizations using new federal funding streams created specifically for homeless people. In this manner, an entire parallel system of mental health, substance abuse, health care and employment services targeted to homeless people was created over the past twenty years. This system is effective at answering homeless people’s emergency needs, but its very effectiveness has allowed mainstream systems to pull back even more from serving homeless people. Today, people become homeless both because mainstream supports have disappeared and because they can only gain access to the services they need in the homeless system.

In the past few years, homeless shelter and service systems have begun attempting to connect their clients back to the mainstream systems traditionally responsible for their care. This transformation has been encouraged and facilitated by the federal government. It is hoped that by doing so, the greater resources of the mainstream systems of care can once again serve and house homeless people (without the stigma of operating separate programs for “the homeless”), while the homeless service system can free up resources for housing development and concentrate on serving the hardest-to-reach homeless individuals.

The Chattanooga region has identified a number of mainstream services and funding resources that can serve homeless people along with other low-income populations. To be successful, those mainstream systems and resources must be adequately funded to absorb homeless people into their care. With states and the federal government both continuing to face fiscal problems, it will be a challenge to transfer the care of homeless people into mainstream systems. Federal and state funding for affordable housing and substance abuse treatment are especially critical to this effort.

Homeless people will be linked to mainstream resources in the following ways:

- a. **Use Workforce Investment Act (WIA) funding and programs to train and place homeless and formerly homeless people into employment.** Homeless people will be supported by additional case management so that they can participate in WIA-funded programs. Conversely, Workforce Investment Act programs will need to be more responsive to homeless people’s needs. To help facilitate the mainstreaming of homeless people into WIA programs, representatives of the homeless services community will sit on the Hamilton County Workforce Investment Board.
- b. **Create job opportunities for homeless and formerly homeless individuals.** Programs for homeless people offer many entry-level job opportunities. Openings in suitable employment positions within programs serving homeless people will be made more accessible to them. In addition, small business

- opportunities such as a copy shop, delivery service, demolition and construction and other services can also be piloted as supportive work environments to give formerly homeless people with no work histories a chance at employment.
- c. **Improve homeless people's access to transportation and day care.** These are two essential elements for a successful employment placement. Yet they are often barriers to people attempting to escape homelessness. The City will explore ways to make these two systems more responsive to the needs of homeless people.
 - d. **Transfer to other federal funding streams some substance abuse, mental health and other service programs for homeless people that are currently funded with federal McKinney-Vento Homeless Assistance Act/Continuum-of-Care homeless funds.** The McKinney Act, the primary federal funding stream for homeless services and housing, will provide \$1.76 million to fund various homeless service and housing programs in the Chattanooga region in 2004. However, many of these programs provide similar or identical services as programs paid for by other federal funding streams, including the Substance Abuse Block Grant, the Community Services Block Grant and the Mental Health Services Block Grant. We will work with the State and federal governments to find opportunities to use these other funding streams to pay for services, housing and programs for homeless people, thereby freeing up McKinney funds for new priorities and initiatives.
 - e. **Review the Chattanooga region's current array of inpatient and outpatient substance abuse treatment services to examine the adequacy of existing capacity, treatment modalities and aftercare supports.** The Chattanooga region has some effective substance abuse treatment programs. But capacity is limited and low-income homeless and housed people alike often wait weeks or months to be accepted into treatment. Medical detoxification is not readily available. Homeless people are particularly disadvantaged by the inability of outreach workers and case managers to place them immediately into treatment. When homeless people are able to gain access to treatment, many do not respond well to existing treatment modalities. A comprehensive review of the substance treatment system, undertaken jointly by treatment providers and the programs that rely on them, will help identify service gaps and strategies to address those gaps.
 - f. **Expedite enrollment of homeless and formerly homeless families and individuals into TennCare and Food Stamps.** In 2003, 83% of people receiving medical services at the Homeless Health Care Center did not have health insurance, even though 91% had incomes equal to or below the poverty rate.⁴⁷ The lack of TennCare coverage means that the County and federal government pay much of the costs associated with medical and psychiatric care. Creating a process that expedites TennCare, Food Stamps and other entitlement applications for homeless and at-risk households will increase successful placements.

⁴⁷ Homeless Health Care Center 2003 preliminary statistical report.

- g. **Develop a plan and implementation strategy to expand homeless and formerly homeless people’s access to Veterans Administration services.** At present, homeless veterans have difficulty securing timely treatment and assistance from the VA. Access to VA services is an issue for many veterans in the Chattanooga region, as the nearest full-service VA healthcare facility is located in Murfreesboro. Providers serving homeless veterans will work with the VA clinic in Chattanooga to identify and implement ways to make its services more accessible to homeless people, especially substance abuse treatment and psychiatric services.
- h. **Improve homeless, at-risk and runaway youth’s access to family counseling and other supports.** Helping to strengthen intra-family relationships is particularly important as a homelessness prevention strategy. Efforts will be made to link homeless youth to all services and supports available to them.

When Cassie Reynolds smiles, it just breaks your heart. At just four months old she's small for her age, but her grip is strong. The day after she was born, she and her mother Vivian were discharged from the hospital – to the streets.

Without any coordination between hospital social workers and case managers serving homeless people in the community, Cassie, Vivian and her on-and-off boyfriend Kevin (Cassie's father) became another tale of homeless hospital discharges who "fall through the cracks." The family spent the first days of Cassie's life living under a tarp by the river, with Cassie in a baby carriage covered in plastic bags to keep her warm.

This makeshift family found their way to the Community Kitchen, where workers quickly prioritized them for beds in the Interfaith Hospitality Network, a volunteer shelter program that rotates homeless families between houses of worship in Chattanooga. But Cassie's future is anything but secure. Her father comes and goes. Sometimes he tries to work, other times he just disappears for awhile. When he returns, he's broke and apparently nursing a hangover.

Her mother Vivian gets frustrated. She's bored and angry hanging out at the Kitchen all day. Developmentally disabled, she doesn't have the skills she needs to take care of Cassie on her own. She's already proven that by losing five previous children to foster care or death. Vivian will often ask the staff to watch Cassie while she goes outside to chain smoke or visit other people. If Cassie is asleep, Vivian often just leaves her in her basket on the floor of the dining area.

Of course, Cassie should not have had to spend the first days of her life on the streets. However, there was no medical justification for keeping her and her mother hospitalized, and the hospital social worker could not find a temporary placement where they could go in the brief time they were at the hospital. The week the family spent homeless was terrible and unnecessary, but perhaps inevitable: there are no beds immediately available for homeless people discharged from acute hospitals who no longer require hospitalization but still need support and some medical care. Moreover, at present, coordination between hospital social workers and case managers serving homeless people is intermittent and inadequate.

Cassie starts life with a host of challenges in front of her, though she won't face them alone. The entire team of Interfaith Hospitality volunteers, Community Kitchen case managers and Homeless Health Care Center health professionals are all working together to look out for her. They will try their best to get Vivian and Kevin into the transitional programs they need to develop a more stable household life for Cassie. With all of their help and support, and no small measure of good fortune, maybe the arrival of Cassie will be the event that helps end her family's cycle of homelessness.

C. Prevent Homelessness

For years, most localities have focused the majority of their resources on interventions that help people only after they become homeless. Certainly, people experiencing housing emergencies need assistance. But it costs far more to shelter, treat and re-house a family or individual after they become homeless than it costs to help them avoid becoming homeless in the first place. Moreover, the disruption caused by a homeless episode can have long-lasting consequences, especially for children's health and educational achievement that require additional public spending far into the future. Preventing homelessness before it happens can save public dollars as well as lives.

Area Residents At Risk for Homelessness

According to the 2000 United States Census, 12.1% of Hamilton County residents, or 36,308 individuals, live below the poverty line. These numbers put Hamilton County slightly below the 2000 national poverty rate of 12.4%, although many other counties in the Southeast Tennessee region have higher rates. National and local poverty rates have since risen as a result of the recession begun in March 2000, adding to the number of people living in poverty in the Chattanooga region.⁴⁸ Tens of thousands of other people in Hamilton County live just above the poverty rate. Almost all of these impoverished and nearly impoverished individuals and families are at risk for homelessness.

Yet many poor households in the Chattanooga region do not receive Food Stamps, TennCare, Section 8 rent subsidies and other financial supports that could help keep them stable. Others require financial and social service assistance on an emergency basis – sometimes repeatedly – to remain stable in housing. Some require ongoing case management support to stay housed. Others need better access to outpatient substance abuse treatment and support. These types of assistance are not consistently available to many households at risk of homelessness.

Institutional Discharges and Homelessness

Similarly, homeless people leaving hospitals, psychiatric facilities, incarcerations and other institutional care are often stabilized during their stays, only to be released to a lack of supports in the community and often, homelessness. They are at high risk of becoming psychiatrically, medically and socially unstable and returning to institutional care, often to repeat the cycle again. These persons need community-based supports to help make the transition from institutional care to permanent housing, both in the first critical days after discharge or re-entry, and on an ongoing basis in the months and years thereafter.

It makes good sense to stop homelessness before it happens whenever possible, to save money and save lives. A growing literature on best practices for preventing homelessness show how earlier interventions increase opportunities for successful interventions. When housed families and individuals are threatened with homelessness, interventions should concentrate on keeping them housed. When homeless individuals

⁴⁸ United States Census 2000.

are institutionalized, hospitalized or otherwise treated, they should not be allowed to become or remain homeless when treatment is completed.

RECOMMENDATION #6:

Establish a system for identifying families and individuals at risk of homelessness

In most cases, low-income families and individuals enter emergency shelter or end up living in public spaces only after a long struggle to remain housed. The vast majority of homeless people first exhaust their savings and sell possessions, then turn to family and friends for assistance, before applying to charitable, faith-based and publicly-funded organizations for shelter. They are in crisis long before they actually become homeless.

By identifying as early as possible at-risk families and individuals whose housing situations are deteriorating— before they suffer full-blown housing emergencies – we can minimize both the disruption they experience and the costs of assisting them.

There are a number of opportunities for early identification of households at risk for homelessness. Before they become homeless, at-risk households often turn for help to religious congregations, the United Way 2-1-1 emergency call-in service (formerly “First Call for Help”), the County or City Departments of Social Services, or the State Department of Human Services. They usually request food packages, emergency cash assistance, or help with entitlements, healthcare or other bureaucratic problems before they request shelter. They may be late paying rent, or threatened with eviction.

Most households facing the immediate or eventual threat of homelessness can be identified and assisted at any one of these junctures. An effective intervention will specifically address housing along with other needs. Followed up with an appropriate level of case management support, these early interventions can make the difference between becoming homeless or staying housed.

It is important to acknowledge that it can be difficult to identify families and individuals who are truly at risk of homelessness. Even the most targeted prevention programs inadvertently help some households who would have remained housed without assistance (although these households may become more stable and receive other benefits from the intervention). Households most likely to become homeless can be better recognized by identifying the specific risk factors most closely associated with homelessness, such as prior homeless episodes, young single mothers with a second pregnancy or child, substance abuse, mental illness and histories of incarceration or institutional care, among other issues.

In addition, prevention assistance that provides particularly attractive interventions (for instance, access to Housing Choice rent subsidy vouchers) can offer a perverse incentive for otherwise stable households to declare themselves at risk. Efforts at preventing

homelessness must ensure that the households most at risk of homelessness are not crowded out by relatively stable households more aggressive at seeking assistance.

A system to identify and link at-risk households to housing and other assistance will allow the United Way 2-1-1 system, DHS, the Departments of Social Services, housing authorities, nonprofit providers and faith-based groups to coordinate their efforts through the Service Point Homeless Management Information System. Such a system will:

- **Track people’s movement through different systems of care and their use of various forms of assistance, allowing better coordination of services**
- **Identify early predictors of homelessness and opportunities for preventive interventions**
- **Evaluate the effectiveness and cost-effectiveness of different interventions**
- **Use shelter and service use data and information on last place of residence to identify neighborhoods, blocks and even buildings that regularly produce high numbers of homeless people**
- **Design and enforce eligibility criteria and safeguards to ensure that interventions target households truly in need of housing assistance.**

The new homelessness prevention system will allow households to be identified as at-risk of homelessness soon after they first turn to what will now be a network of community-based supports available to them through public, nonprofit and faith-based resources. Early identification and monitoring will provide additional time for interventions and improve the entire network’s ability to prevent and respond effectively to housing emergencies. It will also reduce the need for emergency shelter and services.

RECOMMENDATION #7:

Help at-risk households remain stably housed by providing emergency assistance, maximizing their incomes and improving access to supportive services.

Early identifications of at-risk households will reduce homelessness only if they are quickly followed up with effective interventions to help these households stay housed. In some cases, emergency interventions will need to be followed up with ongoing case management and supportive services, both to ensure continued access to supports and to ensure the participation of some households who may initially refuse services. Preventive interventions to help at-risk households remain stable will focus on three assistance strategies:

- a. **Expand the availability of emergency assistance to prevent financial and personal emergencies from becoming destabilizing crises.** At present, households facing financial and personal emergencies call the United Way 2-1-1 emergency call-in service (formerly “First Call for Help”), turn to local congregations or apply for emergency assistance from the Chattanooga or

Hamilton County Departments of Social Services. These already effective services will be improved through these steps:

- Coordinate all frontline emergency assistance programs with United Way 2-1-1 and each other in order to make them more immediately accessible to households in need.
- Strengthen linkages and offer cross-training between frontline emergency assistance programs and service resources available in the community, such as counseling, training in basic household maintenance skills, employment training and job search activities, treatment, legal assistance, child care, transportation and other services.
- Increase the funding for and availability of emergency financial assistance, using additional resources from government, private philanthropy and faith-based communities.
- Identify and eliminate barriers to at-risk households' access to services and financial supports.

b. Reduce the gap between poor people's rents and incomes, by expediting and expanding access to subsidies, entitlements and employment. Many families and individuals who apply for emergency financial assistance face an ongoing imbalance between their housing costs and incomes. Currently, the Chattanooga Housing Authority (CHA) provides public housing or rent subsidies to more than 2,000 families who report zero or almost no income. These households are required to pay a minimum rent of only \$25 per month, yet every month they comprise fully one-fifth of all eviction cases initiated by CHA.⁴⁹ These and other financially distressed households will be assisted to secure quickly all entitlements and subsidies that may be available to them, such as Food Stamps, TennCare, Families First cash assistance, SSI, rental subsidies and other supports. In some cases, the provision of emergency cash assistance will be tied to the recipient household's enrollment in these programs. In addition, heads of at-risk households will be assisted with enrollment in job training and job search activities.

c. Offer at-risk households ongoing case management and supportive services to address the underlying causes of instability. A one-time reliance on emergency assistance can be enough to help some at-risk households successfully stave off homelessness. But many at-risk households have multiple barriers to stability and will require ongoing assistance to remain stable. Households that make repeated requests for financial or social service assistance, or are otherwise identified as being at high risk for homelessness, will be assessed and linked to supportive services and case managers specializing in homelessness prevention. These case managers will provide ongoing support to at-risk households, helping them to secure entitlements, employment and treatment and gain access to other services that keep them stable in housing. Their efforts will be coordinated with

⁴⁹ Chattanooga Housing Authority, 2003.

supportive services operated by the Chattanooga Housing Authority and supported by an expansion of programs that teach budgeting, credit counseling and household management, as well as outpatient substance abuse treatment and support and other services needed by the households.

RECOMMENDATION #8:

Prevent people from becoming homeless when they leave institutional care, such as jail, prison, shelter, hospitalization, treatment and foster care, by developing permanent housing plans prior to release and establishing clear responsibility for their implementation in the community.

Low-income individuals leaving institutional care face an elevated risk of homelessness. As a result of initiatives undertaken by the State Department of Mental Health and Developmental Disabilities in recent years, the vast majority of individuals leaving psychiatric centers are successfully linked to places in permanent housing: in FY2003, less than 1% of discharges from Moccasin Bend resulted in homelessness. Nonetheless, this amounts to 50 to 100 discharges to homelessness per year of persons with severe and persistent mental illness in Hamilton County. Discharges to homelessness are more common from acute hospitals, prison and other institutions. Clearly, there is more that can be done to minimize instances of individuals released to inappropriate housing, or released without adequate supplies of medication, prescriptions or insurance coverage.

In some cases, discharged individuals' housing needs are not adequately addressed in their discharge plans. Or they may be ready for discharge or release before housing plans can be made. In other cases, responsibility for the successful implementation of discharge plans has not been clearly assigned. Sometimes recently discharged individuals require more intensive case management support than is now available in order to cooperate with and follow through on discharge plans.

Efforts to prevent homelessness must also look beyond community-based solutions to systemic reform. Some system-wide policies promulgated at the State and federal level adversely affect the Chattanooga region's ability to reduce and end homelessness. These policies achieve other worthy goals of the health, welfare, mental health and corrections systems; problems related to them reflect the sometimes conflicting missions of these systems when serving both homeless and mainstream populations. The Chattanooga region as a whole will work with State officials to review and in some cases reform administrative policies in order to increase housing placements and stability among homeless and at-risk populations.

To reduce the number of people who become homeless upon leaving institutional care, the following initiatives will be implemented:

- a. **Expedite entitlement applications for individuals leaving institutional care.** Every effort will be made to work with the Tennessee Department of Human Services (DHS) to expedite discharged individuals' applications for TennCare, Food Stamps and other entitlements so that they do not experience gaps in coverage that can cause medical, psychiatric or financial crises and homelessness.
- b. **Establish clear responsibility for implementing discharge plans in the community.** Often, institutions may develop a realistic discharge plan for an individual, but no community-based agency has been identified to implement the plan. Or there may be a gap of a few days before a discharged individual is linked to a community-based provider. In the critical days after discharge, such a gap can be the difference between a successful housing placement and homelessness. To ensure that the transition from institutional care to community living is successful, a referral system will be created so that a case manager from a community-based agency will be assigned to and will meet before or at discharge any individual deemed at risk of homelessness.
- c. **Establish a Community Discharge Coordination Committee to provide forums for homeless service providers and local hospitals and psychiatric facilities to share information, plan for and review discharges to the community.** The Community Discharge Coordination Committee will allow frontline staff of community-based service providers to homeless people to meet regularly with social work staffs of hospitals and psychiatric facilities to discuss future and past discharges. This will improve the capacity of these institutions and community-based providers to respond to the needs of low-income people leaving institutional care.
- d. **Provide access to “alternative level of care” transitional beds to provide a few days or weeks of respite care to disabled and medically frail individuals awaiting placement into permanent housing.** A small but significant number of disabled and medically-frail individuals need 24-hour assistance for a few days or weeks after discharge, while they recover or await housing placement. Yet they do not qualify for or require placement in skilled nursing care facilities, and existing shelters and transitional housing resources can not offer this level of care. It is necessary to provide access for this population to short-term transitional respite care beds, either in existing transitional housing or skilled nursing care facilities.
- e. **Provide interim transitional placements to provide a few days lodging to recently discharged individuals while they await placement in transitional programs or permanent housing.** Some recently discharged individuals cannot be immediately placed into permanent housing. Access to a handful of interim apartments can help providers keep recently discharged individuals stably housed for up to thirty days while they work to place them into permanent housing. These interim housing apartments can also be used to provide temporary shelter to

members of underserved populations who may be at risk in or unable to gain access to emergency shelters, such as the elderly, the gay-lesbian-transgender community, intact families and others.

- f. **Work with Tennessee Department of Corrections and the Hamilton County Jail to 1) facilitate recently released individuals' transitions from incarceration to community living and 2) divert people with mental illness from incarceration to alternative treatment arrangements.** Individuals are released from State and federal prisons with few supports in place. This greatly, and needlessly, increases their chances of failing in their community placements and returning to prison. Often, they do not have TennCare medical coverage upon release. And although they usually have histories of substance abuse, they are not linked to treatment or ongoing sobriety support. Chattanooga will work with the State and County Corrections departments to build on recent coordination efforts that have already been implemented. These efforts seek to improve recently released individuals' ability to make the transition to community living. New efforts will be made to increase information sharing between prisons and parole departments, securing entitlements before release, and helping recently released individuals to enroll in sobriety and employment programs as soon as they return to the community, rather than waiting for crises to occur. In addition, Chattanooga will work with the corrections departments to identify and divert from the criminal justice system and into treatment individuals with mental illness who are arrested for misdemeanors.
- g. **Ensure that youth leaving foster care are provided comprehensive support, services and housing for as long as necessary to achieve independence.** Participation in foster care is a strong predictor of future adult homelessness. Often, youth become homeless during the transition into independence between the ages of 18 to 21. Chattanooga will work with the State Department of Children's Services to increase the number of youth aging out of foster care who continue to receive case management, housing subsidies and employment training and placement assistance until they reach 21 years of age.

Joe Boykins is 60 years old and a hard worker. Fit and focused with no substance abuse problems or mental illness, he's got a sunny outlook and is exceedingly polite. Despite all of his positive attributes, however, Joe was homeless. After 20 years working at the same factory as a training supervisor in forklifts and heavy machinery, he lost his job when the factory closed. "I didn't plan it that way. I just got laid off, and there aren't that many people out there who want to hire a 60 year-old man."

Joe's luck changed unexpectedly as the result of the most basic kind of service coordination: providers talking among each other about challenging cases they couldn't solve. While efforts to coordinate services usually focus on management, service coordination must also include the workers at every level of the system.

Joe had been living in his car and working odd jobs for almost a year when he heard about a forum being held at the Chattanooga Community Kitchen, where he often got his meals. As part of The Blueprint process, some Blueprint Steering Committee members were meeting with homeless people to discuss the issue from a frontline point of view. Joe impressed everyone there with his analyses of the problems faced by homeless people in Chattanooga. Along with a number of the other participants, he was invited to a second public forum on homelessness, where he also contributed keen observations about the issue.

After the second public forum, in which over 100 providers, government administrators, area residents and homeless people participated, some of the participants who had met Joe inquired about how they might help him. "I just want a job," he replied. Soon, the phone calls and emails were flying among providers, government folks and volunteers, many of whom had never spoken with each other before, all looking to see if a position for Joe might be found.

Within a week, a part-time opening at the Chattanooga Food Bank warehouse was offered. Joe eagerly accepted. Three paychecks later, he went full-time and, with a lead provided by another forum participant, moved into a room with a weekly rent. "I'm really grateful for the help," he says. "All I ask for is a chance to earn my keep."

Certainly, Joe's hardworking attitude and steady demeanor made it possible for him to get off the streets. But it would have taken much longer if it hadn't been for the public forum that had brought together Joe and the people who helped him. By meeting together in one room, Joe and his case manager connected with a City employee, who spoke with a few providers, who knew of a possible employer, who in turn trusted their judgment and offered Joe a job.

And Joe wasn't the only person helped that day: a homeless family was placed in transitional housing as a result of the forum as well. In both cases, just having a forum in which they could connect allowed case managers, providers, employers and others to collaborate on a specific problem and solve it quickly. Even more important, the success of the placement established relationships among different agencies and workers that will continue to help homeless people return to housing for years to come.

D. Establish a Mechanism for Planning and Coordination

When homelessness first became widespread twenty years ago, the Chattanooga region's faith-based organizations led emergency efforts to provide shelter and feed indigent families and individuals. City government responded to the crisis by developing and subsidizing affordable housing for low-income households among other efforts. Hamilton County established the Chattanooga Homeless Health Care Center and funded other critical interventions. Various nonprofit organizations from around Southeast Tennessee used private funds to leverage State and federal dollars to provide services and housing to homeless people with special needs.

These disparate efforts have grown over the years. Many have become effective programs. As new needs were recognized, new services were developed to answer them. The homeless service center on 11th Street, Chattanooga Cares' health clinic and The Home Place, a transitional housing program for people living with AIDS, as well as the AIM Center's clubhouse and supportive housing programs are just some of the many successful examples of mature, comprehensive service programs providing an array of supports to Chattanooga's homeless, at-risk and formerly homeless residents.

Today, however, Chattanooga's homeless services community faces a host of challenges. Many efforts operate in isolation of one another. Some programs or services have expanded their scope so that they now duplicate other existing programs. Other programs would benefit from linkages to complementary providers but have little interaction with them. Many frontline case managers are unaware of services and resources that could help their clients. Some providers developing programs would benefit from the expertise of others who have faced the same challenges previously. Public and private funders often have difficulty evaluating the performance and mission of many of the programs they fund.

Creating a Coordinated System

The next stage in the evolution of Chattanooga's response to homelessness will require better coordination and more responsive management of a comprehensive *system* of services to at-risk, homeless and formerly homeless people. Government, nonprofit and faith-based agencies and organizations need a forum in which they can share ideas, coordinate efforts and plan for the future together as a united, but still diverse, body.

Advances in information technology comprise a key part of efforts to coordinate and manage the homeless service and housing system. As demonstrated by the information in Section VI, "Homelessness in Chattanooga Today," the Chattanooga region already has a strong homeless management information system in place. This system is considerably more advanced than in most localities of similar size.

Moving forward, this capacity must be further expanded to find out critical information on how homeless people use the region's system of emergency shelters, transitional housing and permanent housing. By more closely examining shelter use patterns, lengths of stay and client profiles, we will be able to identify and direct people to under-utilized

shelter beds and programs. By matching data from the homeless service system with data from the Corrections, Mental Health, Welfare and Health Care systems, we can identify the system junctures where people become homeless and develop policies and reforms to minimize these occurrences. By tracking housed people's use of emergency assistance programs, we can identify households facing an immediate risk of homelessness more accurately and earlier.⁵⁰

Attracting New Resources

Already, the process of developing *The Blueprint* has helped expand the region's capacity for attracting the funding necessary to end chronic homelessness in the Chattanooga region. Early meetings during *The Blueprint* planning process led a number of area providers to develop a successful joint proposal that was one of only thirteen projects funded nationwide under the competitive federal Collaborative Grant to Help End Chronic Homelessness.⁵¹

The focus on coordination also helped the Chattanooga region stabilize the amount of annual funding it receives from the federal McKinney/Continuum of Care homeless funding stream. In previous years, this amount fluctuated widely. This year, the Chattanooga Regional Homeless Coalition led the application effort with a new focus on collaboration between government and providers. As a result, the Chattanooga region received its largest McKinney/Continuum of Care award ever: \$1,757,000, or 75% more than the average award over the past four years. This included just under \$700,000 to create permanent, affordable supportive housing units in the counties surrounding Hamilton County.

By working together, all of the Chattanooga region's providers and administrators will become stronger and more effective. They will continue to operate independently, each with its own distinct organizational culture and mission. But they will have mechanisms that will allow them to collaborate with each other more readily, respond more nimbly to new demands and to share information, expertise and resources more quickly and responsively. The resulting network of services and housing will answer public and private funding sources' concerns about program performance and accountability, and position Chattanooga to pursue and obtain additional resources.

RECOMMENDATION #9:

Establish the Chattanooga Regional Interagency Council on Homelessness.

To improve coordination, *The Blueprint* proposes a new mechanism that will direct homeless service planning and implementation. Consistent with the management coordination strategies of the federal Interagency Council on Homelessness, the *Chattanooga Regional Interagency Council on Homelessness* will:

⁵⁰ All data matching and research activities must be structured to comply with all regulations and protocols protecting client confidentiality and privacy.

⁵¹ For more information on the Collaborative Grant, see Appendix C.

- Enhance government and nonprofit capacity to raise funds and attract additional resources to reduce and end homelessness.
- Expand capacity for data collection and analysis; establish baseline statistics on the extent and nature of homelessness; and set clear policy goals, timeframes and numerical targets for homelessness reduction
- Establish funding priorities for homelessness reduction efforts across agencies and systems
- Establish and maintain standards for shelters, service delivery and case management
- Increase collaboration between for-profit, governmental, nonprofit and faith-based agencies

The Chattanooga Regional Interagency Council on Homelessness will be a collaborative body that will guide homeless policy in the Southeast Tennessee region. It will include representatives from the following entities and stakeholder groups:

- Chattanooga City government (appointed by the City Mayor)
- Hamilton County government (appointed by the County Mayor)
- Tennessee State government (appointed by the Governor)
- United States Interagency Council on Homelessness (regional representative)
- Southeast Tennessee Development District
- The United Way of Greater Chattanooga
- A representative of the region's faith communities
- A homeless or formerly homeless person

The Chattanooga Regional Interagency Council on Homelessness will be supported by a second advisory body comprised of public, private, nonprofit and faith-based service and housing providers. The daily work of the *Council* will be done by an Executive Director hired by the group and an administrative assistant, supported by staff of the Chattanooga Regional Homeless Coalition. In addition, the Coordinator of Case Management (*see Recommendation #3*) will operate from this office, as will a grants application specialist.

The Council will allow City, County, State and federal governments to work in full partnership with each other and with nonprofit organizations, private foundations and faith-based providers. Although it will not have independent budgeting authority, it will review and approve the region's Continuum of Care application and have advisory powers on how certain County, City, federal and private funds are spent on homelessness.

And while it will not operate the Service Point Homeless Management Information System directly, it will have access to the aggregate data collected and will develop and publish performance reports from the Service Point database, as well as other sources of

information. Programs approved for funding from *The Council* will be required to report to the Service Point database.

The Council's mission will include:

- **Planning:** Propose funding, policy goals, timeframes and reduction targets related to homelessness. Ensure that these plans are integrated into the Consolidated Plans for the City and County, the Annual Agency Plans of the Chattanooga Housing Authority and the Continuum of Care. Establish a clear, coordinated disaster plan for sheltering homeless Chattanoogaans in the event of severe weather or natural disaster.
- **Coordination:** Provide a forum for agencies and organizations to implement, manage and review collaborations and linkages, with a specific emphasis on coordinating case management across agencies.
- **Certification:** Offer a seal of approval, evaluation standards and quality control for specific programs serving homeless people. Establish service delivery standards for outreach, shelters, transitional housing programs and supportive housing.
- **Performance Measurement and Evaluation:** Establish benchmarks for program performance and targets for homelessness reduction, as well as regular evaluation, data standards and reporting. Coordinate matches of data from different public agencies to track the incidence of homelessness across systems.⁵² Publish regular reports on program performance.⁵³
- **Training:** Establish best practices, develop and deliver training curricula for case management, outreach, crisis intervention, shelter management and supportive services. Offer technical assistance to public, nonprofit and faith-based service and housing providers.
- **Resource Manual:** Publish and periodically update a printed and on-line resource manual for services and housing related to the needs of homeless, formerly homeless and at-risk families and individuals. This will be coordinated in conjunction with the United Way 2-1-1 referral service information resources.
- **Information Clearinghouse:** Provide information and consulting services to providers and the public, including facilitating housing locator and job development services.

⁵² Data matches will be conducted under formal agreements that will preserve client confidentiality and protect client privacy in accordance with State and federal law.

⁵³ See Appendix D for a list of some of the statistics and information that can be collected by *The Council*.

- **Public Education:** Promote awareness among the general public of the causes and solutions to homelessness.
- **Secure Additional Funding:** Advise and approve public and private funding of programs, including the Continuum of Care process. Identify public and private funding streams and resources that can be used to fund services and housing for homeless and at-risk people. Expand government and nonprofit capacity to raise funds and attract additional funding and in-kind resources to the effort.

The Chattanooga Regional Interagency Council on Homelessness will help coordinate disparate funding streams and establish clear funding priorities. It will provide a mechanism for recognizing gaps in services and underserved populations and use comprehensive data to advocate for funding for these needs. It will also provide a structure to better coordinate services, improve case management and strengthen planning processes to ensure that resources are used wisely.

IX. Conclusion

As described in *Section VI* of this report, “*Homelessness in Chattanooga Today*,” homelessness in the United States is the result of a number of national socio-economic trends. To end chronic homelessness and reduce other types of homelessness will require not only the sustained leadership of the federal government, but also an expansion in the federal government’s investment in affordable housing, substance abuse treatment and community-based supportive services for low-income families and individuals. Without an ongoing federal commitment to solving the problem, localities attempting to reduce homelessness will have little success.

However, with the full partnership and support of the federal government, local governments can do much to improve the effectiveness of service systems serving homeless people. More than most localities, the Chattanooga region is well-positioned to make significant and lasting improvements to its already effective network of services and housing for homeless people.

By implementing the programs and improvements enumerated in this document, the Chattanooga region can prevent homelessness before it happens, provide comprehensive case management and offer homeless people access to the community-based resources they need. Most important, this document shows how Chattanooga can also expand the availability of permanent housing through subsidies, preservation and new development.

The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years is just the first step in a long-term process of system transformation. Such a transformation will take time. It will require identifying and attracting new resources and reallocating some existing ones. By working together, groups will provide assertive leadership on the issue of reducing homelessness. By fully implementing *The Blueprint* plan, we will end chronic homelessness and significantly reduce all homelessness in the Chattanooga region in ten years.

APPENDIX A

The Blueprint Steering Committee

Jim Schmidt (Co-Chair)

Executive Director
*Chattanooga Regional Homeless
Coalition*

David Eichenthal (Co-Chair)

City Finance Officer/Director, Office of
Performance Review
City of Chattanooga

Judi Byrd

Director of Social Services
Hamilton County

Phyllis Casavant

Director, Area Agency on Aging &
Disability
SE Tennessee Development District

Eva Dillard

President
The United Way of Greater Chattanooga

Ron Fender

Homeless Advocate
*Chattanooga Church
Ministries/Community Kitchen*

John Hayes

Deputy Director, Planning and Program
Development
Chattanooga Housing Authority

Anne Henniss

Chairperson
Chattanooga Housing Authority

Linda Katzman

Health Programs Supervisor,
Homeless Health Care Center
Hamilton County Dept. of Health

Jerry Konohia

President
Chattanooga Neighborhood Enterprise

Earl Medley

Executive Director
Fortwood Mental Health Center

Mary Simons

Regional Housing Facilitator, Creating
Homes Initiative
*Tennessee Dept. of Mental Health &
Developmental Disabilities/AIM Center*

Rayburn Traugber

Administrator, Department of
Community Development Services
City of Chattanooga

Bernadine Turner

Administrator of Human Services
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Angie Hatcher Sledge	V. P., Impact Services, <i>The United Way of Greater Chattanooga/ Center for Nonprofits</i>
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APPENDIX B

What is Supportive Housing?⁵⁴

“Supportive housing” is a general term for programs that combine affordable housing with on-site or visiting supportive services intended to help tenants with barriers to independent living stay stable and housed. Supportive housing has successfully ended homelessness for tens of thousands of very low-income people with chronic health conditions across the country.

Combining Affordable Housing and Comprehensive Services

Supportive housing offers decent, safe and affordable housing, combined with on-site or visiting social services that encourage residents’ independence, personal growth, active lives and employment. Supportive housing residents typically reside in their own apartments and are provided only with the services they need to develop and maintain independent living. These may include counseling, money management, medication management, employment training, socialization, instruction in skills of daily living and referrals to other more specialized services like medical care, mental health services and substance abuse treatment.

Supportive housing residences house people with a wide range of incomes and service needs, including people who were homeless, or have other disabilities, as well as many who are employed in low-wage jobs. The mix of a wide range of residents helps supportive housing blend in with the rest of the community. Supportive housing residents are tenants. They sign leases, pay rent and enjoy the same pride in their homes as their neighbors. Some may eventually choose to move on to more independent living.

Strengthening Communities

Supportive housing looks like the housing around it. Apartments are located in new or rehabilitated buildings that fit in with their neighborhoods. Supportive housing does not look institutional: it can be a renovated YMCA offering furnished single room occupancy apartments; or a multi-family building where tenants with disabilities live alongside working families and individuals with low incomes; or it can be scattered apartments or duplex housing located throughout a neighborhood served by visiting social services staff.

Supportive Housing Helps End Chronic Homelessness

Supportive housing helps end chronic homelessness by:

- **Creating stability:** Unlike other modes of care, residents are not required to move on to other settings as soon as they achieve some measure of stability.
- **Fostering self-sufficiency:** Supportive services – including mental health care, job training, on-site work opportunities, counseling, education and basic life skill

⁵⁴ This description of supportive housing is adapted from materials published by the Connecticut Corporation for Supportive Housing.

development – are designed to help tenants help themselves and minimize long-term dependency on government safety nets.

- **Facilitating employment:** Support staff help tenants who are able to work make connections to vocational training and adult education, then help them to secure and retain appropriate jobs.
- **Minimizing the need for emergency health care:** Tenants are linked to primary health care providers and assisted with maintaining good health. Constant interactions with on-site staff allow for early detection of deteriorated health, relapses and other health conditions. Supportive housing has been proven to decrease tenants' emergency room visits, inpatient hospital days, substance abuse relapses and incarcerations.
- **Rebuilding social supports:** By fostering tenant interaction, tenant associations and peer support groups, supportive housing helps tenants rebuild their support networks of family and friends.
- **Integrating tenants into the community:** Because supportive housing serves tenants with a mix of incomes and needs, and because it looks like the surrounding buildings, tenants with special needs do not experience the stigma associated with most institutional care.

Supportive Housing is Cost-Effective

As the University of Pennsylvania study demonstrated, supportive housing's stability and focus on prevention sharply reduce tenants' dependence on expensive emergency services. Other studies confirm these findings and demonstrate the other benefits of supportive housing:

- In San Francisco, formerly homeless tenants of supportive housing had reduced both emergency room visits and the number of days spent in inpatient care by more than half.
- In Connecticut, formerly homeless tenants of supportive housing had reduced their use of Medicaid-reimbursed inpatient medical care by 71% after moving into supportive apartments.
- Also in Connecticut, a recent evaluation of that state's Supportive Housing Demonstration Program found that supportive housing strengthens local economies:
 - The surrounding neighborhoods of eight out of nine supportive housing residences already developed in Connecticut saw their property values *go up by more than 30%* after the residences were built.
 - The overwhelming majority of neighbors and neighboring business owners said the neighborhoods looked better or much better than before the supportive housing projects were completed. *Not one* respondent said the residences had any negative impacts on neighborhood appearance.
 - The study also found that the supportive housing's total economic and fiscal benefit to the State and local communities was over \$72 million,

with an annual benefit of \$2.9 million per year, in the form of jobs, taxes, contracts for services and other related economic activity.

- In all, the Connecticut Supportive Housing Demonstration Program yielded \$3.43 in economic and fiscal benefits to the State and local economies for every one dollar of State investment.

Communities that have welcomed supportive housing have seen disabled homeless people failed by other systems of care become contributing members of their communities. Formerly homeless people placed into supportive housing reduce their use of expensive emergency services, such as emergency shelter, hospitalizations, psychiatric emergencies and incarcerations. Once-blighted buildings have been rehabilitated as the anchors of revitalized blocks in newly vibrant neighborhoods. The overwhelming success has created a diverse consensus championing supportive housing that includes elected officials of both parties, government administrators, healthcare advocates and preservationists, and even once-skeptical neighborhood groups who have seen how supportive housing has strengthened their communities.

APPENDIX C

The Chattanooga Collaborative Initiative to Help End Chronic Homelessness

In September 2003, Chattanooga housing and service providers, from both government and the nonprofit sector, were awarded a competitive federal grant under the “Collaborative Initiative to Help End Chronic Homelessness.” The Chattanooga Collaborative Initiative was awarded \$2,677,155 in federal funds over five years. Chattanooga’s successful application grew out of the collaboration initiated by *The Blueprint* planning process and can be counted as the first of what is expected to be many significant achievements initiated by *The Blueprint*.

Chattanooga’s application asked for federal funding to establish an Assertive Community Treatment (ACT) team that will serve 50 chronically homeless individuals in scattered-site, permanent housing subsidized with Shelter Plus Care rental subsidy vouchers, beginning in March 2004. The comprehensive, “wrap-around” services of the ACT Team and the stability provided by the housing subsidy will allow former chronically homeless individuals to pursue and achieve independence, sobriety and employment.

Proposed Program Design

The Chattanooga Homeless Healthcare Center will engage and assess 50 chronically homeless individuals currently living in Chattanooga’s camps, bridges, abandoned buildings, river banks and other public spaces. They will be referred to the ACT team operated by Fortwood Center with new funding from the United States Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA).

The ACT team will place the 50 individuals as soon as possible into permanent, scattered-site one-bedroom apartments subsidized by Shelter Plus Care rental vouchers managed by the Chattanooga Housing Authority (CHA). Approximately half of the 50 apartments will be provided out of the 600 rental units managed by Chattanooga Neighborhood Enterprise (CNE).

Staffing

The ACT team will be comprised of: a dedicated psychiatrist, a home health psychiatric nurse, a licensed master’s level supervisor, a master’s level mental health therapist, a licensed alcohol and drug counselor, five case managers (at a 1:10 provider to client ratio) and two peer counselors. The multi-disciplinary nature of the ACT team and its mix of professional and paraprofessional staff will allow it to address a wide range of clinical and psychosocial needs, while maintaining a high level of cultural competency with chronically homeless people.

Services Offered

After placement, services will be inextricably linked with the housing. The ACT team will deliver services primarily on-site in the homes of the program participants. The

services will be tailored to the needs and preferences of each resident, emphasizing client participation and individualized treatment plans. Services will include: mental health and substance abuse counseling, medication and money management, intensive case management, training and support in activities of daily living, pre-vocational activities, rebuilding family relationships and social networks, improving physical health and nutrition, employment and other services as needed.

Replacing Funding with Mainstream Resources

From the beginning of the Collaboration, the ACT team will be operated with the explicit goals of 1) gradually reducing the intensity and frequency of the services and 2) assisting project participants to gain access to mainstream services and supports. During the first year, services will be as intensive as required to place and stabilize the participant in permanent housing. As the resident becomes more stable, the ACT team will assist him or her to begin using less intensive case management services on-site at the Fortwood Center, funded through AdvoCare, the behavioral health insurance program of TennCare.

These services will only be reduced as determined by the participants' level of need. The individualized treatment plan will anticipate a step-down to regular case management and mainstream resources, but only when the participant is ready. Based on prior experience working with chronically homeless individuals, Fortwood Center anticipates that 15 participants will step down to regular case management services after the first 12 months; 20 additional participants will step-down after 24 months; and the remaining 15 participants will step down at the end of 36 months.

During the first year, primary medical care will be provided by the Homeless Health Care Center. Because a majority of the Collaboration's program participants will have been referred from the Center, this will help ensure that the participant will enjoy continuity of care from a medical provider he or she knows and trusts. Once the Homeless Health Care Center and the ACT team decide that the participant has achieved a reasonable level of residential stability (expected to be achieved within the first year in permanent housing) medical care responsibilities will be transferred to the Southside Community Health Center, the Dodson Avenue Community Health Center or to private physicians, depending upon the resources of the individual. If the participant is a veteran, the Veteran's Outpatient Clinic will become the primary health care provider to the participant.

In addition to formal mental health and medical services, participants will be integrated into mainstream neighborhoods and will have access to informal networks and supports. To achieve the anticipated service reductions, the ACT teams will make full use of the array of services and supports available in the Chattanooga provider community. From the beginning of the program, the ACT team will, whenever possible, utilize referrals and linkages to other mainstream providers and programs.

At the end of the five-year period of the Collaboration, the 50 Shelter Plus Care rental subsidies will be replaced by either client income or a Section 8 voucher supplied by the Chattanooga Housing Authority.

Funding and Budget

The total Chattanooga Collaborative Initiative received \$2,677,155 in federal funds, or \$10,709 per client per year for five years. The costs include the following:

- Approximately \$1,374,000 over five years (\$274,800 per year) to CHA for 50 Shelter Plus Care vouchers, paid from the HUD portion of the Collaborative Initiative to Help End Homelessness
- Approximately \$1,303,155 over three years to Fortwood Center for ACT team services, from the SAMHSA portion of the Initiative

These federal funds will leverage other funding, including:

- \$750,000 in development costs for 25 units specifically set aside by Chattanooga Neighborhood Enterprise for the Collaborative Initiative
- \$38,000 in supervisory time and equipment donated by Fortwood Center
- \$50,000 in donated food, clothing, and furniture collected primarily through the faith-based community
- \$333,000 in regular case management costs paid for by TennCare for eligible participants as they move to mainstream medical care

The total cost of the five-year initiative is approximately \$3,350,000, or \$13,400 per client per year over five years. Anticipated savings in reduced emergency shelter and hospitalization costs will decrease this amount considerably.

Participating Entities

Like almost all of Chattanooga's efforts to respond to the needs of homeless people, the Collaborative Initiative will rely on the cooperation of a number of public and nonprofit housing and service providers. The primary partners in the initiative include the following participating agencies:

- **Fortwood Center**, a licensed community mental health center and the Collaborative Initiative's lead applicant, will be responsible for the hiring and supervision of the Assertive Community Treatment (ACT) team, funded by SAMHSA.
- **The Chattanooga Housing Authority (CHA)** will administer the 50 Shelter Plus Care permanent housing subsidies, funded by HUD.
- **Chattanooga Neighborhood Enterprise (CNE)**, a nonprofit developer and manager of affordable housing, will supply at least half of the permanent housing units for the project and help facilitate all housing placements and landlord-tenant relations.
- **The Chattanooga Homeless Health Care Center**, a JCAHO-accredited 330h subsidiary of the Hamilton County Health Department, will provide primary health care services, as well as initial outreach and referrals of potential participants.
- **The Chattanooga VA Outpatient Clinic** will provide primary and other specialized health care to program participants who are veterans of the armed services.

- **The Chattanooga Regional Homeless Coalition**, an alliance of area homeless providers, will help coordinate services and track program performance.
- **Secondary providers** include the **City of Chattanooga, the Creating Homes Initiative, Joe Johnson Center, AIM Center, Erlanger Medical Center** and others.

APPENDIX D

Information Gathering and Statistical Analyses

The Chattanooga region presently collects personal and service use information on homeless people who use publicly funded services through two main database systems, the Hamilton County Department of Health's Homeless Health Care Center and the Service Point Homeless Management Information System managed by the Chattanooga Regional Homeless Coalition.

These two reporting systems provide a wealth of data on the Chattanooga region's homeless population, including ethnographic data, personal characteristics, service needs and patterns of service use. The comprehensiveness and accuracy of the data now collected by Chattanooga compares quite favorably with that of other similar-sized localities.

With the implementation of the recommendations proposed in *The Blueprint*, the Chattanooga region's homeless information management capacity will improve even more. Collection of data will be expanded to track more information about homeless clients. Data reporting will also be expanded to include more providers reporting their activities. Equally important, Chattanooga's capacity to analyze the data collected will be greatly increased through the establishment of *The Chattanooga Regional Interagency Council on Homelessness*.

By improving both the quality of the data collected and the capacity to analyze it, Chattanooga will be able to identify funding priorities and manage its system more efficiently. Matching data with other public databases (such as the databases of the mental health and criminal justice systems) will allow Chattanooga to identify predictors of homelessness, system junctures where people are most at risk of homelessness, segments of the homeless population who are being underserved, and a host of other questions facing our network of homeless services.

It will also help case managers and other frontline workers coordinate with each other and improve the delivery of services to homeless individuals and families. By facilitating the sharing of information (while continuing to ensure that client confidentiality is protected), the needs of homeless people will be addressed more quickly and comprehensively. By collecting information about how shelter beds are utilized, we can manage the shelter system's resources more effectively and efficiently.

Some of the statistical information that *The Council* can collect, match and analyze will include the following:

Counting Homelessness (organized by characteristics - age, family, MI, A & D, etc.):

- # of individuals NEW to Service Point system or the Homeless Health Care Center
- # of individuals in the Homeless Health Care Center/Service Point systems who newly qualify as chronically homeless each year
- # of individuals in both of these systems who “disappear” from HHCC/Service Point (and never re-enter the system)

Measuring Activities (organized by program):

- # of individuals placed in emergency shelter annually
- # of individuals placed in transitional housing annually

- # of bed-nights spent in emergency shelter and transitional housing
- # of bed-nights spent in Moccasin Bend
- # of bed-nights spent incarcerated

- # of individuals placed in permanent housing from emergency shelter annually
- # of individuals placed in permanent housing from transitional housing annually
- # of individuals placed in permanent housing who are still there 6 months later
- # of individuals placed in permanent housing who return to HHCC/Service Point annually

Data Matches (Match the following data groups with HHCC and Service Point data to identify individuals who are in both systems or moving from one system to another):

- All individuals released from Moccasin Bend
- All recently released federal and state prisoners
- All youth who “age out” of foster care
- All individuals with TennCare or no insurance released by acute hospitals
- All households taken off Families First (TANF) or Food Stamps rolls
- All households applying for emergency assistance
- All evictions