The Blueprint to End Homelessness in the Chattanooga Region

A Collaborative Initiative Between

The City of Chattanooga & The Chattanooga Regional Homeless Coalition

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DRAFT PREFACE

On July 13, 2007, Mayor Ron Littlefield charged a group of 40 individuals from the Chattanooga community to review the 2004 Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years in relationship to recommendations made by the Community Advisory Committee on Homeless Issues and current realities regarding homelessness and conditions with the Chattanooga region. The 2007 Blueprint Review Committee was divided into five different areas, four coming directly from the recommendations set forth in the 2004 Blueprint – Housing, Services, Prevention, and Planning/Coordination. The fifth area, Community Reintegration, was added to ensure that a homeless individual or family has the opportunity to fully rejoin the broader community as they move toward self-sufficiency.

These five subcommittees worked diligently from July through early October often drawing the expertise of professionals in the respective fields that were not on the formal Blueprint Committee. The work of bringing together the input from all of the resources fell on the chairs of each of the subcommittees – Phyllis Casavant, Prevention; Clare Sawyer, Reintegration; Karen Guinn, Services; John Hayes, Housing; and John Dorris and Karen McReynolds, Planning and Coordination.

The recommendations included in this update of the Blueprint represents the best thinking of those who are involved in each of these areas either as consumers, providers and professionals. The recommendations provide guidelines for the development of programs to address the needs of those who are (or are about to) become homeless. However, the recommendations do not attempt to micromanage the development of those programs or strategies. The actual implementation of these recommendations will be best determined by the Coordinating Committee working with the City, County and Regional governing bodies to find the funding and resources to carry out the recommendations.

The Steering Committee wishes to thank all of those who have been involved in this process and who have contributed time and energy to ensuring that the community can successfully address the needs of the homeless.

Executive Summary

At least 4,094 different people experienced homelessness in the Chattanooga region at some time during 2006. 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. Nationally, it is estimated that "expanding the definition to include people who are doubled up for economic reasons would increase the current homeless population (744,313 on a given night) by 3.8 million."[1] Locally, The Homeless Health Care Center reports that in 2006, 1,089 individuals reported being homeless in Chattanooga and the Southeast Tennessee region for more than a year.

The Blueprint to End Homelessness in the Chattanooga Region 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 original *Blueprint* was the culmination of a seven-month planning effort in 2004 by the Chattanooga region's homeless service providers, government administrators, housing developers, community leaders and homeless people themselves. The 2007 revision of *The Blueprint* produced by a 40-member Blueprint Task Force, likewise involved a broad array of perspectives (see list of original Blueprint members in Appendix A1 and members of the 2007 Task Force in Appendix A2).

The original *Blueprint* plan was intended to end long-term, or "chronic", homelessness. This emphasis reflected a 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 emerged that all levels of government must focus on improving efforts to house chronically homeless individuals and families. *The Blueprint to End Homelessness in the Chattanooga Region* is consistent with and complementary to the federal government's efforts in this area.

The 2007 revision of *The Blueprint* has expanded its focus to include an equal emphasis on ending non-chronic homelessness as well, thus resulting in the removal of "Chronic" from *The Blueprint* title. Recent research on community plans to end homelessness found that "the majority of communities have, in their planning processes, looked beyond the chronically homeless population and created plans to end homelessness for all homeless people".[2]

1 "Data Snapshot: Doubled Up in the United States", Homelessness Research Institute-National Alliance to End Homelessness, September 2007

2 "A New Vision: What is in Community Plans to End Homelessness?", National Alliance to End Homelessness (November 2006)

This expanded focus highlights the fact that:

- Unless there is an equal effort to assist the non-chronic homeless population today, (comprising approximately 80% of the homeless population) there will be a constant influx of new chronically homeless people tomorrow.

- While the cost savings of helping a chronically homeless person are likely to be greater than the cost savings of helping a non-chronically homeless person, the consequences of not helping are the same: Tragedy and unrealized potential for a member of our community.

Although the above points were implicit in the original *Blueprint*, they are explicitly stated in the 2007 revision to help promote community awareness that homelessness (its tragedy, costs and challenges) extends well beyond the segment we call "chronically homeless".

As implementation of *The Blueprint's* policy recommendations are accelerated, they will significantly reduce all types of homelessness, including chronic, among families, youth and single adults who experience episodic homelessness. *The Blueprint* will guide the Chattanooga region's effort to end homelessness 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 support that prevent homelessness before it happens and diminish opportunities for homelessness to recur

The Homeless Blueprint Oversight Committee (HBOC)

A new mechanism will be established to ensure timely and effective implementation of *The Blueprint*. The Homeless Blueprint Oversight Committee (HBOC) will ensure implementation of *The Blueprint*, promote consistent performance standards, provide a forum for community-wide collaboration and help promote public awareness of homelessness (and progress towards solutions). HBOC will ensure that data and research guide, support and justify all planning efforts and policy initiatives. Furthermore, *HBOC* will ensure that appropriate systems and objective performance measures are developed to monitor progress and effectiveness of *The Blueprint* implementation.

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 the 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 un-reimbursed 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 bases some of its recommendations on the research showing the cost-effectiveness of supportive housing. It will promote expanding the availability of supportive services and case management in the community, and link these services to affordable permanent housing units. Following these strategies will help house homeless people who may not have been previously served and 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 support and services they need to remain stably housed. All programs will affirm the value of education, employment and sobriety.

System of Community Support – Key Perspectives and Emerging Challenges [3]

Looking at a ***community's service delivery system to help people who are homeless (near-homeless)***, we see five key perspectives:

- **Homeless (near-homeless) perspective:** First-hand experience of homelessness and being a recipient of services help identify specific gaps in the service delivery system and opportunities for improvement.
- **Service provider perspective:** Seeing how a segment of the service delivery system operates can provide insight into barriers and gaps related to specific services.
- **Homeless service delivery perspective:** Looking at the issues contributing to homelessness and the mix of services/housing that play a role in recovery can provide a holistic view of homelessness and potential solutions.

3 CCRC Report (not yet published as of November 2007)

- **Systems perspective:** Looking at the interaction of processes (assessment, case management, providing services, measuring performance, identifying gaps and implementing improvements) that make up a system, provides the clarity and objectivity to work towards sustainable improvements.
- **Community perspective:** The foundation of any service delivery system is the community in which the system operates. Therefore, the community must be able to see that the service delivery system is effective and efficient and that there is a positive impact on the broader community.

Key Emerging Challenges

Data Quantity and Quality

The social service environment today is characterized by greater demands that must be met with fewer resources. Increasingly, funding sources are more concerned with an agency's ability to demonstrate positive outcomes as opposed to just measuring output (services provided). Furthermore, the myriad of factors leading to homelessness presents a complex problem best solved by compassion and collaboration guided by accurate information.

The challenge of building an information system to collect an adequate quantity of data still exists but is now being joined by a subsequent challenge: adequate quality of data (data integrity). Many service providers collect data primarily for reporting activities to funding sources; not for analysis to improve processes or identifying service gaps. Such data collection emphasis and under-utilization of data puts numbers and reality on divergent paths that, at best, will lead to lost opportunities and, at worst, wrong policy and agency decisions.

Performance Measurement

The measurement of outcomes presents another challenge. Service providers are being held more accountable for producing positive outcomes. Positive outcomes are more client-dependent than the traditional output measures. An output measure like "number of meals provided" can be more easily controlled by an agency than an outcome such as "percentage of clients maintaining stable housing for 12 months". Agencies without quality processes that can be documented and validated will be at the mercy of chance outcomes that ultimately will indicate poor performance. Then, when confronted with a poor performance, the service providers with inadequate processes will have a difficult time obtaining funding to sustain operations. Conversely, service providers who can demonstrate a quality process can better "weather the storm" of occasional negative outcomes that are inevitable when working with people.

Collaboration

There is an overwhelming need for better collaboration among service providers and other community organizations to improve the service delivery system. The fact that funding sources are placing more emphasis on collaboration has increased the urgency to work together. It is critical to note, however, that a collaboration system that works in one community may not work in another without some modification to "localize" the approach.

RECOMMENDATIONS

To accomplish the next steps in the evolution of our homeless service system, *The Blueprint* offers a comprehensive plan that relies on five spheres of activity, each with its own recommended strategies and actions.

The four spheres of activity from the original *Blueprint* are supplemented by a fifth critical task that extends well beyond the traditional system of services: Reintegration of people who are/were homeless into the broader community. This task relates to some services and challenges mentioned in other sections of the *Blueprint,* but views them in light of what is needed to help each homeless/formerly homeless person fully re-connect to the community. Strategies and actions are also recommended for this task.

These recommendations are based on the best practices of innovative programs across the nation (and locally) that have demonstrated proven success achieving the goals of *The Blueprint.* Briefly, the major recommendations of *The Blueprint* include:

A. Expanding Customer-focused Paths to (and Opportunities for) Permanent Housing

1) Expand permanent housing opportunities to:

1.1) Create a minimum of 200 affordable housing units for homeless people per year through the provision of rent subsidies, new housing development and the preservation of affordable housing stock.

1.2) Facilitate housing placements.

1.3) Implement inclusionary zoning ordinances to encourage, if not require, the development of affordable housing as a percentage of other housing development in the community (see Appendices D1-D8 for a model zoning code and related information from the American Planning Association).

1.4) Provide incentives for developers to build affordable housing.

1.5) Work with schools, employers and businesses moving to the community or developing new sites to include the purchase of land that can be developed for affordable workforce housing near the properties being developed for educational, industrial, business or commercial use.

2) Increase the availability of transitional shelter units that move people to permanent housing:

2.1) Provide adequate transitional shelter space to provide safe, decent and sanitary shelters for homeless individuals, families and youth until adequate and appropriate permanent housing is available.

2.2) Increase funding for emergency or short-term housing that fills the gap between becoming homeless and finding either transitional or permanent housing.

3) Provide permanent special needs housing and alternatives

3.1) Ensure that adequate housing is available for those populations that need more intensive long term case management and supportive services

3.2) Develop housing policies that recognize that despite our best efforts, not all persons we serve will choose to accept the supportive services designed to help them address their mental health or substance abuse issues and will be faced with eviction and homelessness. Such episodic homelessness and violations should not exclude them from assistance in the future either through alternative programs, therapeutic communities or being re-housed in a supportive housing program.

B. Increase Access to Services and Supports

4) 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.

Improve and expand case management

4.1) Maximize current funding and seek additional funding for case management and supportive services to homeless and formerly homeless people.

4.2) Appoint a lead agency to support Case Management Coordinator position and establish a Training, Resources and Practices committee for guiding and coordinating case management provision.

4.3) Develop and implement a system-wide standards and training program for case management to homeless and formerly homeless people.

4.4) 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.

4.5) Develop a community scorecard or similar instrument that links service providers to best practice standards of case management through annual reporting of actual outcomes by provider.

4.6) Create specialty Case titles for Case Managers.

Create Additional Tools and Resources for Case Managers

4.7) Establish a four month to two year rental subsidy that will help employable homeless people to move into permanent housing immediately.

4.8) Create permanent supportive housing for formerly homeless or at-risk youth.

4.9) 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.

4.10) 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.

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

Coordinate Outreach

5.1) Re-deploy 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.
5.2) Evaluate outreach staffs training and supervision needs, hours of employment and pay scales.
5.3) Coordinate outreach efforts with police.

Improve Access to Shelter and Housing

5.4) Establish a drop-in center that provides a safe place for homeless people to go during the day.
5.5) 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.
5.6) Develop a community collaborative approach and seek federal funding for adequate services to homeless youth, including transitional, respite and independent living programs.
5.7) Increase access to permanent housing for homeless people living in public spaces.

Expedite Placements

5.8) Expand and expedite homeless people's access to psychiatric evaluations, prescription medications and dentistry.
5.09) Work with the Tennessee Department of Human Services to expedite the entitlement applications of homeless people, especially those living in public spaces.
5.10) Create a fund to help transient homeless people from outside the Southeast Tennessee region return to stable placements in their home communities.

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

6.1) Use Workforce Investment Act (WIA) funding and programs to train and place homeless and formerly homeless people into employment.
6.2) Create job opportunities for homeless and formerly homeless individuals.
6.3) Improve homeless people's access to transportation and day care.
6.4) 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 administered by HUD.

6.5) Review the Chattanooga region's current array of inpatient and outpatient substance abuse and mental health treatment services to examine the adequacy of existing capacity, treatment modalities and aftercare supports.
6.6) Expedite enrollment of homeless and formerly homeless families and individuals into Tenncare and Food Stamps.
6.7) Develop a plan and implementation strategy to expand homeless and formerly homeless people's access to Veterans Administration services.
6.8) Improve homeless, at-risk and runaway youth's access to family counseling and other supports.

C. Prevent Homelessness

7) Establish an organization or give the responsibility to an existing organization for *Blueprint* implementation which will include promoting prevention of homelessness and providing quick assistance to families and individuals at risk of homelessness. This agency will be charged to identify at-risk individuals and families, coordinate service response, educate and train service providers and advocate for the homeless. An Operations Council can assist agency personnel in program development and will stress early intervention, case management, client responsibility, the sharing of best practices and appropriate use of data tracking software. The lead agent will be customer focused and responsible for beginning a redesign of the service delivery system. The regional dialogue will be diverse and on-going, considering all sources of funding to provide services to the most vulnerable at-risk for homelessness in a customer focused way.

8) Help at-risk households remain stably housed by providing emergency assistance, maximizing their incomes and improving access to supportive services. The lead agent will be responsible for assisting at-risk households with emergency assistance, including brief case management and ultimate entry into the case management system for long-term planning.

8.1) Expand the availability of emergency assistance to prevent financial and personal emergencies from becoming destabilizing crises.
8.2) Reduce the gap between poor people’s rents and incomes by expediting and expanding access to subsidies, entitlements and employment.
8.3) Offer at-risk households ongoing case management and supportive services to address the underlying causes of instability.

9) 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 in the community.

9.1) Expedite entitlement applications for individuals leaving institutional care.
9.2) Establish clear responsibility for implementing discharge plans in the community.
9.3) 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.

9.4) Work with the criminal justice system to facilitate individuals' reentry from incarceration to community living and instead of incarceration, develop and implement pre-trial diversion as well as post trial alternatives for persons with mental illnesses to be placed in treatment and housing facilities in the community.
9.5) Develop a resource guide and map to provide to people when they are discharged from institutional care.
9.6) Institute a strong transition to adulthood program for youth leaving foster care to ensure comprehensive support, education and housing for as long as necessary to achieve independence.
9.7) Establish emergency temporary housing opportunities for individuals and families that leave institutional care between 6 p.m. and 8 a.m. and on weekends.
9.8) Provide structure and funding for low income persons traveling through our community who would otherwise be homeless. These persons must be on their way to gainful employment or appropriate living situations.

D. Develop a Mechanism for Planning and Coordination

10) Establish the Homeless Blueprint Oversight Committee (HBOC) to take the lead responsibility in performing or ensuring performance of the following tasks:

10.1) Monitoring progress of *Blueprint* implementation and adherence to policies/standards as specified in the *Blueprint*
10.2) Increasing the number of service provider agencies certified by the lead agency as adopting and implementing best practices.
10.3) Providing a forum for increasing collaboration between for-profit, governmental, nonprofit and faith-based agencies to support implementation of the *Blueprint.*
10.4) Promoting public awareness of progress on the *Blueprint* implementation.

E. Community Reintegration

11) Develop a central intake point to start the process of linking a homeless/formerly homeless person to the case management and other assistance and follow-up support they need to become more self-sufficient.

11.1) Develop a central intake point, accessible at all hours of every day, to access immediate needs and start a person on their way to housing.
11.2) Develop a model for casework, using the resources of the Human Services Department at the University of Tennessee at Chattanooga, and other models which focus on the short, mid, and long-term needs peculiar to the various segments of the homeless population.
11.3) Utilize more volunteers, particularly faith-based groups, to assist caseworkers in follow up and support, problem solve, and encourage newly housed persons. Access Americorp volunteers.

11.4) Develop improved follow up systems, able to trace housing placements through the first year of housing and prevent dropping through the cracks.
11.5) Increase use of Service Point or other data based information tools.

12) Make mainstream resources (food stamps, SSI, etc.), health services, case management services and getting personal identification documents more accessible by either convenient location or available transportation.

12.1) Expand assistance and convenience to food stamp application, other documentation, driver's license or other picture ID, e.g. food stamp application at satellite locations, SS services at TN Career Center.
12.2) Close contact by case managers or volunteers regarding medical needs, prescriptions, and transportation to appointments to maintain and improve health.
12.3) Accessing assistance in areas of startup deposits, food, furniture, utility and rental assistance.
12.4) Better communication between service providers as to services provided, overlaps, gaps and coordination through the Chattanooga Regional Homeless Coalition to provide a seamless system.

13) Provide assistance in re-establishing a home

13.1) A centralized point of contact for housing resources with access to all available housing units and connections to casework charged with mentoring through the reintegration process, following along for six months to one year. Continue to expand web-based housing inventory programs, e.g. "Housing Within Reach" and "My Community Rents".
13.2) Coordination and collaboration of organizations providing immediate supports, e.g. furniture, financial assistance for rental and utility deposits. Database of organizations who maintain a furniture and household goods bank, e.g. First Centenary UMC.
13.3) Apply Habitat principles of "sweat equity" to earn housing credit.
13.4) Continuous and early planning for the Continuum of Care grant to provide the most creative and broad housing programs, with concentration on the bottom line number of new units to come on line.

14) Connect homeless/formerly homeless people to community services/education that help them obtain, maintain and advance in employment to their fullest potential

14.1) Expand use of TN Career Center to obtain documentation, skills training and employment counseling.
14.2) Inclusion of employment preparation in discharge planning and care plans.
14.3) Emphasis on soft skill training in programs funded through the Continuum of Care and elsewhere.
14.4) Job coaching to smooth over workplace problems

A New Approach

Chattanooga's new approach reflects a national change in strategy occurring in over 300 cities across the country. Supported by the federal government, the efforts to help chronically homeless people, in particular, build on what is often referred to as a "housing first" approach: low barrier entry into housing (with the required supportive services). The "housing first" approach is also one of the approaches that can be used to help other segments of the homeless population obtain and maintain stable housing. 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 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 Chattanoogans traditionally apply to major initiatives in their community is employed in the implementation of *The Blueprint*, we can make great progress in ending homelessness in the Chattanooga region.

As in other cities, chronically homeless Chattanoogans 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 including 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 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.

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, their cars, under bridges and in other out-of-the-way public spaces. More careful observation readily conveys the true extent of the problem.

At least 4,094 different people experienced homelessness in the Chattanooga region during 2006. 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.[4]

Every night, an average of 370 Chattanoogans 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.[4a]

The Blueprint to End Homelessness in the Chattanooga Region is a long-range, comprehensive plan to help homeless people in our area return to healthy and stable lives in permanent housing. The original *Blueprint* was the culmination of a seven-month planning effort in 2004 by the Chattanooga region's homeless service providers, government administrators, housing developers, community leaders and homeless people themselves. The 2007 revision of *The Blueprint*, produced by a 40-member Blueprint Task Force, likewise involved a broad array of perspectives (see list of members in Appendix A2).

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4 From original Blueprint. A comparable figure for 2006 was not obtained, although it is expected to be of the same magnitude as the original amount reported. The total amount currently being spent annually will be obtained as part of the implementation plan to improve data accuracy and completeness of data. The amount recieved by the community through the Continuum of Care has decreased by nearly 25% since 2003, the funding for supportive services through the Collaborative Grant has ended and not been renewed, and we are forced to serve more homeless with fewer resources than in the past.

5 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.

5a 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.

A majority of these individuals can be considered chronically homeless.[6] Under the leadership of the United States Interagency Council on Homelessness, a national consensus emerged that all levels of government must focus on improving efforts to house chronically homeless individuals and families. *The Blueprint to End Homelessness in the Chattanooga Region* is consistent with, and complementary to, the federal government's efforts in this area.

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- Unless there is an equal effort to assist the non-chronic homeless population today (comprising approximately 80% of the homeless population) there will be a constant influx of new chronically homeless people tomorrow.

- While the cost savings of helping a chronically homeless person are likely to be greater than the cost savings of helping a non-chronically homeless person, the consequences of not helping are the same: Tragedy and lost potential for a member of our community.

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6 From 2006 Homeless Health Care Center data.
7 "A New Vision: What is in Community Plans to End Homelessness?", National Alliance to End Homelessness (November 2006)

Furthermore, *HBOC* will ensure that appropriate systems and objective performance measures are developed to monitor progress and effectiveness of *The Blueprint* implementation.

II. Guiding Beliefs

- Homelessness is a tragedy not a crime.
- People who are homeless should have the same freedom to choose their life's path (including path to recovery) as anyone else.
- Perceptions of the community regarding people who are homeless are a reality to be considered when exploring possible solutions. But, rather than molding a solution to accommodate a misperception, the focus should be on correcting the misperception; a solution based on assuming the worst about people who are homeless is no solution.
- Ending homelessness is a bold and ambitious goal. Effective efforts to achieve such a goal are focused on the people in need, the conditions that led to their situation and the system of support (including housing); not just on the presence or visibility of homeless people in specific locations of the community. Efforts that primarily focus on the presence or visibility of homeless people in specific locations may appear to produce positive results in the short-term but will ultimately do very little to achieve the desired goal. Neither does this kind of effort send any message of hope or compassion to our community members in need.

III. Homelessness Today

The Blueprint 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 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 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 ServicePoint reporting system, new data fields are added and the information collected becomes more accurate.[8]

8 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 six 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.

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 ServicePoint over the next few years may create the appearance that homelessness itself is increasing, whether or not such a rise actually occurs. As ServicePoint 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.

Enough data has been collected in the past few years to show the potential for improved coordination and better decision making that comes from more data. In 2007, the level of data being collected continues to increase, presenting an equally important challenge: Data quality. Interfacing with information systems of other community organizations can help complement (and provide validation of) ServicePoint data and help complete the picture of how the community is fully impacted by homelessness. Such interfaces, whether electronic or just organizational, are critical to providing a truly coordinated community effort to address homeless issues. 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 4,094 individuals experienced homelessness in the Chattanooga region. This total figure only counts those individuals who have identified themselves as homeless and have been entered with a "homeless" designation in the ServicePoint database. This group has been recorded as receiving services in fiscal year 2006 from nonprofit, faith-based and government agencies and organizations reporting to the ServicePoint database.[9] This figure includes many of the 1,091 children who experienced homelessness in Hamilton County in 2006 (675 in shelters, 416 living doubled up)[10]. An additional estimated 2,848 individuals experienced homelessness in the region surrounding Hamilton County at some point between October 1, 2006 and September 30, 2007. [11]

These numbers include only people who experienced actual homelessness, i.e. at one time during the year, they resided in an emergency shelter, a transitional housing program and/or in public spaces. With the exception of the 416 school age children living

9 The Coalition's fiscal year is from July 1st to June 30th.
10 Tennessee Department of Education
11 Service Point data and Coalition and provider extrapolations and estimates

doubled-up, the numbers above do not include thousands of other Chattanoogans who live doubled up with relatives and friends, reside in substandard or overcrowded housing, or face other housing-related problems. In all, 1,328 different homeless individuals (950 single adults and 378 members of families) spent at least one night in emergency shelter or transitional housing in Hamilton County during FY2006. An estimated 789 others utilized Hamilton County shelters not reporting to ServicePoint at some point during the year. The remaining 852 or so – most, but not all of them, single adults – resided in places not meant for human habitation or in 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.[12]

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 January 25, 2007, 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 ServicePoint, we know that on any given night, approximately 407 unduplicated homeless individuals reside in shelters, transitional housing programs and public spaces in Chattanooga. These include 319 unaccompanied single adults, among them:

- Approximately 188 homeless single adults in six emergency shelters and five transitional housing programs reporting to Service Point.
- Approximately 50 homeless single adults in three faith-based emergency shelters that do not report to Service Point.
- Approximately 96 homeless single adults on the streets, in camps and in other public spaces.

Every night, approximately 87 family members in 37 families are homeless in Chattanooga, including:

- Approximately 87 family members in four emergency shelters and two transitional housing programs.
- An estimated 82 family members in public spaces, mostly in local campgrounds (did not have any families to report living in camps during the point in time count in 2007)

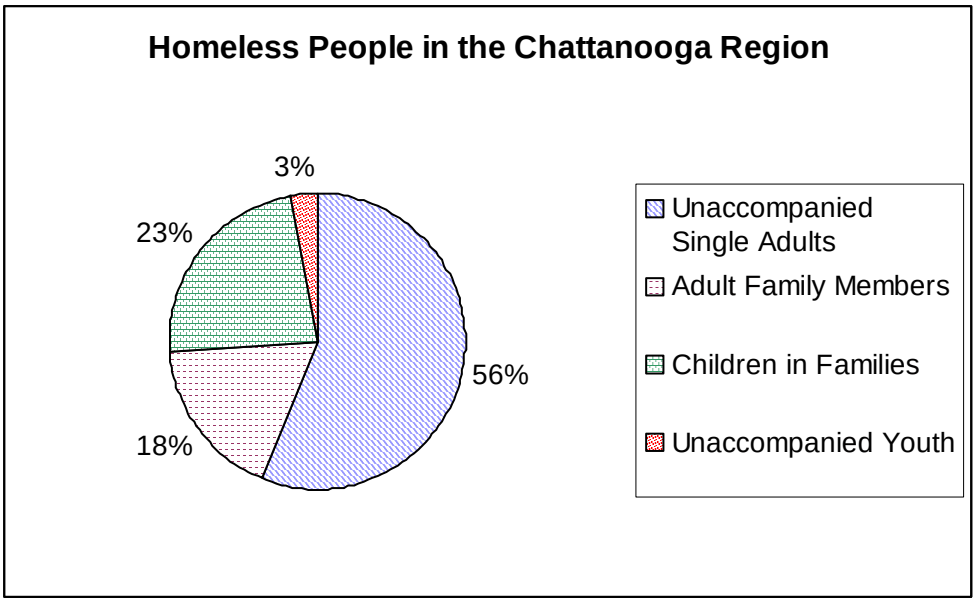
Homeless families who are victims of domestic violence may gain access to 40 beds in emergency shelters and transitional housing programs set aside for the domestic violence population. If there is no domestic violence involved, families must compete for 159 beds at 6 emergency shelters.

12 Service Point data, FY2006.

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. Chart 1 breaks down the population between these four groups, using data both from the Homeless Health Care Center and Service Point: [13]

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 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 ServicePoint 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.

13 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.

- 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.
- 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.
- A survey of 98 homeless individuals in Fall 2006 found that 21.4% were currently working and 46.9% had worked in the last 6 months.[14]
- 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.[15]

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 until 2003 and has steadily increased the last three years.[16] 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 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. A 2007 review indicates that the food shortage is currently even more acute than when the original *Blueprint* was published. [16a]

14 Fall 2006 Survey by Tammy Garland, PhD (University of Tennessee at Chattanooga)
15 All ethnographic statistics extrapolated from the Homeless Health Care Center 2003 data, Service Point, provider interviews and program observation.
16 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 until 2003. In 2006 the number was 3,058. Homeless Health Care received 17,564 client visits (of which 7,251 were medical visits).
16a Chattanooga Area Food Bank

Chronically Homeless vs. Non-Chronically Homeless

On November 7, 2007 HUD announced an 11.5% reduction in number of chronically homeless from 2005 to 2006. This is a very positive sign with respect to nationwide chronic homelessness. However, the results are mixed for the southeast region (See Table 1 below)*. The decrease of 3,707 people who are chronically homeless in the Southeast was more than offset by the increase of 10,877 people who are homeless but do not fall in the chronic homeless category. Tennessee has the distinction of being the only state in the Southeast for which both chronic homelessness and non-chronic homelessness increased from 2005 to 2006. These statistics point to the urgent need to address the needs of the non-chronically homeless population while pursuing the evidence-based approaches that show promise in reducing chronic homelessness or else this unfortunate trend will continue. The fact that the non-chronic homeless population today could become the chronic homeless population of tomorrow suggests that the ending (and prevention) of all homelessness must be implicit in the effort to end chronic homelessness.

Table 1 – Chronic and Non-Chronic homeless population in the Southeast

State	#Persons homeless in 2005	#Persons homeless in 2006	Change	#Chronically homeless persons in 2005	#Chronically homeless persons in 2006	Change	#Non-Chronically homeless persons in 2005	#Non-Chronically homeless persons in 2006	Change
TN	8156	9560	1404	2183	2338	155	5973	7222	1249
AL	4707	5579	872	1543	1091	-452	3164	4488	1324
KY	4934	7045	2111	892	697	-195	4042	6348	2306
NC	11350	12414	1064	2414	2215	-199	8936	10199	1263
SC	7663	9614	1951	1882	1550	-332	5781	8064	2283
FL	62461	62229	-232	13698	11014	-2684	48763	51215	2452
Total			7170			-3707			10877

Grand total change in #people who are homeless (from 2005 to 2006 in TN): Increase of 1,404 persons
Grand total change in #people who are homeless (from 2005 to 2006 in above states): Increase of 7,170 persons

Critical Point: Reducing the number of people who are chronically homeless is a positive sign.
However, it is important to note the increase of 10,877 non-chronically homeless people in the region.
The gains with chronic homelessness will be lost if we do not provide more supportive services and affordable housing to the non-chronic population (who could easily fall into the "chronic category in a matter of months).

Notes:

-TN was the only state listed above to experience an increase in both chronically homeless and non-chronically homeless populations

- This report is based on point-in-time information provided to HUD by Continuums of Care (CoCs) in the 2006 and 2005 Continuum of Care Homeless Assistance Programs applications and has not been independently verified by HUD. The user is cautioned that although CoCs are required to provide an unduplicated count of homeless persons, a standardized methodology to determine unduplicated counts of homeless persons within CoCs has not yet been implemented and the reliability of different street count methodologies can vary. Furthermore any data within this report that aggregates information above the CoC level is not unduplicated for homeless persons that may have been counted in more than one CoC.

For inquiries about data reported by a specific Continuum of Care, please contact that jurisdiction directly. CoC contact information can be found on the HUD web site.

***** - Data for both 2005 and 2006 was not available for Georgia and Mississippi

Individuals and Families

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 2006 Hunger and Homelessness Survey by the United States Conference of Mayors found that 68 percent of the survey cities report an increase in requests for emergency shelter during the last year. People remain homeless for an average of 8 months in the survey cities. Across the survey cities, the average increase in requests for emergency shelter by homeless families with children was 5 percent. Nashville (one of the 23 cities in the survey) experienced a 20 percent increase in requests for emergency shelter by homeless families. During the last year, 87 percent of the survey cities say that there was an increase in homeless children in the emergency shelter system; 13 percent of the cities said that there was no increase. [17]

Veterans

Convergent sources estimate that between 23 and 40 percent of homeless adults are veterans. The U.S. Department of Veterans estimates that as many as 200,000 homeless people are veterans, and that over the course of the year, as many as 336,627* veterans experience homelessness. They are veterans of different conflicts, including World War II, Korean Conflict, Vietnam Conflict, Grenada, Panama, Lebanon; research indicates that those serving in late Vietnam and post-Vietnam era are at greatest risk of homelessness. Recent media accounts highlight a small but growing trend of veterans from Iraq and Afghanistan showing up in shelters.[18]

*Note: Due to a calculation error, an earlier version of the report incorrectly listed the estimated number of homeless veterans over the course of a year as 495,400. The correct estimate is 336,627.

Tennessee: [19]
Number of veterans in 2005: 509,881
Number of veterans with severe housing cost burden* in 2005: 9,147
Number of homeless veterans in 2005: 2,515
Number of homeless veterans in 2006: 2,844 (a 13.1% increase from 2005)
.49% of veterans were homeless in 2005
* - Severe housing burden is considered to be paying 50% or more of income for housing (rent)

Veterans Returning from Iraq and Afghanistan
Are veterans who are returning from Iraq and Afghanistan becoming homeless? The Department of Veterans Affairs (VA) has reported that hundreds of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans are homeless.

17 U.S. Conference of Mayors – Sodexho Hunger and Homelessness Survey - December 2006
18 National Alliance to End Homelessness web site
19 National Alliance to end Homelessness, "Homeless Veterans in America" web link: http://naeh.org/section/data/homelessnessinst/_naeh_page (accessed 11/15/07)

According to a report prepared by the Congressional Research Service, "300 OEF/OIF veterans have used VA services for homeless veterans, and the VA has classified 1,049 as being at risk of homelessness."[20] Research on Vietnam veterans shows that significant time had passed before they became homeless.[21] It is unclear if the same pattern will hold for OIF/OEF veterans. Some data indicates that OIF and OEF veterans may experience homelessness sooner than their counterparts from Vietnam. Some troubling indicators include a large number of veterans who served after September 11 who are paying too much for rent, and a number of troops returning from Iraq and Afghanistan who have high levels of Post Traumatic Stress Disorder and Traumatic Brain Injury (TBI).

High Rates of PTSD and TBI

Recent studies suggest that veterans returning from Iraq and Afghanistan may face high risks of homelessness because of mental health problems: 19 percent of Iraq veterans reported a mental health problem, compared to 11.3 percent of those returning from Afghanistan.[22] It appears that combat exposure is an important contributing factor, as rates of PTSD for those returning from Iraq were almost twice the PTSD rates before deployment. Concern about the number of returning veterans with Traumatic Brain Injury, which is caused by concussive force, is also an issue. The symptoms of TBI "…are similar to PTSD. Survivors may appear normal but their memory is diminished; they lose their temper, cannot maintain family relationships and get in trouble with the law."[23] Headaches, dizziness, and trouble concentrating or sleeping are also side effects. The extent of the problem is still unknown. Government reports find that 65 percent of the veterans who served in Iraq and Afghanistan treated at Walter Reed Hospital were diagnosed with TBI.[24]

Weak Social Networks

Social networks made up of family and friends are important for everyone, but they are especially critical for those who are returning home to what often looks like a changed world. For returning veterans, adjusting to civilian life is the first major challenge. This includes reconnecting with family and friends, adjusting to lack of a structured lifestyle, addressing mental health or disabling conditions, identifying and navigating veteran's services, and finding employment and housing. Adjusting to civilian life could be more difficult for veterans returning from Iraq and Afghanistan because of longer tour duties of up to 2 years.[25] Research shows that the greatest risk factors for homelessness are lack of support and social isolation after discharge. Veterans have low marriage rates and high divorce rates and, currently, one in five veterans is living alone.

20 Perl, L. 2007. CRS Report for Congress: Veterans and Homelessness. Washington, DC: Congressional Research Service.
21 As cited in Perl, L. 2007. CRS Report for Congress: Veterans and Homelessness. Washington, DC: Congressional Research Service.
22 Hoge, C., Auchterlonie, J., & Milliken, C. 2006. Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. Journal of the American Medical Association. 295 (9): 1023-32.
23 Swords to Plowshares Iraq Veteran Project. Risk and Protective Factors for Homelessness Among OIF/OEF Veterans. Prepared for the National Coalition for Homeless Veterans. June 6, 2006.
24 U.S. House of Representatives Veterans' Affairs Committee. Press Release issued July 18, 2007.
25 Swords to Plowshares Iraq Veteran Project. *Risk and Protective Factors for Homelessness Among OIF/OEF Veterans*. Prepared for the National Coalition for Homeless Veterans. June 6, 2006. This source was cited in the "Vital Mission Ending Homelessness Among Veterans" report by National Alliance to End Homelessness, November 2007

Social networks are particularly important for those who have a crisis or need temporary help. Without this assistance, they are at high risk for homelessness.[26]

26 Swords to Plowshares Iraq Veteran Project. *Risk and Protective Factors for Homelessness Among OIF/OEF Veterans*. Prepared for the National Coalition for Homeless Veterans. June 6, 2006. This source was cited in the "Vital Mission Ending Homelessness Among Veterans" report by National Alliance to End Homelessness, November 2007

IV. Causes of Homelessness

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.[27]

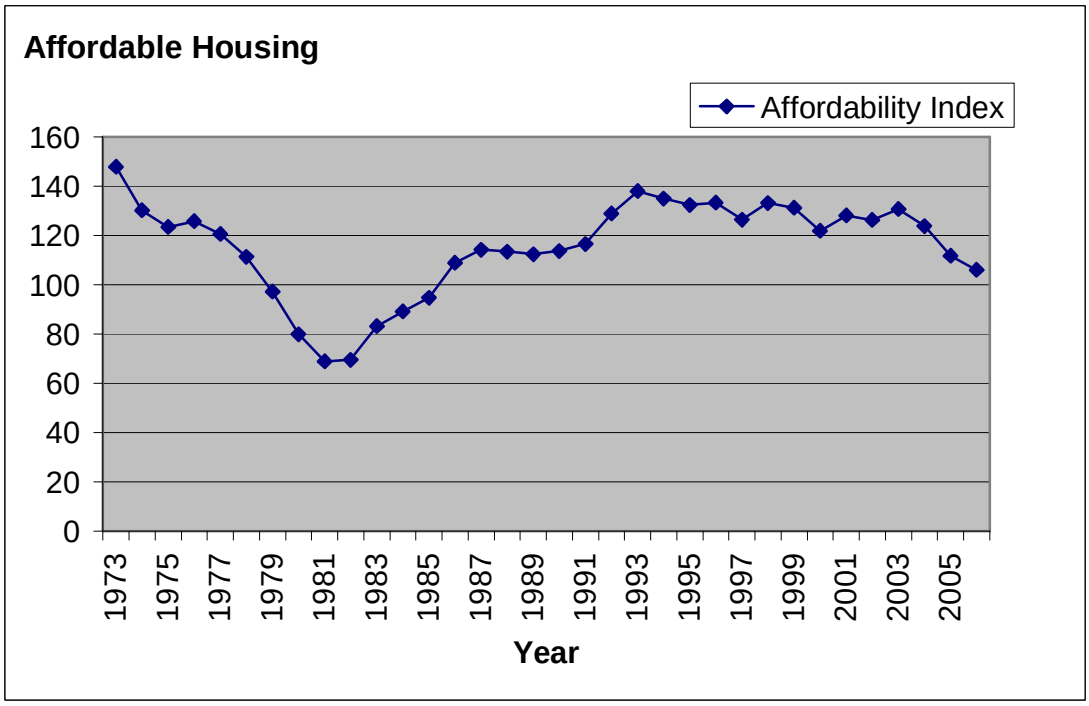
The shortage of affordable housing means some low-income households will become homeless. Those most at risk are people with disabilities, poor work histories, mental illness and/or addictions. These individuals and families can benefit from services and supports to overcome these barriers. But a successful 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 (and 10 percent in 2004[28]), compared to 2-5% in the most crowded cities.[29] As a result, housing here is also relatively inexpensive. A recent report calculates that an American family must, on average, earn at least $16.31 an hour to afford to rent a two-bedroom apartment. The Stamford-Norwalk, CT area had the highest Housing Wage* ($30.62), while rural areas of Louisiana had a Housing Wage of $8.42, the lowest for an area outside of Puerto Rico. By comparison, Chattanooga MSA's housing wage is $11.69 per hour.[30]

* Housing Wage is the full-time[31] hourly wage you would need to earn in order to pay what HUD estimates to be the Fair Market Rent for a home where you live spending no more than 30% of your income on housing costs.[32] (National Low Income Housing Coalition, "Out of Reach, 2006")

27 National Alliance to End Homelessness web site
28 Housing and Urban Development, Comprehensive Market Analysis Reports "*Analysis of the Chattanooga, Tennessee Housing Market as of August 1, 2004"*
29 Chattanooga Community Research Council, Quick Table DP-1: Profile of General Demographic Characteristics: 2000 U. S. Census.
30 "Out of Reach, 2006: America's Housing Wage Climbs," National Low Income Housing Coalition, 2006. 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.
31 Full-time work is defined as 2,080 hours of annual employment (40 hours per week, 52 weeks per year). In fact, this is a conservative estimate of the requisite wage because the necessary income must typically be earned in far fewer hours of annual employment (roughly 34 hours a week or 1,760 hours a year). See The Employment Situation: October 2006 retrieved November 19, 2006 from http://www.bls.gov/schedule/archives/empsit_nr.htm#2006.
32 The Housing and Urban-Rural Recovery Act of 1983 made the 30% of income standard applicable to all current rental housing assistance programs. This standard has remained in place since.

Availability of Affordable Housing in the United States



* The composite affordability index is the ratio of median family income to qualifying income. Values over 100 indicate that the typical (median) family has more than sufficient income to purchase the median-priced home.

Source: Publication of U.S. Housing Market Conditions – Feb. 2007, U.S. Dept. of Housing & Urban Development – Office of Policy Development & Research (Source of data for publication: National Association of Realtors, http://www.realtor.org/research.nsf/pages/HousingInx)

The US Department of Housing and Urban Development reports 5 million extremely poor households paying >50% of income for housing or living in severely substandard housing (*Source:* -National Low Income Housing Coalition)

Availability of Affordable Housing in Tennessee

"A 2003 study by the Tennessee Department of Mental Health and Developmental Disabilities reported that 2,000 persons live in 212 assisted living facilities for the mentally ill. In addition, 20 percent of those in the criminal justice system and 25 percent of the homeless have a diagnosed mental illness, about 12,000 Tennessee citizens. Programs such as the Creating Homes Initiative have helped address this need, but appropriate permanent units have been developed for less than a quarter of the population with special housing needs. In 2001, a statewide study estimated over 180 persons remained in Tennessee's Regional Mental Health Institutes because they lacked appropriate supportive community housing placement options. [33]"

33 Tennessee Department of Mental Health and Development and Disabilities, *Creating Homes Initiative (CHI) Phase II 2005 More!,* March 27, 2003, pp. 1-3.

Source: State of Tennessee Comptroller of the Treasury-Office of Research, "Seeking a way out Services and challenges affecting Tennessee's poor", April 2004

"As of March 31, 2004, THDA had 5,844 Section 8 vouchers available for use in 5,844 units across the state.[34] THDA has another 5,557 families on waiting lists for vouchers.[35] The agency reports a 36 percent success rate for vouchers. In other words, THDA generally issues two vouchers that expire before a voucher-holding family finds a suitable unit.[36] Section 8 vouchers are generally good for 60 days with a possible extension up to 120 days. Administrators note that some families have housing requirements that are hard to fill (i.e., large families, suitable location), making them less likely to secure housing. Local housing authority administrators in rural, urban, and suburban areas report that families often need more than the maximum allowable time to find suitable housing. They must reapply and begin again, sometimes ending up on waiting lists for rental assistance or moving into public housing developments."

34 "Number of Units by County as of March 31, 2004," Tennessee Housing Development Authority, http://10.171.13.4/s8ra/unitsxcty/asp, accessed April 7, 2004.
35 "Families on Waiting Lists by County as of April 7, 2004," Tennessee Housing Development Authority, http://10.171.13.4/s8ra/waiting.asp, accessed April 7, 2004.
36 Interview with Janice Myrick, Executive Director, THDA, Nov. 25, 2003.

Source: State of Tennessee Comptroller of the Treasury-Office of Research, "Seeking a way out Services and challenges affecting Tennessee's poor", April 2004

Availability of Affordable Housing in Chattanooga/Hamilton County

Occupants with Housing Cost Burden in Hamilton County[37]

Type of Occupant	Year ---->	Percent paying 30% or more of income for housing 2002	2005
Owners with mortgage ---------->		26%	28%
Owners without mortgage ---------->		5%	10%
Renters ---------->		34%	44%

Estimated Qualitative Demand for New Market-Rate Rental Housing Chattanooga HMA (August 1, 2004 to August 1, 2007) [38]

One Bedroom		Two Bedrooms		Three Bedrooms	
Monthly Gross Rent ($)	Units of Demand	Monthly Gross Rent ($)	Units of Demand	Monthly Gross Rent ($)	Units of Demand
500	325	650	675	800	500
550	275	700	550	850	400
600	250	750	500	900	375
650	225	800	425	950	350
700	200	850	350	1,000	300
750	150	900	275	1,100	250
800	125	950	225	1,200	225
900	100	1,050	175	1,300	200
1,000	75	1,150	125	1,400	175
1,100 and higher	1,250 and 50	1,500 and higher	100	higher	100

Note: Distribution above is not cumulative
Source: Estimates by Analyst

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 on second or third shift, the only times shelter beds are available.

Lack of transportation is also a major barrier to employment because many available jobs are not accessible by public transportation. The percentage of households in Hamilton County that do not have access to private transportation has increased from 5% in 2002 to 8% in 2005 [39]. Therefore, this transportation "gap" is also a barrier to employment for formerly homeless people or people who are on the brink of homelessness.

37 U.S. Census Bureau, American Community Survey (for 2002 & 2005)
38 U.S. Dept. of Housing & Urban Development – Office of Policy Development & Research, Comprehensive Market Analysis Reports "Analysis of the Chattanooga, Tennessee Housing Market as of August 1, 2004"
39 U.S. Census Bureau, American Community Survey (for 2002 & 2005)

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 $603 per month, while the fair market rent for a one-bedroom apartment is $516 per month.[40] 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 in Food Stamps.[41] 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. As of November 18, 2007, there were waiting lists of 582 households for public housing and 3,383 households waiting for Housing Choice vouchers.[42]

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.

40 "Out of Reach, 2006: America's Housing Wage Climbs," National Low Income Housing Coalition, 2006.
41 Tennessee Department of Human Services Rate Sheet, Rev. 11/7/03.
42 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 32,586 Housing Choice vouchers in use in Tennessee. The Chattanooga Housing Authority manages 3,040 of these, while the counties surrounding Chattanooga control approximately 1,140 additional vouchers. Source: Chattanooga Housing Authority, 2007

What do people who are homeless give as the reason for their homelessness?

Ranking	Primary Reason for Homelessness
1	Unemployment
2	Substance Abuse
3	Evicted
4	Mental Illness/Disability
5	Domestic Violence
6	Moved to Seek Work
7	Other
8	Unable to Pay Rent/Mortgage
9	Underemployment/Low Income
10	No Affordable Housing

Source: Chattanooga Regional Homeless Coalition – 2006

V. Current Response to Homelessness

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 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 Homeless Network collaborate to address the varied and often complicated needs of homeless people.

In 2006 The Community Kitchen provided 117,650 meals 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. Through partnerships with 45 area congregations, the Interfaith Homeless Network operates 365 days and evenings yearly providing day and overnight shelter, meals, case management, supportive services, links to community resources and follow up services for up to 22 homeless individuals in families.

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 Homeless 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 Tenncare[43] 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

43 Tenncare is the Tennessee State-administered medical insurance program that, until recently, operated under a federal waiver to fulfill the role of Medicaid.

$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 Homeless Network, a system of rotating church and synagogue-based shelters administered by volunteers.

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 his/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 with a CHA waiting list of 3,383 households. Public housing also has a 582-household 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.[44] 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 increases their length of stay 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 2005, 919 individuals served by the Homeless Health Care Center reported being homeless for more than one year; in 2006, the number was 1,089. [45]

44 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.

45 Homeless Health Care Center

VI. Current Impact of Homelessness

The Financial 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.[46]

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.[47]

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 much as 70% of these costs are borne by states, for psychiatric hospitalizations and additional Medicaid spending. Counties also spend substantial sums in un-reimbursed medical costs and incarceration expenses related to homelessness, while localities providing shelter and other emergency assistance pay for homelessness as well.[48]

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)*.[49] 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.

46 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.

47 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.

48 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.

49 Chattanooga/Hamilton County Regional Homeless Services Funding for 2004, Chattanooga Regional Homeless Coalition. $7.3 million spending on homelessness is from original *Blueprint*. A comparable figure for 2006 was not obtained, although it is expected to be of the same magnitude as the original amount reported. The total amount currently being spent annually will be obtained as part of the implementation plan to improve data accuracy and completeness of data. The amount received by the community through the Continuum of Care has decreased by nearly 25% since 2003, the funding for supportive services through the Collaborative Grant has ended and not been renewed, and we are forced to serve more homeless with fewer resources than in the past.

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[50]	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 [51]	64,500
Philanthropy	$3,182,000
Total	$7,324,000

50 "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.

51 "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 FY 2006, the City spent $3.7 million in CDBG and HOME funds on affordable housing development; in the previous year, $2.6 million was allocated to affordable housing. Approximately $2.6 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 60 - 65% of its HOME and CDBG budget to affordable housing. [52]

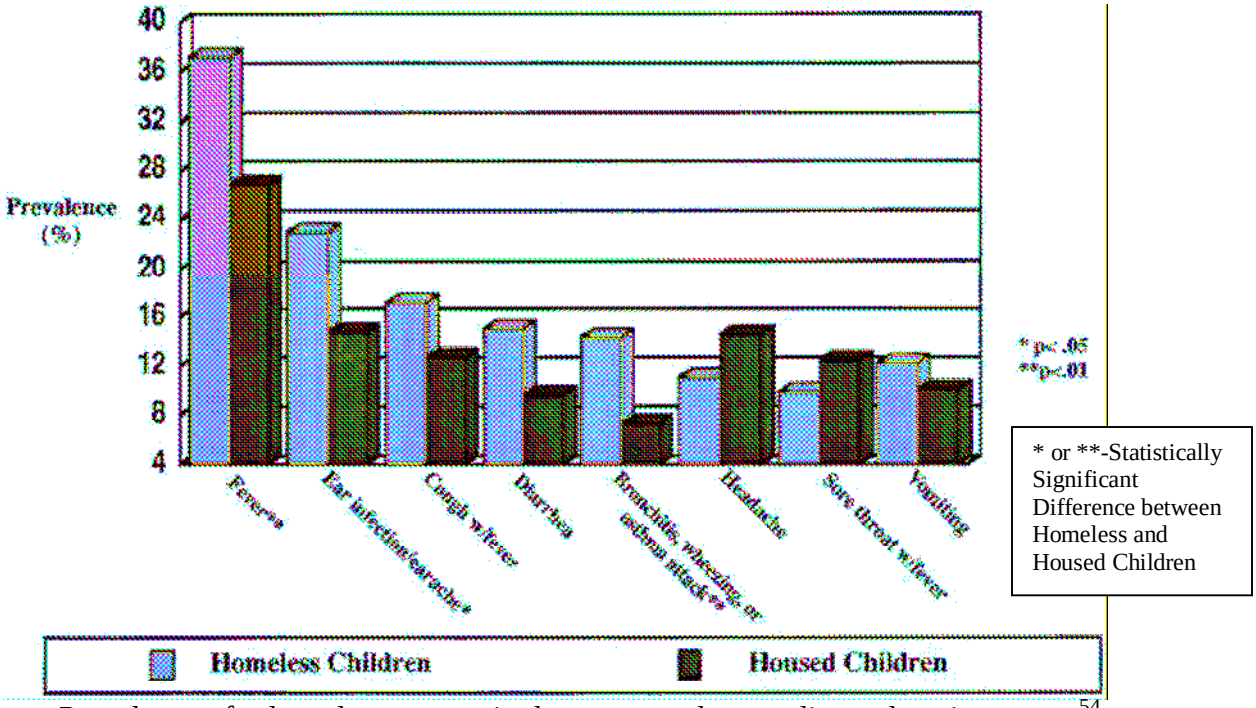
In addition, the Chattanooga Housing Authority manages over 3,000 units of publicly subsidized housing, funded with $14.2 million in federal funds. An additional $16 million in federal funds pays for Section 8/Housing Choice rental subsidy vouchers in Hamilton County. Recently, CHA used tax credits to fund construction of a 57-unit community and the renovation of a 98-unit development.[53]

52 City of Chattanooga Office of Economic and Community Development, 2006.
53 Information provided by Chattanooga Housing Authority (CHA), 2007.

The Personal Costs of Homelessness

"In the past two decades, there has been a dramatic rise in the number of homeless students enrolled in U.S. schools. Overwhelmed school personnel lack adequate resources and skills to successfully address the myriad of challenges – especially those outside the scope of academics – faced by homeless children. Issues like hunger, inadequate housing, poor health care, emotional difficulties, domestic violence, and family substance abuse, among others, have prompted educators to look increasingly toward collaborations with social service agencies as a possible solution."
"Achieving their educational potential is difficult for homeless children as they are twice as likely to repeat a grade or be suspended from school, and many attend three or more different schools in a year (Better Homes Fund, 1999)."
Source: "Collaborations of Schools and Social Service Agencies", Jan Moore, National Center for Homeless Education, December 2005

	Percent
Asthma Rate of Homeless Children Nationwide	20
Asthma Rate of All Children Nationwide	7
Homelessness also leads to higher rates of general illness: 54% of these children become sick more often after becoming homeless.	
Article: Family Homelessness in New York City – April 2001 *Source: Institute for Children and Poverty; National Center for Health Statistics*	



Prevalence of selected symptoms in the past month according to housing status.[54]

54 "Determinants of Health and Service Use Patterns in Homeless and Low-income Housed Children", Linda Weinreb, Robert Goldberg, Ellen Bassuk and Jennifer Perloff (http://www.pediatrics.org/cgi/content/full/102/3/554) PEDIATRICS Vol. 102 No. 3 September 1998, Page 557

In 1988, the Institute of Medicine of the National Academy of Sciences found that homelessness and poor health were strongly correlated in three ways[55]:

- Health Problems Cause Homelessness. Half of all personal bankruptcies in the United States result from health problems,[56] and it is a short downhill slide from bankruptcy to eviction to homelessness. Moreover, some health problems that are more prevalent among homeless people than in the general population – such as addictions, mental illnesses and HIV/AIDS – are known to undermine the family and social supports that provide a bulwark against homelessness for many vulnerable people.
- Homelessness Causes Health Problems. People without homes are mercilessly exposed to the elements, to violence, to communicable diseases and parasitic infestations. Circulatory, dermatological and musculoskeletal problems are common results of excessive walking, standing, and sleeping sitting up. Homelessness and malnutrition go hand-in-hand, increasing vulnerability to acute and chronic illnesses. Stresses associated with homelessness also reduce resistance to disease, account for the emergence of some mental illnesses, and enhance the false promises of relief offered by alcohol and drugs. Homeless people experience illnesses at three to six times the rates experienced by housed people.[57]
- Homelessness Complicates Efforts to Treat Health Problems. The health care delivery system is not well attuned to the realities of living without stable housing. Health care facilities often are located far from where homeless people stay, public transportation systems are insufficient or nonexistent in many places, and most homeless people don't have cars. Clinic appointment systems are not easily negotiated by people without telephones, for whom other survival needs (finding food and shelter) may take priority. Standard treatment plans often require resources not available to homeless persons, such as places to obtain bedrest, refrigeration for medications, proper nutrition or clean bandages.

55 Institute of Medicine, Committee on Health Care for Homeless People. Homelessness, Health, and Human Needs. Washington, D.C.: National Academy Press, 1988: http://www.nap.edu/openbook/0309038324/html/
56 Himmelstein DU, Warren E, Thorne D and Woolhandler S, Physicians for a National Health Plan. Illness and Injury as Contributors to Bankruptcy. Journal of Health Affairs Web Exclusive, February 2005: http://www.pnhp.org/news/2005/february/bankruptcy_study_hig.php
57 Wright JD. Poor People, Poor Health: The health status of the homeless. In: Brickner PW, Scharer LK, Conanan BA, Savarese M, Scanlan BC. Under the Safety Net: The Health and Social Welfare of the Homeless in the United States. New York: WW Norton & Co., 1990: 15–31.

"The experience of homelessness both causes and exacerbates poor health. Homeless people are at higher risk for chronic, uncontrolled medical conditions such as asthma (4–6 times higher), cardiovascular diseases (2–4 times higher), and diabetes (up to 2 times higher) than are people in stable housing (Bonin et al. 2004, Zerger 2002). In national studies, overall prevalence rates of chronic medical illnesses range from one-third to one-half of surveyed homeless populations, compared with less than one-quarter of the housed population (Zerger 2002)."

Source: Medical Respite Care for People without Stable Housing by Robert Donovan, MD; Dawn Dee, RN, PHN; Lisa Thompson, RN, ND;Patricia Post, MPA; Suzanne Zerger, MA (Published by Health Care for the Homeless Clinicians' Network National Health Care for the Homeless Council, Inc. in Homeless Health Care Case Report: Sharing Practice-Based Experience Volume 2, Number 3 | March 2007)

"Homeless persons have been shown to have high mortality rates in studies from Atlanta [58] and San Francisco.[59] In Philadelphia, the mortality rate in a cohort of homeless adults was 3.5 times that of the general population.[60] Hwang and colleagues in Boston found that homeless men aged 18 to 24 years were 5.9 times more likely to die than housed counterparts, and men aged 25 to 44 years three times more likely to die.[61]"

58 "Deaths among the Homeless: Atlanta, Georgia," Morbidity and Mortality Weekly Report 1987; 36:297-299.
59 "Deaths among Homeless Persons: San Francisco, 1985-1990," Morbidity and Mortality Weekly Report 1991; 40:877-880.
60 Hibbs JR, Benner L, Klugman L. "Mortality in a Cohort of Homeless Adults in Philadelphia," New England Journal of Medicine 1994; 331:304-309.
61 Hwang SW, Orav EJ, O'Connell JJ, Lebow JM, Brennan TA. "Causes of Death in Homeless Adults in Boston," Annals of Internal Medicine 1997; 126:625-628.

Life Expectancy

US Population: 77 years

Homeless in Boston: 47 years

Homeless in Atlanta: 44 years

Homeless in San Francisco: 41 years

Source: The National Health Care for the Homeless Council publication

VII. System of Community Support – Key Perspectives and Emerging Challenges [62]

Key Perspectives

Looking at a ***community's service delivery system to help people who are homeless (near-homeless)***, we see five key perspectives:

- **Homeless (near-homeless) perspective:** First-hand experience of homelessness and being a recipient of services help identify specific gaps in the service delivery system and opportunities for improvement.
- **Service provider perspective:** Seeing how a segment of the service delivery system operates can provide insight into barriers and gaps related to specific services.
- **Homeless service delivery perspective:** Looking at the issues contributing to homelessness and the mix of services/housing that play a role in recovery can provide a holistic view of homelessness and potential solutions.
- **Systems perspective:** Looking at the interaction of processes (assessment, case management, providing services, measuring performance, identifying gaps, implementing improvements) that make up a system provides the clarity and objectivity to work towards sustainable improvements.
- **Community perspective:** The foundation of any service delivery system is the community in which the system operates. Therefore, the community must be able to see that the service delivery system is effective and efficient and that there is a positive impact on the broader community.

Key Emerging Challenges

Data Quantity and Quality

The social service environment today is characterized by greater demands that must be met with fewer resources. Increasingly, funding sources are more concerned with an agency's ability to demonstrate positive outcomes as opposed to just measuring output (services provided). Furthermore, the myriad of factors leading to homelessness presents a complex problem best solved by compassion and collaboration guided by accurate information.

The challenge of building an information system to collect an adequate quantity of data still exists but is now being joined by a subsequent challenge: adequate quality of data (data integrity). Many service providers collect data primarily for reporting activities to funding sources; not for analysis to improve processes or identifying service gaps. Such data collection emphasis and under-utilization of data puts numbers and reality on divergent paths that, at best, will lead to lost opportunities and, at worst, wrong policy and agency decisions.

62 Section VII comes from Chattanooga Community Resource Center [CCRC] report (not yet published as of November 2007)

To illustrate a data integrity issue, we can compare the classification of one group of individuals who have been entered into two information systems.[63] The results are as follows:

Six hundred thirty two people had their homeless status (homeless or not) specified in both systems. Of those 632 people, 229 had discrepancies in their homeless status (i.e. were listed as homeless in one system and not homeless in the other system). Another subset of people appearing in both databases showed that 49 out of 189 had race discrepancies and even 9 out of 178 had gender discrepancies.

Both of these organizations work diligently to collect and enter critical community data. These discrepancies (a data integrity issue) should not reflect negatively on their operations but should demonstrate the need for more consistent definitions and classification processes across community systems.

Performance Measurement

The measurement of outcomes presents another challenge. Service providers are being held more accountable for producing positive outcomes. Positive outcomes are more client-dependent than the traditional output measures. An output measure like "number of meals provided" can be more easily controlled by an agency than an outcome such as "percentage of clients maintaining stable housing for 12 months". Agencies without quality processes that can be documented and validated will be at the mercy of chance outcomes that ultimately will indicate poor performance. Then, when confronted with a poor performance, the service providers with inadequate processes will have a difficult time obtaining funding to sustain operations. Conversely, service providers who can demonstrate a quality process can better "weather the storm" of occasional negative outcomes that are inevitable when working with people.

Data quality and performance measurement challenges are not unique to homelessness or the Chattanooga region, as shown by just one of many national efforts regarding these issues:

"The National Working Group to Improve Child Welfare Data comprises representatives from state child welfare agencies and is facilitated by the Child Welfare League of America. The National Working Group collaborates with researchers, other national organizations, and the Children's Bureau to address data quality and comparability between states. In the Fall of 2005, the National Working Group released a new report on data comparability— *Defining Reunification for Consistent Performance Measurement*. The group also has initiated an effort to develop common definitions to promote more uniformity in state data reporting, and ultimately more meaningful comparison among state data and outcome measures. Reports can be accessed at http://ndas.cwla.org."
Source: Child Maltreatment 2004 - Department of Health & Human Services Administration for Children and Families

63 Analysis done as part of CCRC research. Data Sources: Chattanooga Regional Homeless Coalition ServicePoint Homeless Management Information System and Hamilton County Sheriff Department

"Finally, one of the original charges to the Work Group was to 'itemize accountability and evaluation processes.' This called for establishing *monitoring and evaluation benchmarks* pertaining to chronic homelessness. However, the absence of data to inform the Department about a baseline suggested considerable developmental work would be needed before empirical benchmarks could be established. Over the past several years, the ability to demonstrate results towards ending and reducing homelessness in a quantitative fashion has increased, and thus, where the original plan included a recommendation for this work, a more focused effort to develop data and performance measurements will be critical to documenting future success and is a key component to the revised strategic action plan."

Source: "Strategic Action Plan on Homelessness" U.S. Department of Health and Human Services, March 2007

Collaboration

There is an overwhelming need for better collaboration among service providers and other community organizations to improve the service delivery system. The fact that nearly all funding sources are placing more emphasis on collaboration has increased the urgency to work together. It is critical to note, however, that a collaboration system that works in one community may not work in another without some modification to "localize" the approach.

A similar note of caution is expressed by the National Center for Homeless Education in the context of schools collaborating with social service agencies:

"There's no doubt that successful collaboration is difficult to accomplish. It requires not only pre-planning but constant monitoring as the collaborative matures. Unfortunately, there seems to be no one size fits all pattern of collaboration. A collaborative group must examine each member's organizational capabilities to determine the overall goal. They must also be flexible and creative enough to choose the right bits and pieces from other collaboratives to emulate and fuse them in the right combination to create their own opportunity for success. What leads to a very successful collaborative effort in one situation may not be at all useful in a different situation."

Source: "Collaborations of Schools and Social Service Agencies", Jan Moore, National Center for Homeless Education, December 2005

The National Center for Homeless Education also points out that "Starting the collaboration with a small manageable project will build confidence to maintain momentum and undertake larger tasks."

VIII. The Blueprint Planning/Revision 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."*[64]

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 Chattanoogans with extensive experience and expertise in homelessness, housing, mental health and emergency services to lead the effort by serving on a Blueprint Steering Committee.[65] 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.[66] 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

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

65 See Appendix A1 for a list of the members of original Blueprint Steering Committee.

66 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.

providers, housing developers, government administrators, foundation executives, business and community leaders, national experts and homeless people themselves. To ensure that all of the voices of the community were heard, and the full extent of national knowledge and expertise were utilized, The original 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.

Process for 2007 Update of *The Blueprint*:
In July 2007, Mayor Littlefield asked a broad range of community members to form the Blueprint Task Force. The mission of the Blueprint Task Force was to update the Blueprint to ensure it meets the challenges of homelessness in 2007 and to develop an implementation plan. All Task Force members were asked to fully engage people who are homeless in the process by either inviting individuals who are homeless to participate in discussions or by reflecting the homeless perspective based on focus group discussions and experience helping people who are homeless.

The Task Force consisted of a Steering Committee and five sub-committees with guidelines listed below:

Steering Committee:

- Ensures adherence to timeline and process.
- Establishes scope of Task Force assignment.
- Prepares report to be given to mayor.

Each Sub-Committee:

- Works on assigned issue within its assigned scope.
- Provides the necessary focus on a specific issue.
- Makes recommendations to Steering Committee regarding assigned issue.
- Is free to engage other members of the community (if necessary to fully address a specific issues that arises).

Membership of each Sub-Committee should ideally have approximately 7 members with:

- At least one member having extensive *Blueprint* knowledge.
- At least two members who are experts on the Sub-Committee issue.
- At least one member representing homeless/formerly homeless population.
- One or two members to provide business, faith-based and general public perspectives.

Scope of activity for each Sub-Committee:

- Specifies incidents/examples that illustrate how assigned issue interacts with issues of other Sub-Committees.
- Make recommendations to Steering Committee regarding:
    1) Adding/Dropping/Emphasizing specific elements of the *Blueprint.*
    2) Revising any numeric goals stated in the *Blueprint.*

Guidelines for each Sub-Committee:

- Sub-Committee would have specific *Blueprint* element(s) on which to focus.
- Sub-Committee only makes recommendations regarding assigned elements.

Sub-Committees:

- Housing – Assigned *Blueprint* elements: Recommendations #1, 2.
- Services – Assigned *Blueprint* elements: Recommendations #3, 4, 5.
- Prevention– Assigned *Blueprint* elements: Recommendations #6, 7, 8.
- Planning/Coordination– Assigned *Blueprint* elements: Recommendation #9.
- Community Reintegration – New.

<u>Timeline:</u>
July 13, 2007 - Mayor Littlefield convened the Blueprint Task Force
July 14, 2007 - October 15, 2007: Sub-Committees met to discuss assigned issue(s)
August 28, 2007 - Subcommittee updates given to Blueprint Task Force
October 26, 2007 - November 20, 2007: Steering Committee review of revisions and discussion of implementation issues

IX. Design Guidelines

The Blueprint 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 nine principles:

1. Every effort will be made to prevent homelessness before it happens.

2. The goal of 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.

9. The *Blueprint* is a "living document" whose relevance must be maintained through periodic revision to respond to current needs and new challenges.

X. A New Approach

A Tradition of Care

Over the past twenty-five 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.

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 homelessness in the Chattanooga region.

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.[67] 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%.[68]

Prevention, Rapid Intervention and Community-based Supportive Services

The Blueprint 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 help better serve and house people who are homeless, 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.

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.

67 See Appendix B for more on supportive housing.
68 Culhane et al, 2001.

Chattanooga's new approach reflects a national change in strategy now occurring nationwide: using an array of best-fit strategies to help homeless people become self-sufficient. Rather than restricting a community's strategy to a "one size fits all" effort, the *Blueprint* promotes client-driven, research-based approaches that recognize the best solution is one that takes into account the unique challenges presented to different segments of the homeless population. For example, the efforts to help chronically homeless people build on what is often referred to as a "housing first" approach: low barrier entry into housing (with the required supportive services). The "housing first" approach is also one of the approaches that can be used to help other segments of the homeless population obtain and maintain stable housing. *The Blueprint* refocuses efforts away from mitigating the discomfort of homeless people and toward actually trying to end their homelessness. An array of best-fit, segment-specific, evidence-based approaches is believed to be an effective strategy to end homelessness, while addressing the unique needs of the most vulnerable members of our community.

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 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 Chattanoogans traditionally apply to major initiatives in their community is employed in the implementation of *The Blueprint*, then we can make great progress in ending homelessness in the Chattanooga region.

XI. RECOMMENDATIONS

Toward a New System of Homeless Services

The Blueprint 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* offers a comprehensive plan that relies on five spheres of activity, each with its own recommended strategies and actions:

A. Expanding customer-focused paths to (and opportunities for) permanent housing
B. Increase access to services and supports
C. Prevent homelessness
D. Establish a mechanism for planning and coordination
E. Community reintegration

The first two "spheres" of activity are the most critical in helping people who are homeless obtain and maintain permanent housing. Housing and supportive services are not independent of each other when it comes to ending homelessness. The most effective approach involves an increase in availability and intensity of supportive services that is proportionate to the increase in affordable housing. Some people who are homeless and provided housing are able to maintain their housing and become more self-sufficient. However, many people who are homeless need supportive services and a social network to maintain their housing long-term. Furthermore, providing only housing to someone who also needs supportive services runs the risk of a bad housing experience that may discourage the landlord from making housing units available to homeless people in the future.

Community Reintegration

The first four spheres of activity above are supplemented by a fifth one not included in the original *Blueprint*: Community Reintegration. This activity is a critical task that extends well beyond the traditional system of services; reintegrating people who are/were homeless into the broader community and providing a welcoming, supportive environment in which to move toward self-sufficiency.

What often makes the difference between homelessness or stable housing for someone experiencing personal or economic challenges is a positive social network. Such a network goes beyond any clinical network of support and helps build the relationships needed to fully connect a homeless/formerly homeless person to the broader community. The opportunity for such connections is a vital step in restoring a sense of citizenship. The essence of community reintegration has been achieved for people who are/were homeless when each person feels welcome to be a part of a community and to participate (or not participate) as they desire.

Jack Webster[69] *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."

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

A. Expanding Customer-focused Paths to (and Opportunities for) Permanent Housing

The number of people experiencing homelessness in the Chattanooga region at some time during the course of each year is increasing, especially among families. In 1993, homeless children comprised approximately one-quarter of the total number of homeless on the streets. This estimate has increased to approximately one-third of the total homeless population as the economic circumstances for Chattanooga's low-income population have worsened and the amount of affordable housing available has decreased over the years, in spite of increased availability of housing vouchers, public housing and shelter plus care vouchers for specific homeless populations. The growth has not kept pace with the decline in affordable housing in the private market place, especially with the number of neighborhoods asking for and obtaining zoning decisions that cause properties formerly zoned for multi-family to revert to R-1 zoning.

Not only have we seen an increase in the number of individuals and families on the streets and in shelters, thousands more of the region's residents live doubled up in the homes of family and friends or live in hotels on a week to week basis. Many of these individuals are at imminent risk of homelessness, living in temporary, substandard or overcrowded housing they cannot afford.

In 2003, *The Blueprint to End Chronic Homelessness in the Chattanooga Region in Ten Years* laid out the foundations for a long-range, comprehensive plan to help homeless people in our area return to healthy and stable lives in permanent housing. The Committee appointed to re-examine *The Blueprint* and make recommendations for improving the Region's chances of either ending or significantly reducing homelessness as it relates to moving people toward permanent housing has examined housing conditions in today's economic climate. The Committee has worked diligently to ensure that while we move people and families toward permanent housing we do not overlook the need for safe, sanitary and decent shelter while a more permanent home is being prepared for them.

As its original title clearly indicated, *The Blueprint* plan was intended to end long-term, or "chronic" homelessness. But the scope of *The Blueprint* was not limited to chronic homelessness and neither are these recommendations. The policy recommendations must also result in a significant reduction of all types of homelessness, including homelessness among families, youth and single adults who experience episodic homelessness.

To do this, we must invest resources in a coordinated, sustained effort that addresses the underlying causes of homelessness. This effort will:

- Reduce the number of people who become homeless each year.

- Decrease the number of homeless individuals and families who are unsheltered on any given day or night.
- Increase the number of homeless people placed into permanent housing each year.
- 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.

Housing Issues

In 2003, *The Blueprint* recommended creating 1,400 units of permanent affordable housing for homeless people by 2014. This was to be accomplished through a combination of rental subsidies, preservation and new development. The region has seen an increase in 671 units of housing become available for homeless individuals and families and an increase in allocation of resources to preservation and new development. However, we have lost nearly as many affordable housing units through demolition, obsolescence, deterioration, rezoning and conversion to "market-rate" housing as we have seen an increase in "affordable" units. Moreover, zoning restrictions and neighborhood opposition to multi-family and special needs housing in the Chattanooga region has resulted in the loss of grants and investment dollars that could have significantly moved the community toward the housing production goals initially set forth by *The Blueprint.*

In 2003 there did not appear to be a need to increase emergency shelter and transitional housing capacity, except for some specialized populations, such as youth. Instead, *The Blueprint* recommended that we move homeless people through emergency and transitional programs more quickly in order to free up shelter and program space to allow transitional programs to serve a greater number of homeless people each year. In 2007, it is still true that shelters and transitional programs need to be focused on transitioning their clients into permanent housing and evaluated based on the number of persons/families who achieve and remain in permanent housing more than 12 months, but the original recommendation did not fully account for the fact that there is shelter space for less than half of those who are homeless on any given night. Nor did it recognize that (1) there is not enough affordable housing available in the community to meet the current demand, let alone the demands of those who are homeless; (2) the affordable housing that is available is often not in areas where the homeless individual or family would like to live; (3) there is not enough either, temporary or transitional shelter capacity to provide safe, decent places to stay while they are waiting for permanent housing to become available; (4) even when, either a housing voucher or housing unit becomes available, there can still be anywhere from a 2-week to 6-month wait before they will actually be housed; (5) even with a voucher in hand and knowledge of what is available that they can afford, homeless individuals and families have difficulty getting to the units in a timely manner due to lack of transportation; (6) when they do connect with a landlord, they often have difficulty overcoming the landlord's preconceived stereotypes of homeless persons, their lack of a positive housing history and negotiating with prospective landlords to take a chance on them and working with the Section 8 housing program; and (7) there are additional costs of getting into permanent housing that are often overlooked, such as security and utility deposits, furniture, household goods, and cooking utensils.

The Costs of Homelessness and the Savings of Supportive Housing

It is a fact that homelessness is itself expensive to the community due to the use of costly emergency services by unsheltered and unsupported individuals and families and that supportive housing where housing is linked to on-site or visiting case managers and counselors can reduce these costs. However, the costs of supportive housing must still be factored into the equation as well. Following the lessons learned from the Collaborative Grant to End Chronic Homeless which served 50 chronically homeless with a mentally illness diagnosis, providing both subsidized housing and supportive services for 1,400 homeless individuals would require an investment of between $22 - $44 million annually by the community. The evaluation of the Collaborative Grants nationally revealed that about half of the participants were still in permanent housing after three years in the program, about one-quarter were back on the street and about one-quarter treated the program much like transitional housing and moved back into the private sector as a result of the program.

The recent research quoted above, as well as other research listed in the appendix to this report, suggests that transitional housing programs can be equally successful for helping homeless individuals and families who are not seriously mentally ill move into and retain permanent housing without the ongoing more intensive and costly supportive services associated with *supportive housing.* These transitional programs must maintain contact with and provide minimal support for a period of 6-12 months to graduates in permanent housing to obtain the highest levels of successful placement, but such follow-up is not nearly as costly or long-term as the supportive housing model.

RECOMMENDATIONS

To help address these shelter and housing 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 three main strategies: 1) expanding permanent housing opportunities, 2) increasing the availability of transitional shelter units that move people to permanent housing, and 3) providing permanent special needs housing and alternatives.

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: Expand Permanent Housing Opportunities.

1.1) Create a minimum of 200 affordable housing units for homeless people per year through the provision of rent subsidies, new housing development and the preservation of affordable housing stock.

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

1.1.1) Increase the number of federally-funded Section 8/Housing Choice rental subsidy[70] vouchers available to people who are homeless or have special needs in the Chattanooga region, from the following sources:

- Fifty vouchers recently awarded to a collaboration of providers and government agencies through the federal Collaborative Grant to Help End Chronic Homelessness.[71]
- Thirty Five 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).[72]
- In 2005, Chattanooga was one of 11 cities around the country to receive a two-year grant through HUD's new *Housing for People Who Are Homeless and Addicted To Alcohol* program, a special initiative designed to assist homeless persons who also struggle with chronic alcoholism. The grant provided housing vouchers for 100 people in Chattanooga and the surrounding counties (with matching supportive services to be provided by local service providers).
- 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.[73]

1.1.2) Develop a local program to provide a time-limited rental subsidy of 4 months to 2 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

70 The federal Section 8/Housing Choice voucher program is administered by the United States Departmentof 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.

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

72 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.

73 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.

of such similar efforts as the Individual Self-Sufficiency Initiative (ISSI) in Massachusetts.[74] By the end of the local subsidy's time limit, recipients will either earn adequate income to remain housed or be provided a Section 8/Housing Choice voucher.

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

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

1.1.3) 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.

1.1.4) 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.[75]

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

1.1.5) Develop new affordable housing units through new construction, acquisition and major rehabilitation, using the following resources:

- Ten percent of Tennessee's allocation of the federal Low Income Housing Tax Credit earmarked for people with special needs.
- Ten percent of Tennessee's allocation of federal HOME dollars earmarked for people with special needs.
- Fifteen percent of Tennessee's allocation of federal HOME dollars earmarked for Community Housing Development Organizations.
- Federal 811, 202, 221(d) and 236 housing development programs.
- Federal Community Development Block Grant (CDBG) allocation to the Chattanooga region.
- Grants and discounted loans from the Federal Home Loan Bank of Cincinnati.[76]
- 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.

1.2) 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

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

76 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.

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 by:

1.2.1) Funding a "Housing Ombudsman" who can negotiate with landlords on behalf of homeless persons and coordinate the linkage between the landlord, homeless persons and support agencies to decrease the housing search time for homeless persons and families. The ombudsman should also arbitrate or mediate conflicts between landlords and a homeless family/individual to help keep the family/individual in housing once housed.

1.2.2) Providing preferences for homeless people in publicly-subsidized permanent housing. 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.

1.2.3) Creating a local community housing subsidy program that will bridge the affordability gap for individuals until either employment and income increase eliminating the need for the subsidy, or more permanent affordable housing alternatives become available.

1.2.4) Implementing a Community Furniture Bank to provide furniture and household goods to homeless individuals and families who are moving into permanent housing.

1.2.5) Providing a fund to cover the initial costs of permanent housing such as security deposits, utility deposits, excessive utility costs, and damages and repairs to units cause by a formerly homeless family or individual.

1.3. Implement inclusionary zoning ordinances to encourage, if not require, the development of affordable housing as a percentage of other housing development in the community (see Appendices D1-D8 for a model zoning code from the American Planning Association)

1.4. Provide incentives for developers to build affordable housing

1.4.1) Ensure that adequate public transportation is available to serve such affordable housing to increase marketability of the housing.

1.4.2) Provide tax breaks for developers who include affordable housing.

1.4.3) Reduce the barriers to obtaining building permits for developers who include affordable housing in their plans.

1.5. Work with schools, employers and businesses moving to the community or developing new sites to include the purchase of land that can be developed for affordable workforce housing near the properties being developed for educational, industrial, business or commercial use.

Recommendation #2: Increase the availability of transitional shelter units that move people to permanent housing.

2.1) Provide adequate transitional shelter space to provide safe, decent and sanitary shelters for homeless individuals, families and youth until adequate and appropriate permanent housing is available

2.1.1) Persons entering transitional housing programs should be placed on the waiting list for permanent housing as soon as feasible and not wait until they have completed the program before seeking permanent housing.

2.1.2) Transitional programs should be funded to provide a minimum of twelve-months follow up once a family or individual moves into permanent housing unless they move into a supportive housing program.

2.2. Increase funding for emergency or short-term housing that fills the gap between becoming homeless and finding either transitional or permanent housing

2.2.1) Increase the number of shelter beds for homeless persons, especially women and families

2.2.2) Increase the number of shelter beds for intact families (mother/father and siblings of all ages) instead of separating families based on sex and age.

2.2.3) Increase the number of units available for homeless emancipated teens separate from adults

Recommendation #3: Provide Permanent Special Needs Housing and Alternatives.

3.1) Ensure that adequate housing is available for those populations that need more intensive long term case management and supportive services:

3.1.1) Housing for persons with disabilities.

3.1.2) Housing for elderly.
3.1.3) Housing for persons with mental illness.
3.1.4) Housing for persons with substance abuse issues.

3.2) Develop housing policies that recognize that, despite our best efforts, not all persons we serve will choose to accept the supportive services designed to help them address their mental health or substance abuse issues and will be faced with eviction and homelessness. Such episodic homelessness and violations should not exclude them from assistance in the future, either through alternative programs, therapeutic communities or being re-housed in a supportive housing program.

3.2.1) While we believe that homeless and formerly homeless people should be offered choices in services and housing, it is also imperative that we recognize they have the right not to accept the choices offered.

3.2.2) Services must be delivered to people both in and outside permanent housing settings.

3.2.2.1) Attention must be paid to preparing people for permanent housing and the expectations association with obtaining and retaining permanent housing.

3.2.2.2) Once they get into housing, attention must be focused on issues ensuring that they maintain and retain their housing:
- Paying bills on time.
- Budgeting.
- Increasing income (employment, etc.).
- Dealing with conflict with neighbors and landlords.
- Accessing services.
- Property damages and responsibilities.

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 homelessness, 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, and provide aftercare. 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, many 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 an individual's 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 #4: Reconfigure case management to be assertive, coordinated and focused on placing and maintaining homeless people in permanent housing. Prioritize funding both for case management to homeless people and continuing case management and supportive services to formerly homeless people placed in permanent housing.

In theory, 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. General 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

4.1) Maximize current funding and seek additional funding for case management and supportive services to homeless and formerly homeless people. A variety of existing funding sources can maximize 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.

4.2) Appoint a lead agency to support a Case Management Coordinator position 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, establish best practices and benchmarks, 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 ServicePoint homeless

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

4.3) Develop and implement a system-wide standards and training program for case management to homeless and formerly homeless people.

4.3.1) Link to other training and licensing programs.

4.3.2) Include training in local resources and procedures, including expedited entitlements application procedures.

4.3.3) Establish clear guidelines for designing case management service plans with measurable milestones.

4.4) 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 have support systems for success in place. 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.

4.5) Develop a community scorecard, or similar instrument, that links service providers to best practice standards of case management through annual reporting of actual outcomes by provider. In order to encourage and be accountable for best practices in our community, it is recommended that the case management committee establish best practice standards for the case management services and report results to the community on an annual basis. As the funding environment turns to results-oriented, performance-based systems, it is essential that the case management committee incorporates this approach into their work. By tracking provider specific results, continuous quality improvement initiatives can maintain and raise the overall service standards. Annual reporting to the community will raise the community's awareness and thus, their engagement with this issue.

4.6) Create specialty case titles for Case Managers. To ensure seamless services, it is necessary to distinguish whether a "case manager" is trained on best practices. Also, for homeless services providers, it is necessary to distinguish whether a case manager primarily serves the homeless for crisis services or permanency services.

Create Additional Tools and Resources for Case Managers

4.7) 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.

4.8) 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.

4.9) 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.

Agreements should be initiated with business representatives to discount required deposits. In addition, many items such as furniture and appliances are needed when moving into permanent housing. Arrangements with community groups and businesses can assist in supplying the furniture and equipment necessary to equip a home.

Donations from the public, community groups, and businesses are successful in outfitting a new home. Warehouse space must be available to store furniture, appliances, equipment, etc. until claimed by the homeless person moving into housing.

4.10) 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 #5: 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 into permanent housing with supportive services is similarly unavailable.
- There are few 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

5.1) 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 is also a need for additional 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.

5.2) Evaluate outreach staffs 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.

5.3) 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.

Improve Access to Shelter and Housing

5.4) 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.

5.5) 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.

5.6) Develop a community collaborative approach and seek federal funding for adequate services to homeless youth, including transitional, respite and independent living programs. A successful transitional living program that provided shelter and flexible supportive services for homeless, runaway and "aging out" of foster care 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 youth. Additionally, the state funds local services for youth "aging out of foster care" for only three months and this is not enough to ensure self-sufficiency. Funding will be sought to create a transitional living program that will, once again, fill this need. A new program will incorporate evidence-based practices identified by the federal Interagency Council on Homelessness and the Department of Health and Human Services from a joint report on strategies to end youth homelessness.

5.7) 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 had 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

5.8) 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.

5.9) 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.

5.10) 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 fund to pay transportation costs for people who can prove they have an appropriate place in transitional or permanent housing waiting for them.

Recommendation #6: 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 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:

6.1) 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.

6.2) 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.

6.3) 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. Transportation is particularly crucial to improving access to services and supports, in addition to overcoming the barriers to employment. Transportation provides access to medical care, substance abuse and mental health treatment services, counseling services, day care, job training and placement. The end result is to move homeless people into mainstream service systems. The City will explore ways to make these two systems more responsive to the needs of homeless people.

6.4) 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 administered by HUD. The McKinney Act, the primary federal funding stream for homeless services and housing, provided $910,084 million to fund various homeless service and housing programs in the Chattanooga region in 2006 for the local Continuum of Care, funneled through the Chattanooga Regional Homeless Coalition. 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. Identify the state and federal governments' funding opportunities and 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.

6.5) Review the Chattanooga region's current array of inpatient and outpatient substance abuse and mental health treatment services to examine the adequacy of existing capacity, treatment modalities and aftercare supports. The Chattanooga region has some effective substance abuse and mental health 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 abuse and mental health 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.

6.6) Expedite enrollment of homeless and formerly homeless families and individuals into TennCare and food stamps. In 2006, 90% of people receiving medical services at the Homeless Health Care Center did not have health insurance, even though 95 % had incomes equal to or below the poverty rate. 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.

6.7) 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.

6.8) Improve homeless, at-risk and runaway youths' 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 Homeless 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 Homeless 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

While preventing homelessness can be very challenging, communities do have the opportunity to address the need in a systematic and effective way. We recommend that a lead agency be designated with the expertise to develop new resources, coordinate existing services and implement both short and long term plans to meet the needs of chronically homeless individuals as well as families currently in crisis or potentially homeless.

Focusing on the prevention of homelessness presents many challenges. Individuals may be unaware they are at risk of losing their housing and often are dealing with multiple issues that make finding permanent, safe housing problematic. Or they may be discharged from a system and have little or no resources and the necessary skills to move on to the next step of their lives. It is for these and many other reasons that most localities for years have focused the majority of their resources on interventions that help people only after they become homeless. But while preventing homelessness can be very challenging, regions do have the opportunity to address prevention in a systematic and effective way. 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. A total of 30,104 individuals in the nine surrounding Southeast Tennessee counties, or 16.30%, live below the line. In fact, a little over 25% of the residents of Bledsoe County live below the poverty line. Almost all of these impoverished individuals and families, in both the urban and rural areas, are at risk of homelessness.

Any life event or situation can tip these families into homelessness. Other populations at particular risk include:

- Youth aging out of foster care
- The near elderly who may be unable to work but who are not quite old enough to receive either Social Security or Medicare
- Individuals with mental illness
- Individuals discharged from health care
- Those discharged from jail/prison
- Family violence victims
- Families who are just above the limit for TennCare or Medicaid
- Families at risk of foreclosure/bankruptcy
- Those in danger of eviction
- People in substandard housing
- Those displaced by natural disasters
- Families whose residences are burned

- Travelers who are passing through without resources to continue

This is just a sampling of those at risk. For each one of these homelessness feeder systems, there are different questions to ask; for some there are existing services that are not being utilized. Some need help on an emergency basis, while others need long term care plans and/or treatment. Those who are homeless for the first time present very different opportunities and challenges than the long-term homeless. The solutions vary as widely as the individuals involved.

In addition, recent events, as well as changes in the social services delivery systems, affect the need for interventions to prevent homelessness. There have been massive changes to TennCare in the last two years. Tennessee's Families First Waiver has recently expired causing big changes as well; there is a new statewide provider and transportation services and training options have been eliminated. It has become harder to apply for bankruptcy and many families on the margin are facing crippling increases in their Adjustable Rate Mortgages. There is no limit to the factors, or combination of events, that can cause homelessness. It is important to have a lead agency appointed to insure access.

There is value in asking the right questions to assure access to existing available services, training for service providers, advocacy for system change, the avoidance of the duplication of services, and continually collecting the data needed to make informed decisions to prevent homelessness of all kinds. Focusing on the customer, not existing or proposed service delivery systems, gives a community a far better chance to prevent homelessness.

While it makes good sense to stop homelessness before it happens whenever possible to save money, save lives, and keep families intact, best practices indicate that intervening as early as possible increases the chances for the ultimate success of the interventions. Interventions that concentrate on keeping at-risk families and individuals housed allow social service delivery systems more chance for lasting success. Interventions with those homeless for the first time can be particularly successful in preventing the establishment of patterns than can lead to chronic long-term homelessness.

Long range care plans that allow for continuous housing with adequate appropriate supportive services afford communities the best avenue for the prevention of all kinds of homelessness.

A business case needs to be developed that includes a cost benefit study, accurate data, an audit of existing resources, a gap analysis of services needed and a marketing plan. While the long term implementation plan is being developed, the lead agent needs to institute short term interventions to meet the needs of families who are in crisis now. The lead agent also needs to make a concerted effort to cultivate the leadership and support that can bring both expertise and resources to the table. A community champion could galvanize the region's response to preventing homelessness by providing the visibility and credibility needed to assure lasting change and strong, effective advocacy.

Recommendation #7: Establish an organization or give the responsibility to an existing organization for *Blueprint* implementation which will include promoting prevention of homelessness and providing quick assistance to families and individuals at risk of homelessness. This agency will be charged to identify at risk individuals and families, coordinate service response, educate and train service providers and advocate for the homeless. An Operations Council can assist agency personnel in program development and will stress early intervention, case management, client responsibility, the sharing of best practices and appropriate use of data tracking software. The lead agent will be customer focused and responsible for beginning a redesign of the service delivery system. The regional dialogue will be diverse and ongoing, considering all sources of funding to provide services to the most vulnerable at-risk for homelessness in a customer focused way.

By providing access to information and services as early as possible for 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, United Way 2-1-1 emergency call-in services, the County or City Departments of Social Services, the Department of Human Services, the Department of Children's Services, the Workforce Development system or a myriad of formal and informal social service delivery systems.

It is imperative to identify groups of those at risk for homelessness and who are homeless for the first time. By identifying the critical points where individuals and families are at risk more effective strategies can be developed to address need. 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 preventing homelessness is difficult and there are no pat answers. A region dedicated to preventing at risk individuals and families from becoming homeless must commit to a continuing focus on identifying pressure points that can vary due to multiple factors, both within and without the service delivery system.

The Service Point Homeless Management Information System will play a key role in the prevention effort. 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 in need of housing assistance.
- can serve as a common base for emergency preparedness planning in the community.
- provide regular feedback to service delivery agencies and the community, both aggregate and agency specific data.

The homelessness prevention system allows 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 provides additional time for interventions and improves the entire network's ability to prevent and respond effectively to housing emergencies. It also reduces the need for emergency shelter and services.

Recommendation #8: Help at-risk households remain stably housed by providing emergency assistance, maximizing their incomes and improving access to supportive services. The lead agent will be responsible for assisting at-risk households with emergency assistance, including brief case management and ultimate entry into the case management system for long-term planning.

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:

8.1) Expand the availability of emergency assistance to prevent financial and personal emergencies from becoming destabililzing crises. At present, households facing financial and personal emergencies call the United Way 2-1-1 emergency call-in service, turn to local congregations, apply for emergency assistance from the Chattanooga or Hamilton County Departments of Social Services. These already effective services will be improved through the following steps.

8.1.1) 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.

8.1.2) Increase the funding for and availability of emergency financial assistance, using additional resources from government, private philanthropy and faith-based communities.

8.1.3) Identify and eliminate barriers to at-risk households' access to services and financial supports.

8.2) 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.

8.3) 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-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 through the entity designated as coordinating entity for Blueprint implementation.

Recommendation #9: Prevent people from becoming homeless when they leave institutional care, such as jail, prison, shelter, hospitalization, treatment, foster care, by developing permanent housing plans prior to release and establishing clear responsibility in the community.

Low income individuals leaving institutional care face an elevated risk of homelessness. Discharges to homelessness are very common from prisons and jails.

- Inmates committed to the Hamilton County Jail who self-reported as being homeless during the period of July 1, 2006 through June 30, 2007 numbered 554.
- A total of 83 persons were arrested on multiple occasions totaling 268 times.
- The remaining 286 commitments were one-time only arrests.
- Tracking these individuals we see that:
    - 42 were released by their own recognizance.
    - 81 made bond.
    - 163 releases were by suspended sentence.

- A total of 189 were transferred to the Silverdale Workhouse for confinement.
- Seventeen were released by time served.
- Thirteen were still in custody at the end of the reporting period.
- Thirty six were transferred to other jurisdictions for incarceration or deportation.
- Four were released to a community corrections program.
- Nine were released based on their cases being dismissed.

Of the actual 541 persons released:

- Two hundred twenty nine were transferred to another confinement facility or into a community corrections program.
- The 81 who made bond leads one to believe that they had a family member of financial means to make the bond.
- The 42 released on their own recognizance spent on average two days in custody with 34 actually spending less than a day.
- There were 189 released upon returning from court (suspended sentences, time served, cases dismissed). This final group of inmates averaged 11.5 days in custody.

While it is possible to develop a transition plan back into the community for those who are in the system for a sufficient length of time, it is very difficult to address the needs of whose who stay in custody less than two or three days. The longer a person stays in custody, the easier it is to reach by assessing, identifying needed resources, and developing a reentry plan into the community. What is needed is a screening mechanism at the jail booking area to identify individuals (other than those self-reporting) as being homeless or having the potential for homelessness. A case manager trained to assess this screening instrument can then interview individuals determined to be at risk of homelessness to determine their needs and develop a transition plan.

In most instances 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. Any institution should be required to notify the organization charged with the prevention of homelessness of persons ready for discharge for whom a housing plan is not available. This type of information can be used for determining what type of resources and how much are needed to prevent this problem.

Efforts to prevent homelessness must also look beyond community-based solutions to systemic reform. Some system-wide policies promulgated at the state and federal levels adversely affect the Chattanooga region's ability to reduce and end homelessness. This is another example of the importance of the policy advocacy role of the homeless lead agency regardless of where it is located.

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

9.1) Expedite entitlement applications for individuals leaving institutional care. Project SOAR and other initiatives designed to expedite benefit process will be expanded to meet the needs of discharged individuals who need to access TennCare, Food Stamps and other entitlements so they do not experience gaps in coverage that can cause medical, psychiatric or financial crises and homelessness.

9.2) 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. The lead agent for Blueprint implementation will be notified and charged with identifying what resources are needed to prevent the discharge of individuals into homelessness. An ongoing committee of community-based service providers, staffed by the lead agency, will meet regularly to discuss future and past discharges and improve the capacity of all institutions and community-based providers to respond to the needs of those leaving institutional care.

9.3) 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.

9.4) Work with the criminal justice system to

9.4.1) facilitate individuals' reentry from incarceration to community living.

9.4.2) avoid incarceration by developing and implementing pre-trial diversion as well as post trial alternatives for persons with mental illnesses to be placed in treatment and housing facilities in the community.

9.4.3) establish a screening mechanism at the jail booking area to identify (other than those self-reporting) as being homeless or having the potential for homelessness. A case manager needs to assess this screening mechanism,

interview these persons, determine their needs, and develop a transition plan.

9.4.4) Collaborate with government and private agencies to develop a temporary identification card program which would enable recently discharged individuals from local confinement facilities to have some form of official identification to assist in accessing various community resources (i.e., bus passes, accessing various benefits, library services, employment opportunities, check cashing, etc.).

9.5) Develop a resource guide and map to provide to inmates at time of discharge. This would include a variety of information on local resources and their location. Information could include housing, employment, meals, substance abuse assistance, transportation, clothing, health care, mental health care, showers, homeless children assistance. Distribute climate appropriate clothing to be issued at time of discharge for those whose clothing is inadequate for the weather or based on its wear and tear is unsuitable.

9.6) Institute a strong transition to adulthood program for youth leaving foster care to ensure comprehensive support, education and housing for as long as necessary to achieve independence. Participation in foster care is a strong predictor of future adult homelessness. According to Kids Count, The State of the Child in Tennessee 2006, only 54% of youth "aging out" of foster care graduate from high school, less than half have jobs within four years, 25% experience homelessness, 30% have no health care and 60% of the girls have given birth within four years. Chattanooga will take a leadership role with the State Department of Children's Services to ensure that all youth "aging out" of foster care receive significant case management, employment training and placement, college scholarships and encouragement to attend college, housing subsidies and mentoring until they are capable of independent living.

9.7) Establish emergency temporary housing opportunities for individuals and families that leave institutional care between 6 p.m. and 8 a.m. and on weekends.

9.8) Provide structure and funding for low income persons traveling through our community who would otherwise be homeless. These persons must be on their way to gainful employment or appropriate living situations.

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-five 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 Chattanooga Area Food Bank, homeless services 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 funding organizations 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 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 III, "Homelessness 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 gather critical information about 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.[77]

The increased reliance on data to guide system improvements requires an increased emphasis on quantity and quality of data. Coordination of such an effort is critical to building the network of data systems needed to guide decisions and allocate community resources.

Attracting New Resources

The process of developing the original *Blueprint* helped expand the region's capacity for attracting the funding necessary to end chronic homelessness in the Chattanooga region. Early meetings during the original *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.[78]

Another result of area cooperation among service providers is the Serial Inebriate Grant. This grant, awarded in 2005, provides assistance to 100 chronically homeless individuals with alcohol dependency issues. The grant involved a partnership between several service providers in the Chattanooga region (including outlying counties).

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 seamlessly 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.

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

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

Recommendation #10: Establish the *Homeless Blueprint Oversight Committee*

The revised *Blueprint* proposes a new mechanism, the *Homeless Blueprint Oversight Committee (HBOC),* to improve coordination of community efforts and enhance homeless service planning and implementation. The monitoring and coordination strategies of best-practice organizations and the federal Interagency Council on Homelessness will provide input to help guide the *HBOC* effort.

Homeless Blueprint Oversight Committee (HBOC)

The mission of HBOC is to ensure that the Blueprint is implemented (in a timely manner), progress is monitored and efforts are leveraged to maximize funding for ending homelessness in the Chattanooga region.

The strategy for accomplishing the above mission involves the *HBOC* taking lead responsibility in performing or ensuring performance of the following tasks:

10.1) monitoring progress of Blueprint implementation and adherence to policies/standards as specified in the Blueprint.
10.2) increasing the number of service provider agencies certified by the Homeless Coalition as adopting and implementing best practices.
10.3) providing a forum for increasing collaboration between for-profit, governmental, nonprofit and faith-based agencies to support implementation of the Blueprint.
10.4) promoting public awareness of progress on the Blueprint implementation.

Performing the above tasks will require a high degree of collaboration with networks and coalitions in disciplines such as; social services, health, government, business, education, and faith-based organizations.

Examples of initial collaboration include:

- working with the Chattanooga Regional Homeless Coalition to improve data quality of its ServicePoint Homeless Management Information System, a major data source for monitoring Blueprint progress.
- working with community-oriented organizations (correctional facilities, medical facilities, etc.) to collect data that supplements the Homeless Management Information System data.
- monitoring compliance to certification standards developed by the Chattanooga Regional Homeless Coalition.

HBOC will be a collaborative body and will promote efforts that implement (or are consistent with) the Blueprint. *HBOC* will include representatives from the following stakeholder groups:

• Homeless/formerly homeless member of community.

- Someone who has experienced homelessness and who is willing to give feedback to *HBOC* and participate in *HBOC* meetings.

• Representative appointed by Chattanooga City Mayor.
• Representative appointed by Hamilton County Mayor.
• Representative appointed by the Chattanooga Regional Homeless Coalition.
• Regional representative to be jointly appointed by the county governments of Tennessee counties near Hamilton County. SETHRA, an organization with representation from each rural county, is an example of one organization that could fill this role.
• Education
  - A representative from an educational institution with research, data analysis, and process evaluation experience.
• Social services
  - A representative from a social service agency that is knowledgeable about effective collaboration and that provides direct services to people who are homeless.
• Faith-Based Organizations
  - A representative from a faith-based organization that provides direct services to people who are homeless.
• Health Care
  - A representative from a major health care provider who has experience and knowledge related to emergency health care of homeless people.
• Workforce Development
  - A representative from a business that interacts with workforce development organizations to develop skills necessary to obtain, maintain and advance in employment.
• Law Enforcement
  - A representative from either Chattanooga City Police or Hamilton County Sheriff Department who has experience supervising other officers and working with people who are homeless.
• Business community
  - A representative who is from the general business community and can provide a business management perspective.

Five members of HBOC would form the Operations Council. The Operations Council would represent the five Spheres of Activity referred to elsewhere in the Blueprint and would fully develop the implementation plan and be directly involved with putting it into operation. (See Operations Council detail below).

It is critical that Operations Council members either represent organizations actually implementing Blueprint tasks or are in regular contact with organizations actually performing Blueprint tasks. Therefore, the above list of representatives may need to be supplemented by a few additional members to ensure proper composition of the Operations Council. HBOC will be most agile and efficient if it contains no more than seventeen members (including Operations Council representatives).

In addition to the above list of representatives, there will be a Chairperson of HBOC. There are future plans to look at funding an HBOC Executive Director position. The

Executive Director position would be a full-time, funded position and HBOC would be a 501c(3) organization.

Duties of the Chairperson position are to:

- Call *HBOC* meetings.
- Set agenda for meetings.
- Ensure that meeting minutes are kept.
- Facilitate *HBOC* meetings.
- Guide *HBOC* in setting goals and objectives.

Qualifications for the Chairperson position are:

- Extensive knowledge of (and vested interest in) the Blueprint.
- Senior level administration experience working with a Board of Directors.
- Ability to see that clerical/administrative duties are properly performed.
- Positive working relationship with City and County government and with community organizations.

Implementation Guidelines for *HBOC*

The Operations Council would consist of five members (one member from each of the five Implementation "Spheres of Activity" listed below)

Prevention
- Lead organization or committee for implementing the "Prevention" recommendations.

Services
- Lead organization or committee for implementing the "Services" recommendations.

Housing
- Lead organization or committee for implementing the "Housing" recommendations.

Community Reintegration
- Lead organization or committee for implementing the "Community Reintegration" recommendations.

Systems & Performance
- Lead organization or committee to facilitate data collection and preparation of evaluation reports for HBOC.

Terms of Membership:

Members of HBOC will serve one three-year term. Therefore, one third of the membership will rotate off every year.

A representative's membership on *HBOC* can be terminated prior to the end of his/her term with a vote of at least two thirds of the *HBOC* membership.

Special Membership Terms:

- Three members of the initial *HBOC* Board will have a one-year term. Another four members of the initial *HBOC* Board will have a two-year term. The remaining initial *HBOC* members and all succeeding members will have three-year terms. Note: Selection of term length for initial members will be made at first *HBOC* meeting.
- Interim replacements – If an *HBOC* member vacates their position before the end of his/her term then the remaining members of *HBOC* will select a replacement to complete the term. Person filling the interim member position is eligible to serve an additional full term provided the total serving time on *HBOC* does not exceed four years.

HBOC may, at its discretion, call together ad hoc task force committees to address specific issues.

The *HBOC* will have an advisory role on how certain County, City, federal and private funds are spent on homelessness. Such advisory powers will be limited to assessing the degree to which programs and policies are consistent with the Blueprint. Such an assessment includes a review of the Continuum of Care application.

An annual review of progress on Blueprint implementation will be performed by *HBOC*. Interim reports will also be produced at a frequency determined by *HBOC* after consideration of current progress and stage of implementation plan.

The Blueprint document will be reviewed annually and updated as necessary to keep it relevant to current conditions and needs of the Chattanooga region.

HBOC will develop procedures for:

- monitoring progress of Blueprint implementation and adherence to policies/standards as specified in the Blueprint.
- increasing the number of service provider agencies certified by the Homeless Coalition as adopting and implementing best practices.
- providing forums for increasing collaboration between for-profit, governmental, nonprofit and faith-based agencies to support implementation of the Blueprint.
- promoting public awareness of progress on the Blueprint implementation.
- guiding *HBOC* review of Chattanooga Regional Homeless Coalition service provider certification process.
- new *HBOC* Board Member Orientation.
- addressing data collection and data quality issues such as:
    - Specifying data needs and consistent definition of key terms;
    - Identifying sources of data (current and desired);
    - Evaluating quality of data.

The Planning/Coordinating Committee will recommend original *HBOC* board members. However, the Blueprint Task Force Steering Committee will have final approval of *HBOC* original membership.

E. Community Reintegration

The four spheres of activity above are supplemented by a critical task that extends well beyond the traditional system of services: Reintegration of people who are/were homeless into the broader community.

What often makes the difference between homelessness or stable housing for someone experiencing personal or economic challenges is a positive social network. Such a network goes beyond any clinical network of support and helps build the relationships needed to fully connect a homeless/formerly person to the broader community. The opportunity for such connections is a vital step in restoring a sense of citizenship. The essence of community reintegration has been achieved for people who are/were homeless when each person feels welcome to be a part of (and contributor to) the community and to participate (or not participate) as they desire.

The goal of community reintegration is made all the more difficult when the degree to which the person has become disaffiliated from society is considered. Mental illness, substance abuse, and personality characteristics often impact their history of relationships with the rest of society, and many experiencing homelessness bear deep seated problems of self esteem, isolation and abilities to relate to others.

The reintegration process can be said to begin with a personal decision by a homeless individual or family that their present circumstances are no longer acceptable, and a new path needs to be forged. The decision may be a part of a discharge plan from mental health facility or hospital. It may be a caseworker-advised personal development plan begun as part of a jobs program or shelter experience or it may occur in the middle of the night in a jail cell. In any case, it is critical that the process begin immediately or as soon as possible following a decision, in order to have the best chance of success.

A formerly homeless person or family may be considered successfully reintegrated, or making progress to reintegration, when they are:

- living in a safe place.
- reestablishing contact with broken ties.
- medical or treatment programs are ongoing.
- employment or satisfying activity allows them to give back to the community.
- self-esteem is reestablished.
- they have the means to maintain their housing situation.
- support services are in place.

Community reintegration services that promote recovery [for people with mental illness who have been incarcerated]:

- services that provide customized services.
- comprehensive, co-located services (“one-stop” facilities)
- services available during convenient hours
- supported housing that does not discriminate against mental health consumers or

persons with experience in the criminal justice system
- a living wage, businesses owned and operated by former offenders and consumers, and employment commensurate with individual abilities and/or limitations.

Policy recommendations:
- Address fragmentation in mental health service systems (for example, by creating one-stop service centers that engage in outreach and follow-up).
- Circumvent criminal history as a barrier to employment and assist rehabilitation by expunging and sealing records and by providing certificates of rehabilitation.
- Take a holistic approach to housing and employment.
- Develop outcome measures to improve accountability of programs.
- Create one-stop transition centers.
- Create links among the criminal justice system, traditional service providers, and peer-run programs in the communities.
- Provide the services of job coaches, retraining educators, business mentors, and consumer-run employment agencies.
- Constitute transition teams whose members understand multiple community systems.
- Establish technical assistance centers to guide professionals and consumers on issues at the intersection of the mental health and criminal justice fields.
- Train transition teams to address access to housing, substance use and mental health treatment, and employment.
- Identify and create evidence-based practices and promising practices.

Source: "Building Bridges – Consumers and Representatives of the Mental Health and Criminal Justice Systems in Dialogue", U.S. Department of Health and Human Services, 2005

Community reintegration recommendations focus on four formidable barriers to a homeless/formerly homeless person fully re-connecting to the community; Linking to Case Management/Follow-up, Support Services, Housing, and Employment.

Recommendation #11: Develop a central intake point to start the process of linking a homeless/formerly homeless person to the case management and other assistance and follow-up support they need to become more self-sufficient.

Case Management Committed case management can mean the difference between successful reintegration or failure and a return to homelessness. Caseworkers attentive to the needs of their caseload can head off problems before they happen. Caseworkers currently are often tied to programs guidelines, unable to follow the individual once he or she leaves that program. Caseloads are overwhelming or support service is not funded once the client moves into housing. Funding for the number of caseworkers needed is nowhere near adequate.

11.1) Develop a central intake point, accessible at all hours of every day, to access immediate needs and start a person on their way to housing.

11.2) Developing a model for casework, using the resources of the Human Services Department at the University of Tennessee at Chattanooga, and other models which focuses on the short, mid, and long-term needs peculiar to the various segments of the homeless population.

11.3) Utilize more volunteers, particularly faith-based groups, to assist caseworkers in follow-up and support, problem solve, and encourage newly housed persons. Access Americorp volunteers.

11.4) Develop improved follow-up systems, able to trace housing placements through the first year of housing and prevent dropping through the cracks.

11.5) Increased use of Service Point or other data based information tools.

Recommendation #12: Make mainstream resources (food stamps, SSI, etc.), health services, day care services, case management services and getting personal identification documents more accessible by either convenient location or available transportation.

Support Services. Where support services are included in care plans, there is a noticeable difference in success rates. Without supports for day care, emergency assistance, transportation, etc., it is all too easy to return to homelessness.

12.1) Expanding assistance and convenience to food stamp application, other documentation, driver's license or other picture ID, e.g. food stamp application at satellite locations, social security services at TN Career Center.

12.2) Close contact by case managers or volunteers re medical needs, prescriptions, and transportation to appointments to maintain and improve health.

12.3) Accessing assistance in areas of startup deposits, food, furniture, utility and rental assistance.

12.4) Better communication between service providers as to services provided, overlaps, gaps and coordination through the Chattanooga Regional Homeless Coalition to provide a seamless system.

Recommendation #13: Provide assistance in re-establishing a home.

Housing. In Tennessee's Third District there is a deficit of 7,494 affordable rental housing units to serve 29,447 extremely low income and very low income families. Convenience to public transportation, work sites, medical care and schools, or inaccessibility to persons with disabilities further complicate the issue.

Even when housing preferences for the homeless are in place, income for startup utilities, supplies, furnishings, transportation, is difficult to come by. Casework can help to navigate the rigors of reestablishing a home.

13.1) A centralized point of contact for housing resources with access to all available housing units and connections to casework charged with mentoring through the reintegration process, following along for 6 months to 1 year. Continue to expand web-based housing inventory programs, e.g. "Housing Within Reach" and "My Community Rents".
13.2) Coordination and collaboration of organizations providing immediate supports, e.g. furniture, financial assistance for rental and utility deposits. Database of organizations who maintain a furniture and household goods bank, e.g. First Centenary UMC.
13.3) Apply Habitat principles of "sweat equity" to earn housing credit.
13.4) Continuous and early planning for the Continuum of Care grant to provide the most creative and broad housing programs, with concentration on the bottom line number of new units to come on line.

Recommendation #14: Connect homeless/formerly homeless people to community services/education that help them obtain, maintain and advance in employment to their fullest potential.

Employment. Too often-homeless individuals do not possess the soft skills needed to make them employable, and many possess language barriers. Transportation to work, particularly for second and third shifts, is unavailable or sparse. Clients do not possess the documentation, e.g. driver's license, birth certificate, Social Security card, required by employers. Once employed, they often cannot overcome or maneuver around problems such as day care, family responsibilities, and punctuality.

14.1) Expanded use of TN Career Center to obtain documentation, skills training and employment counseling.
14.2) Inclusion of employment preparation in discharge planning and care plans.
14.3) Emphasis on soft skill training in programs funded through the Continuum of Care and elsewhere.
14.4) Job coaching to smooth over workplace problems.

The Community Reintegration Committee listened to numerous stories of efforts of individuals and families to reintegrate into the community. Where supports are in place, and case management is ongoing, success has a far better chance. When it is not, failure is almost predictable. Over and over again, the committee returned to the glaring fact that rarely is there one point that can get a person started on the reintegration process and take them all the way through to a happy ending.

We strongly recommend more coordination, and more and stronger case management. The cost will be significant, but the cost of not developing a workable system will continue to drain public and private resources even more significantly.

For a person trying to make a new start, the community can be a forbidding place. Many people can be generally unaccepting of differences, and see homelessness as a personal weakness and of no concern to them. Chattanooga is known for collaborations for economic development and revitalizations. Our achievements are celebrated and legendary. Revitalizing human beings is a much more difficult challenge. Our efforts are disjointed, under-funded, and sporadic. Is it possible we can apply our formula for success with places to our work with people?

IX. Conclusion

As described in *Section III* of this report, *"Homelessness Today"*, homelessness in the United States is the result of a number of national socio-economic trends. Ending 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 Homelessness in the Chattanooga Region* 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 homelessness in the Chattanooga region.

APPENDIX A1

The Original (2004) 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 Traughber
Administrator, Department of Community Development Services
City of Chattanooga

Bernadine Turner
Administrator of Human Services
City of Chattanooga

Staff Support and Other Participants
Janna Jahn Blueprint Coordinator, *City of Chattanooga*
Marilyn Forsythe Administrative Support, *City of Chattanooga*
Mo Mullen Research Analyst, *City of Chattanooga*
Karen McReynolds Director of Planning, Chattanooga Regional Homeless Coalition
Stacy Jones Research Analyst, Chattanooga Regional Homeless Coalition
Shakir Rashed Sr. Vice President of Corporate Affairs, *Chattanooga*

Neighborhood Enterprise
Angie Hatcher Sledge V. P., Impact Services, *The United Way of Greater Chattanooga/* Center for Nonprofits
Ted Houghton Consultant

APPENDIX A2

The 2007 Blueprint Revision Committee

Committee Issue: Housing		
Name	***Title***	***Organization***
John Hayes	Director, Building Stable Lives	United Way
James Sherrill	President, Local AIA Chapter	American Institute of Architects
Donna Maddox	Director	Johnson Mental Health Center
Julianne Crow	Chattanooga Regional Homeless Coalition Board Chair	Chattanooga Regional Homeless Coalition / READ
John Atherton		Habitat for Humanity
Bob Dull	Executive Director	Chattanooga Housing Authority
Dianne White		Housing Rehab / CDBG
Mary Ellen Galloway	Executive Director	Interfaith Homeless Network
Susan Greene	Regional Housing Facilitator, CHI Initiative	AIM Center

Committee Issue: Services		
Name	***Title***	***Organization***
Wayne Owens		SETHRA
Karen Guinn	Director	Hamilton County Homeless Healthcare Center
Charlie Hughes	Executive Director	Chattanooga Community Kitchen
Sandra Hollett	Executive Director	Partnership for Families, Children and Adults
Maj. Jim Lawrence		Salvation Army

Lou Garcia		
Susan Kirk		Tennessee Department of Human Services
Bill Staley		UTC / SGA President
Erin Creal	Executive Director	Chattanooga Room in the Inn

Committee Issue: Prevention		
Name	***Title***	***Organization***
Phyllis Casavant	Deputy Director	Southeast Development District
Pete Cooper	President	Community Foundation
Earl Medley	Executive Director	Fort Wood
Bernadine Turner	Administrator	City of Chattanooga Human Services
Jim Hart		Hamilton County Sheriff's Department
Britt Tabor	Chief Financial Officer	Erlanger
Lee Ann Burke	Principal	Brown Academy Elementary School Principal
Mike Feely	Executive Director	St. Andrews Center
Howard Roddy		Memorial Hospital
Captain Tracy Arnold	Captain	Chattanooga Police Department

Committee Issue: Planning & Coordination		
Name	***Title***	***Organization***
Karen McReynolds	Executive Director	Chattanooga Regional Homeless Coalition

John Dorris	Project Consultant	Chattanooga Community Resource Center
Manny Rico	Councilman	City of Chattanooga City Council
Eva Dillard	Executive Director	United Way of Greater Chattanooga
Charlotte Boatwright	President	The Coalition Against Domestic & Community Violence of Greater Chattanooga
Dr. Roger Thompson	Professor, Criminology Department	University of Tennessee at Chattanooga
Ralph Anderson	Professor, Department of Political Science/Public Administration & Non-Profit Management	University of Tennessee at Chattanooga
Merri-Mai Williamson	President	Application Researchers, LLC

Committee Issue: Reintegration		
Name	***Title***	***Organization***
Clare Sawyer	Executive Director	Chattanooga Area Food Bank
Ron Fender	Outreach Case Manager	Community Kitchen
Gary Thornton	Disability Program Navigator	Tennessee Career Center
Moses Freeman	Resident	M.L. King Neighborhood
Barry Kidwell	Pastor	Preacher
Gina Turley		AIM Center
Kay Andrews		Chamber of Commerce
Jamie Bergman	Vice President - Impact Services	United Way
Lieutenant Tom Kennedy		Chattanooga Police Department

APPENDIX B

What is Supportive Housing?[79]

"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

79 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 D1:
"IMPACT FEES: EQUITY AND HOUSING AFFORDABILITY - A Guidebook for Practitioners" Prepared for: U.S. Department of Housing and Urban Development Washington, DC. Prepared by: Liza K. Bowles Newport Partners, LLC Davidsonville, MD and Arthur C. Nelson, Ph.D., FAICP Virginia Polytechnic Institute and State University April 2007

APPENDIX D2.1:
GROWING SMART[SM] LEGISLATIVE GUIDEBOOK, 2002 EDITION - CHAPTER 4 "Alternative 1 – A Model Balanced and Affordable Housing Act"

APPENDIX D2.2:
GROWING SMART[SM] LEGISLATIVE GUIDEBOOK, 2002 EDITION - CHAPTER 4 "Alternative 2 – Application for Affordable Housing Development; Affordable Housing Appeals"

APPENDIX D3:
"EXPANDING AFFORDABLE HOUSING THROUGH INCLUSIONARY ZONING:LESSONS FROM THE WASHINGTON METROPOLITAN AREA", Karen Destorel Brown A Discussion Paper Prepared byThe Brookings Institution Center on Urban and Metropolitan Policy, October 2001

APPENDIX D4:
"The Inclusionary Housing Debate: The Effectiveness of Mandatory Programs Over Voluntary Programs", By Nicholas J. Brunick, ZONING PRACTICE, AMERICAN PLANNING ASSOCIATION
ISSUE NUMBER NINE INCLUSIONARY HOUSING-PART ONE, September 2004

APPENDIX D5:
"Inclusionary Housing:Proven Success in Large Cities", By Nicholas J. Brunick, ZONING PRACTICE, AMERICAN PLANNING ASSOCIATION
ISSUE NUMBER TEN INCLUSIONARY HOUSING-PART TWO, October 2004

APPENDIX D6:
"Zoning Affordability: The Challenges of Inclusionary Housing", By Lynn M. Ross, ZONING News, AMERICAN PLANNING ASSOCIATION, August 2003

APPENDIX D7:
"INCLUSIONARY ZONING: LEGAL ISSUES", CALIFORNIA AFFORDABLE HOUSING LAW PROJECT of the Public Interest Law Project and WESTERN CENTER ON LAW & POVERTY, December 2002

APPENDIX D8:
"'Why Not In Our Community?' Removing Barriers to Affordable Housing"- An Update to the Report of the Advisory Commission on Regulatory Barriers to Affordable Housing U.S. Department of Housing and Urban Development, February 2005

APPENDIX E

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 Homeless Blueprint Oversight Committee.*

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 *HBOC* can help collect, match and analyze will include the following:

APPENDIX E (cont'd)

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

APPENDIX F - Definitions

Homeless:

The term "homeless individual" means an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.
--Public Service Health Act, Section 330(h)(5)(A)

A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation. A recognition of the instability of an individual's living arrangements is critical to the definition of homelessness.
--Bureau of Primary Health Care, HCH Principles of Practice, Program Assistance Letter 99-12

Chronically Homeless:

HHS, the U.S. Department of Housing and Urban Development (HUD), the U.S Department of Veterans Affairs (VA) and the U.S. Interagency Council on Homelessness (USICH) have agreed on the following definition of chronically homeless: "An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or has had at least four episodes of homelessness in the past three years."

Homeless Family:

HHS definition: For the purposes of the HHS Strategic Plan, a homeless family is defined as one or two adults accompanied by at least one minor child who are either not housed or who have had recent periods during which they lacked housing.

At-Risk Individuals:

HHS definition: For the purposes of the HHS Strategic Plan, homeless youth are defined as persons between the ages of 16-24 who do not have familial support and are unaccompanied – living in shelters or on the street. Other vulnerable groups at-risk of homelessness include individuals with disabilities, immigrants, persons leaving institutions (e.g., incarceration, inpatient care for psychiatric or chronic medical conditions), youth aging out of foster care, frail elderly, persons experiencing abuse, and disaster victims.