Virginian Association of Housing Counselors, Inc.

Housing Specialty Homeless Counseling Certification

Introduction

The Virginia Association of Housing Counselors, Inc. (VAHC) is a group of housing counselors and other housing professionals who have joined together for the purpose of strengthening the housing counseling industry and assuring that all low and moderate income families and individuals are offered the opportunity to live in safe, decent, and affordable housing. The homeless, renters, homebuyers, and homeowners are all served by the members of this organization. This training manual is designed to assist housing counselors and housing professionals in preparation for Housing Specialty Homeless Counseling Certification (HSHCC) exam administered by the VAHC.

Special thanks to the following individuals who were instrumental in the creation of the curriculum and training materials used for this certification.

We express our sincere gratitude to Aisha Williams, Independent Consultant; Kay Moshier McDivitt and Norm Suchar, Directors from the Center for Capacity Building in the development of this training manual.

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Norm Suchar joined the staff of the Alliance in 2002. He directs the Alliance’s Capacity Building Center, which helps communities implement system-wide strategies that prevent and end homelessness. He assists communities with implementation of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act and the Homelessness Prevention and Rapid Re-Housing Program (HPRP).
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Chapter One
Background Knowledge of Homelessness

INTRODUCTION

This introductory chapter defines homelessness, summarizes different populations experiencing homelessness, and provides statistical information concerning homelessness in the United States. The chapter then describes some key causes of and contributing factors to homelessness and provides a brief historical overview of homeless assistance laws. This brief historical perspective is followed by an in-depth discussion of the Homeless Emergency Assistance and Rapid Transition to Housing Act. The chapter concludes with brief information concerning Fair Housing, the Americans with Disabilities Act, and the Health Insurance Portability and Accountability Act.

Objectives

Students will:
- Understand the definition of homelessness
- Know the different types, demographic categories, and subpopulations of homeless
- Understand the various causes of homelessness
- Understand the HEARTH Act
- Be familiar with laws governing federal and local responses to homelessness

Topics:
A. Homeless Definition
B. Understanding the Homeless Population/Who Experiences Homelessness
C. Statistics
D. Reasons for Homelessness
E. Understanding Homeless Assistance Laws
F. Practice Questions
A. **Homeless Definition**

Homelessness, its definition, and its solutions have evolved over time. The McKinney-Vento Homeless Assistance Act, as amended by the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009, defines “homeless,” a “homeless individual” and a “homeless person” in the following ways:

1. **An individual or family who lacks a fixed, regular, and adequate nighttime residence;**
2. **An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;**
3. **An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements;**
4. **An individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;**
5. **An individual or family who—**
   - **Will imminently lose their housing, including housing they own, rent, or live in without paying rent, are sharing with others, and rooms in hotels or motels not paid for by federal, state, or local government programs for low-income individuals or by charitable organizations,**
   - **Has no subsequent residence identified,** and
   - **Lacks the resources or support networks needed to obtain other permanent housing;**
6. **Unaccompanied youth and homeless families with children and youth defined as homeless under other federal statutes who—**
   - **Have experienced a long term period without living independently in permanent housing,**
   - **Have experienced persistent instability as measured by frequent moves over such period,** and
   - **Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment;**
7. **Any individual or family who is fleeing from domestic violence or other dangerous and life-threatening conditions are also considered homeless.**

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1. This includes a car, park, abandoned building, bus or train station, airport, or camping ground.
2. This includes congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals.
3. This component of the definition is qualified with the following information: “exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.”
4. This component of the definition must be substantiated with one of the following types of evidence:
   - i. A court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;
   - ii. The individual or family having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days; or
   - iii. Credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause.
5. This includes any individual or family who is fleeing, or is attempting to flee domestic violence.
The Department of Housing and Urban Development (HUD) further divides homelessness into four categories: literally homeless, imminent risk of homelessness, homeless under other federal statutes, and fleeing or attempting to flee domestic violence. “Literally homeless” refers to an individual or family who lacks a fixed, regular, and adequate nighttime residence, while “imminent risk of homelessness” refers to an individual or family who will imminently lose their primary nighttime residence. Persons who are “homeless under other federal statutes” include unaccompanied youth under 25 years of age, families with children, and youth who do not otherwise qualify as homeless under the HUD definition. Finally, people who are fleeing or attempting to flee domestic violence includes people who are fleeing domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual’s or family’s current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing.

Service providers should familiarize themselves with the above definitions of homelessness and the four categories of homelessness, as they inform practice and compliance standards and are directly linked to funding and service eligibility requirements.

B. UNDERSTANDING THE HOMELESS POPULATION/WHO EXPERIENCES HOMELESSNESS

In addition to the previously noted definitions and categories of homelessness, one may also think of homelessness in terms of episodic, transitional and chronic homelessness as well as in terms of demographics. In fact, thinking of homelessness in these ways can aid providers in understanding their clients and shaping appropriate services because homelessness research and best practice literature often frame the discussions in these ways.

Episodic, Transitional and Chronic Homeless

Homelessness among families or single adults may be considered episodic, transitional or chronic. These client profiles are defined as follows:

1. Transitional: Transitional homelessness involves relatively short stays in the homeless assistance system. Households who exit homelessness rarely return. The majority of families and single adults who become homeless fall into this category. Their homelessness is the result of a temporary financial or other situation (e.g. family conflict, losing a job, important material loss, loss of main breadwinner, father, husband, wife) that led to their housing crisis. Rapid re-housing is the best approach to serve this group.

2. Episodic: People who use shelter repeatedly are considered episodically homeless. This group falls in and out of homelessness frequently, and their use of public systems such as jails, prisons, hospitals and shelters has a high public cost. Many have active substance use issues, and they are dependent on these systems for survival.iii
younger than other homeless populations. Transitional housing programs that encourage this group to address their addictions either in a strict sobriety environment or in a low-demand environment may work well for this group.iv

(3) Chronic: A chronically homeless person is someone who—
   a. Lives or resides in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
   b. Has been homeless and living or residing as such continuously for at least 1 year or on at least 4 separate occasions in the last 3 years; and
   c. Has an adult head of household (or minor if no adult is present) with a diagnosable substance use disorder, serious mental illness, developmental disability, post traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of 2 or more of those conditions.v

People who are chronically homeless are not likely to ever generate significant earnings, though they may have some income from public benefits and/or very limited wages. Housing solutions for this group typically includes long term subsidized housing and services because of their disabilities, making permanent supportive housing the best intervention for this population.

Key Demographic Groups of Homeless

Homeless populations may also be considered in terms of demographic groups: Single Adults, Families, Youth, Veterans, and the Elderly. These groups are described here.

(1) Single Adults: The majority of the homeless population is made up of single unaccompanied adults, and single-person households are at increased risk of homelessness compared to households with multiple adults. This may be due to a number of reasons including increased household income and social support in households with more than one adult. Single adults may be episodically, transitionally, or chronically homeless, and they may overlap with other demographic categories of homeless populations such as youth, veterans, and elderly populations. As such, the solutions for homeless single adults vary, though prevention and rapid re-housing are typically the best approaches for most single adults.

(2) Families: Families experiencing homelessness are similar to other, housed families living in poverty: they are usually headed by a single woman with limited education, are usually young, and have higher rates of domestic violence and mental illness. Some families living in poverty become homeless due to some unforeseen financial challenge, such as a death in the family, a lost job, or an unexpected bill, creating a situation where the family cannot maintain housing. Family conflict is also a factor, as many families are living with other friends or relatives prior to becoming homeless. Homelessness among families is typically not a long-term experience. Most families (about 75 percent) who enter shelter are able to quickly exit with little or no assistance and never return. Some families, however, require more intensive assistance. Rapid re-housing and prevention activities are usually the best suited interventions for homeless families.vi

(3) Youth: Youth often become homeless due to family conflict, including divorce, neglect, or abuse. A large majority of young people experience short-term homelessness, returning back home or to family/friends.vii Most homeless youth are considered transitionally homeless because they will spend a short time homeless before exiting the system and not returning. Homeless assistance for this population may include rapid re-housing, transitional housing, or another housing and/or service combination depending on the needs, age, and circumstances of the client.
(4) Veterans: The veteran homeless population is made up of veterans who served in several different conflicts, ranging from World War II to the recent conflicts. As with other homeless populations, rapid re-housing and prevention strategies are critical for many veterans experiencing homelessness. However, some veterans have severe physical and mental health disabilities – often caused by their military service – and may require permanent housing with supportive services.

(5) Elderly: The elderly have historically been underrepresented among the homeless population. However, homelessness is beginning to increase among elderly adults. Factors such as the anticipated growth of the elderly population as baby boomers turn 65 years of age and the aging of the chronically homeless population are contributing to this increase and may lead to a dramatic increase in the elderly homeless population by 2020. Some elderly adults may become newly homeless (i.e. they did not experience homelessness prior to turning 65 years of age) for various reasons such as inadequate income or discontinued public assistance, mental health problems, relationship breakdown, physical health problems, and issues related to work and job loss. Newly elderly homeless (i.e. those who do not come from other shelters or the streets) often come from housing with family or friends and have a history of stable employment. Solutions for this population ranges from rapid re-housing and subsidized housing to permanent supportive housing.

C. STATISTICS

According to the National Alliance to End Homelessness, there are 610,042 people experiencing homelessness on any given night in the US. Of that number single adults represent over half (387,845) of the homeless population, while approximately 36.4 percent are people in families.

Approximately 1.5 million people who use emergency shelters at some point during the year, and this does not include people who sleep outside and never use a shelter. Within the entire population of people experiencing homelessness, people who are considered episodic homeless represent about 9 percent of the total homeless population, and number around 135,000.
Thirteen percent (62,619) of people experiencing homelessness are veterans. According to the National Coalition for Homeless Veterans and the U.S. Department of Veterans Affairs, homeless veterans are predominantly male, and only 8 percent are female. The majority are single, live in urban areas, and suffer from mental illness, alcohol and/or substance abuse, or co-occurring disorders. Approximately, 40 percent of all homeless veterans are African American or Hispanic. Additionally, homeless veterans are younger on average than the total veteran population. Approximately 9 percent are between the ages of 18 and 30, and 41 percent are between the ages of 31 and 50. About 1.4 million veterans are considered at risk of homelessness due to poverty, lack of support networks, and dismal living conditions in overcrowded or substandard housing.

There are approximately 550,000 unaccompanied, single youth and young adults up to age 24, and approximately 150,000 homeless young adults are ages 18 – 24. According to the National Incidence Studies of Missing, Abducted, Runaway and Throwaway Children about 380,000 of homeless youth who are under the age of 18 will experience a homelessness episode of longer than one week, and 131,000 remain gone for over one month. Over 99 percent of all homeless youth eventually go home.

HUD’s 2012 Annual Homeless Assessment Report indicates that around 239,403 people in families were homeless on a single night in 2012. Homeless families are typically comprised of a mother in her late twenties with two children, and more than half of all homeless mothers do not have a high school diploma. Eighty-four percent (84%) of families experiencing homelessness are female-headed, and 42 percent of children in homeless families are under age six. Homeless families have much higher rates of family separation than other low-income families. Twenty-nine percent (29%) of adults in homeless families are working.

The elderly homeless are increasing around the country, though not much historical data exists on this population. According to the National Coalition for the Homeless and HUD, 16.8 percent of sheltered homeless people in 2008 were 51 and older. Additionally, 30.6 percent of the individuals who stayed in emergency shelters for more than 180 days were 51 and older.
In the state of Virginia, there were 8,424 homeless people counted in the 2012 Point in Time Count. Of these, 5,077 were people in households without children, 3,340 were in households with at least one child, and seven (7) were in households with only children. There were 1,541 chronically homeless people counted in Virginia in 2012, 881 veterans, 1,266 victims of domestic violence, and five (5) unaccompanied youth under the age of 18. In 2012, Fairfax County, with over 1,500 homeless people, and Richmond, with over 900 homeless people, had the highest homeless populations.

These numbers, both nationally and locally, are staggering and suggest that there is a lot of work to be done. Fortunately, many communities have implemented best practices including prevention, rapid re-housing, and permanent supportive housing to address the needs of their homeless populations, and federal laws now support and encourage implementation of these strategies. The effectiveness of these strategies is clear in data from local communities around the country.

D. REASONS FOR HOMELESSNESS

The causes of homelessness vary from household to household. However, the primary reason people experience homelessness is because they cannot find housing they can afford. Affordable housing is scarce in the US and especially in urban areas. This scarcity means that for many people, especially poor households, acquiring and maintaining affordable housing is a challenge. The financial difficulty of finding and acquiring affordable housing makes homelessness an economic issue for families and communities everywhere. Other factors contributing to a household’s homelessness are typically indirect causes because they further interrupt an individual’s or family’s ability to afford their housing. Understanding homelessness from this perspective is important because this perspective shapes current homeless assistance laws, the federal response to homelessness, and emerging best practices concerning homeless assistance.

Indirect Causes of Homelessness

According to the National Coalition for the Homeless (NCH), foreclosure, poverty, declining employment and income, declining public assistance, lack of affordable health care, domestic violence, mental illness, and addiction are all factors that contribute to homelessness. Five of these factors (foreclosure, poverty,
employment, public assistance, and health care) are clearly economic in nature. The remaining three factors (domestic violence, mental illness, and addiction) interrupt an individual’s or family’s ability to afford their housing.

1. Poverty: NCH also suggests that poor people are frequently unable to pay for housing, food, childcare, and health care. Housing absorbs a high proportion of income; so when difficult choices must be made, housing is often dropped or lost in an effort to afford these other necessities. Most poor people are only an illness, an accident, or a paycheck away from living on the streets.

2. Declining Work Opportunities and Income: According to NCH, declining wages put housing out of reach for many workers, and in every state, the cost of a one- or two-bedroom apartment at fair market rent exceeds the minimum wage. Many shelters have at least some homeless people who work full time, and NCH states that a 2007 survey performed by the U.S. Conference of Mayors found 17.4 percent of homeless adults in families were employed while 13 percent of homeless single adults or unaccompanied youth were employed. In the report, eleven (11) out of nineteen (19) cities reported an increase in employed homeless people. Insufficient pay, layoffs, and lack of work opportunities all contribute to homelessness for the working poor.

3. Declining Public Assistance: The loss of benefits and insufficient benefits means that many households are unable to afford housing. This is especially true for seniors whose Social Security, Medicaid, and Medicare are not enough to cover their expenses and leave insufficient housing funds.

4. Lack of Affordable Health Care: High medical bills for uninsured families and individuals often result in a struggle to pay rent, the loss of a job, and depletion of savings, all of which can lead to the loss of housing. High medical costs for seniors contribute to their homelessness because their benefits do not cover the costs of physical and prescription bills, forcing them to use housing funds to cover these expenses.

5. Domestic Violence: Homeless families are often headed by a young, single woman with limited education and low or no income. These families also have high rates of domestic violence. In these situations women are often forced to choose between abusive relationships and homelessness because they cannot afford housing on their own. Many become homeless. Approximately 63 percent of homeless women have experienced domestic violence in their adult lives, according to NCH.

6. Mental Illness: Approximately 16 percent of the single adult homeless population suffers from some form of severe and persistent mental illness, according to NCH. Many mentally ill homeless people are unable to access supportive housing and/or other treatment services. Their untreated illnesses and lack of support leave them unable to access and maintain housing that they can afford, contributing to homelessness for this group.6

7. Addiction Disorders: There is a clear correlation between homelessness and addiction when one considers the episodic homeless population. Many people who are addicted to alcohol and drugs never become homeless, but people who are poor and addicted are at increased risk of homelessness because the costs of their addictions leave insufficient funds for housing. Addiction

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6 For more information about the impact of mental illness on homelessness and mental health resources, review Chapter 9 of this manual.
increases the risk of displacement for the precariously housed, and once they become homeless, this group often faces high barriers to obtaining appropriate treatment services and recovery supports. This often results in their circulating in and out of jails, hospitals, and other institutions.7

E. UNDERSTANDING HOMELESS ASSISTANCE LEGISLATION

Prior to the 1980s, homelessness was temporary for most people. Local government typically responded to and quickly resolved the needs of people experiencing homelessness. Deinstitutionalization of people in mental health facilities, economic fluctuations, and decreasing availability of affordable housing caused a significant surge in the homeless population around the 1980s, and led to homelessness as we know it today.

In 1983, the first federal task force on homelessness was created to help local agencies address homelessness by acquiring surplus federal property. In 1986, several emergency relief, homeless prevention, income-based and other policy solutions were enacted to address the growth in homelessness. These measures, which were part of the Homeless Housing Act, created the Emergency Solutions Grant program (formerly the Emergency Shelter Grant program) and transitional housing. In 1987, the McKinney-Vento Homeless Assistance Act (formerly the Stuart B. McKinney Homeless Assistance Act) passed Congress and was signed into law by President Reagan to provide further federal assistance for people experiencing homelessness.

McKinney-Vento Act

The McKinney-Vento Act originally consisted of fifteen programs and included services for emergency shelter, transitional housing, job training, primary health care, education and permanent housing. It also created the Emergency Food and Shelter Program, and created supportive housing and SRO programs. Since originally being signed into law, the McKinney-Vento Act has been amended five times, in 1988, 1990, 1992, 1994, and 2009. Significant amendments to the law in the 1990s included but were not limited to:

• Creation of the Shelter Plus Care program
• Amendments to the Projects for Assistance in Transition from Homeless (PATH) program (formerly the Community Mental Health Services program)
• Creation of the Rural Homeless Housing Assistance grant program
• Creation of “safe havens”
• Creation of the Access to Community Care and Effective Services and Support (ACCESS) program

The amendments also changed the Education of Homeless Children and Youth program by ensuring that homeless preschoolers have access to public preschool education, allowing parents and youth more flexibility and choice in school placement, and requiring school officials to coordinate with housing authorities regarding homeless children’s education.

7 For more information about the impact of addiction disorders on homelessness and addiction disorder resources, review Chapter 9 of this manual.
HEARTH Act

In May 2009, President Obama signed into law a bill to reauthorize the McKinney-Vento Homeless Assistance programs. These reauthorizations are known as the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act and represent the most comprehensive and significant change to the McKinney-Vento programs in two decades. The HEARTH Act fundamentally shifts and updates the federal response to homelessness and, thus, completely shifts the way local agencies and nonprofits conduct services for people experiencing homelessness. These shifts, changes, and updates are described here.

(Shift 1) Programs → Systems

The first change implemented by the HEARTH Act is the shift from HUD funding individual agencies based on individual agency performance to funding community systems based on community-level performance. When applying for homeless assistance funding, a community organizes into a Continuum of Care (CoC) and submits a joint application to HUD. Similar to the previous process, the entire application is scored, and projects are funded in the order that they are prioritized in the application. Now, however, one entity applies for funding in the community, and that entity is known as a Collaborative Applicant. The Collaborative Applicant:

- Can receive up to 3 percent of its community’s funding for administrative costs.8

8 Collaborative Applicants can apply to HUD for funding, receive all of the funding designated for the community they represent, and then subgrant funds to all the project sponsors in the community. A Collaborative Applicant that subgrants funds to projects in a community is known as a “Unified Funding Agency.” (A Unified Funding Agency collects and subgrants all funds to participating agencies.) A Collaborative Applicant can become a Unified Funding Agency in one of two ways: 1) by applying to HUD for that status, or 2) by being designated by HUD if HUD finds that the Collaborative Applicant has the requisite capacity, that HUD and the Collaborative Applicant agree on what technical assistance would be needed, and that the designation would benefit the community. In addition to these two methods, HUD can also designate a Collaborative Applicant as a Unified Funding Agency if HUD determines that it is in the best interest of the community.
May designate another entity, such as a consultant, to help it apply for and receive grants and perform other administrative duties.

Is responsible for ensuring that its community participates in the Homeless Management Information System (HMIS).\(^9\)

According to HUD the reason for this update to the way funds are acquired and distributed within a community – particularly, ensuring that service providers all participate in the HMIS, creating a formal applicant, and single funding distribution source – is: “HUD really wants ... communities to be strategic, to have the tough conversations, and really use their data to be sure that whatever programs they have in place ... are part of a larger system approach, and have the best outcomes possible”.\(^{xix}\) By ensuring that entities are participating in the HMIS, the CoC, led by the Collaborative Applicant, can have a data-driven and outcomes-focused conversation about the ways in which programs are impacting homelessness. As a result, the application and prioritization process is then based on substantive information about which programs contribute to community goals to end homelessness.

Further implementation of the HEARTH Act uses interim rules, such as those published in 2012 in the Federal Register, which state that the purpose of the CoC is to promote community-wide goals to end homelessness. In the rule, HUD requires that all CoCs establish and operate a centralized or coordinated assessment system to conduct an initial, comprehensive assessment of the housing and services needs for all people entering the homeless assistance system. These systems must be designed in response to local needs and conditions and should include use of a locally-designed, common assessment tool. Further, each CoC must develop and follow written standards administering assistance through coordinated assessment and providing assistance. The standards must outline the following processes:

- Evaluating eligibility for assistance;
- Prioritizing who receives transitional housing;
- Prioritizing who receives rapid re-housing;
- Determining what percentage or amount of rent people receiving rapid re-housing must pay;
- Prioritizing people for permanent supportive housing; and
- Prioritizing who receives homelessness prevention assistance (high performing communities only).

Finally, HUD also issued a rule requiring that all Emergency Solution Grant (ESG) recipients participate in the centralized or coordinated assessment system.

These requirements related to coordinated assessment encourage communities to identify and review all programs so that agencies can adjust their services offered, subpopulations served, and goals to fit within the broader community system, context, goals, local homeless population needs,

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9 In 2011 HUD issued an interim rule requiring all recipients of financial assistance under the CoC program, the ESG program, the Rural Housing Stability Assistance program, as well as HUD programs previously funded under the McKinney-Vento Act (the Supportive Housing Program, the Shelter Plus Care program, and the Section 8 Single Room Occupancy Moderate Rehabilitation program) to use HMIS to collect client-level data on persons served. The rule also states that homeless and nonhomeless projects not funded under the McKinney-Vento Act may participate in the local HMIS, and must follow HMIS regulations and any additional requirements as may be issued by notice. (Federal Register/ Vol. 76, No. 237 / Friday, December 9, 2011 / Proposed Rules)
and housing resources. This also empowers consumers to partner with the program that best matches their personal needs, goals, and approach to improving their housing circumstances.

**(Shift 2) Activities → Outcomes**

The HEARTH Act shifts the emphasis from activities and outputs to outcome achievement. To begin, the HEARTH Act identifies a goal that people who become homeless are housed in permanent housing within 30 days of intake into the homeless assistance system. This means that from the time a household enters a community’s homeless assistance system to the time of exit, including all programs, assessments, assistance, etc., only 30 days have passed. Further, the HEARTH Act identifies seven key outcomes that communities must focus on to ensure their programs to meet the requirements and goals of the HEARTH Act. These seven outcomes are outlined in Table 1 along with corresponding strategies that will help achieve the goal.

In addition, transitional housing is not considered permanent housing under the HEARTH Act. Prior to HEARTH, McKinney-Vento’s funding structure encouraged communities and agencies to fill shelter or other program beds and keep people in shelter while they received services. The number of service activities and the number of program slots filled formed the basis of HUD’s evaluation of CoCs and their agencies and determined funding levels. Now, communities are paid for their services but evaluated on the effectiveness of those services at quickly ending each household’s homelessness.

Under HEARTH, HUD must provide (funding) incentives to use strategies that are proven to reduce homelessness such as rapid re-housing and permanent supportive housing. HUD may also add

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<tr>
<th>HEARTH Goal/Outcome</th>
<th>Best Practices System Component and Strategies</th>
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| 1. Reduce Overall Homelessness | Homeless Assistance System  
- Outreach and Engagement  
- Coordinated Assessment  
- Emergency Shelter  
- Rapid Re-housing  
- Permanent Supportive Housing  
- Case Management |
| 2. Reduce the number of people who become homeless | Coordinated Assessment Prevention/Diversion |
| 3. Reduce length of homelessness | Rapid Re-Housing  
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| 4. Reduce return to homelessness | Prevention/Diversion  
Case Management |
| 5. Increase jobs and income | Case Management |
| 6. Other Accomplishments Related to reducing homelessness | N/A  
10 |
| 7. Thoroughness in reaching homeless population | Outreach and Engagement |

10 Other Accomplishments is defined by each local CoC.
incentives for additional evidenced-based strategies that are proven to end homelessness. In addition, HUD must now use performance-based criteria to determine CoC funding awards. These criteria include but are not limited to:

- **Performance:** A community’s progress in reducing the number of people who become homeless, the length of time people spend homeless, returns to homelessness (recidivism), and the overall number of people who become homeless. In addition, a community is evaluated on whether it increases in jobs and income for people experiencing homelessness and its thoroughness in counting the homeless population.

- **Plans:** The quality and comprehensiveness of a community’s plan to reduce and prevent homelessness and, among other things, the extent to which the plan identifies proven methods, quantifiable performance measures, timelines, and accountable entities.

- **Data and Funding Strategies:** Whether a community prioritizes and distributes funding based on regularly collected and analyzed data as well as whether the community leverages and coordinates funding to achieve the community’s plan to reduce homelessness.

For the first time, HUD may designate and offer additional funding to high-performing communities. A high performing community is one in which:

- The average length of stay in homelessness has declined by 10 percent from the previous year or where the length of stay is less than 20 days;
- The rate of returns to homelessness is less than 5 percent within a 2 year period or has declined 20 percent from the previous year;
- Participation in homeless assistance services is encouraged; and,
- If using funds to serve people identified as homeless in other federal definitions of homelessness – Effectiveness in helping those households avoid homelessness and live independently.
- For communities that have previously been designated as high performing – Effectiveness in using the additional funding received through the designation as high performing.

**(Shift 3) Shelter → Prevention**

The HEARTH Act includes more funding for prevention activities and shifts the emphasis of shelter activities from filling beds and using shelter to “house” people to preventing homelessness and keeping people in their homes and/or out of shelter where possible. Forty percent of ESG funds are dedicated to prevention and rapid re-housing activities. Further, homelessness prevention assistance funds can only be used for people who are truly “at risk of literal homelessness.”

People who are “at risk of homelessness” include the following groups:

1. Individuals and families who demonstrate all three of the following characteristics:
   - An income below 30 percent of area median income;
   - Insufficient resources (i.e. family, friends, faith-based or social networks) immediately available to attain housing stability and avoid entrance into an emergency shelter or literal homelessness; and
   - One or more of the following qualifying risk factors:
     i. Have moved frequently (2 or more times during the 60 days immediately prior to application for assistance) because of economic reasons;
     ii. Are living in the home of another because of economic hardship;
     iii. Have been notified that their right to occupy their current housing or living situation will be terminated;
iv. Live in a hotel or motel;

v. Otherwise live in housing that has characteristics associated with instability and an increased risk of homelessness

vi. Live in severely overcrowded housing;

vii. Are exiting an institution.

2. Children and youth who qualify as homeless under other federal statutes, including the Runaway and Homeless Youth Act, Head Start Act, Violence Against Women Act, Public Health Service Act, Food and Nutrition Act, or Child Nutrition Act;

3. Children and youth (and their parents/guardians who live with them) who qualify as homeless under the Department of Education definition.

Eligible prevention activities to serve those at risk of homelessness overlap with re-housing activities. They include but are not limited to the following:

- Short- (i.e. up to 3 months) or medium- (i.e. 3 – 12 months) term rental assistance;
- Rental assistance of a one-time payment for up to 6 months of rent arrears;
- Legal services;
- Moving costs or other relocation;
- Utility payments.

(Shift 4) Transitioning → Rapid Re-housing

The HEARTH Act shifts homelessness assistance from keeping people in shelter and transitional housing for several months or years while they undergo various life improvement programs to moving them on from shelter as quickly as possible. (Again, the language in the HEARTH Act sets a federal goal of getting people into permanent housing within 30 days of system entry.) In fact, the renaming of the Emergency Shelter Grant program to the Emergency Solutions Grant symbolically underscores the shift housing-oriented solutions such as preventing homelessness where possible and rapidly re-housing people where it cannot be prevented. Further, for the 40 percent of ESG funds dedicated to prevention and re-housing activities (as noted above) the strategies noted under prevention (i.e. Shift 3) can be used in rapid re-housing programs. HEARTH outlines additional strategies that one may consider to be even more rapid re-housing focused, though they may also be used for prevention. These strategies are:

- Housing relocation or stabilization services such as housing search, mediation, or outreach to property owners;
- Security or utility deposits; and
- Credit repair.

The housing relocation and stabilized services described here are standard practices in a rapid re-housing intervention that have been proven effective in helping people access housing quickly and reducing the length of time they spend homeless. Services such as credit repair often happen during supportive services after a family has been rehoused to prevent issues with their current housing or accessing affordable housing in the future if the family wants to move.

Case management requirements under HEARTH implementation also favor a rapid re-housing approach. Interim rules specify that housing counselors or case managers working with ESG program participants must develop an individualized permanent housing plan and help connect households with the appropriate financial assistance and mainstream resources to achieve stability in permanent housing. Housing stability case management can last no more than 30 days while the program
participant seeks permanent housing and no more than 24 months once the program participant is in permanent housing. Eligible case management activities include:

- Using the centralized or coordinated assessment system;
- Conducting an initial evaluation;
- Counseling;
- Developing, securing, and coordinating services and public benefits;
- Monitoring and evaluating program participant progress;
- Providing information and referrals to other providers;
- Developing an individualized housing and service plan; and
- Conducting re-evaluations.

Finally, in 2011 HUD issued an interim rule that communities must immediately (beginning in January 2012) implement prevention and rapid re-housing activities that are eligible under the HEARTH Act. At the time of the rule, communities had already received one allocation of FY 2011 Emergency Shelter Grant resources, and they received a second FY 2011 ESG allocation. All funds under the second allocation were required to be used for newly-eligible activities, including prevention and rapid re-housing. No resources from the second FY 2011 allocation could be used for street outreach or emergency shelter.

McKinney-Vento and HEARTH Act Summary

As one can see, the changes to the McKinney-Vento homeless assistance programs through HEARTH favor new, evidence-based practices such as prevention and rapid re-housing. Further, HEARTH requires communities to take stock of their current homelessness assistance resources and reorient them toward a system/community based approach that is data-driven and outcome-focused. These outcomes include reducing the number of people who become homeless, reducing the length of time people spend homeless, reducing returns to homelessness, and increasing employment and income, among other outcomes.

Fair Housing

The Fair Housing Act “prohibits discrimination in the sale, rental, and financing of dwellings, and in other housing-related transactions, based on race, color, national origin, religion, sex, familial status (including children under the age of 18 living with parents or legal custodians, pregnant women, and people securing custody of children under the age of 18), and disability.”xvii HUD is responsible for enforcing the Fair Housing Act, and persons who have been a victim of housing discrimination can file a complaint with HUD.

The Fair Housing Act applies to most housing and applies apply to any other person or entity whose actions could “make housing unavailable.” This encompasses a wide range of people and entities, including for-profit and non-profit housing agencies. In the homeless assistance field, this would cover at least the following types of agencies:xviii

- Organizations offering rental assistance, such as vouchers or subsidies
- Agencies operating housing counseling and placement programs
- Temporary or longer-term shelters
- Clean and sober housing
- Transitional housing
- Motels that function as primary housing rather than vacation lodging
Anyone who is impacted by a fair housing violation can file a complaint, including program applicants, clients, tenants and residents, program participants, staff, and guests of the program or resident. Likewise, anyone who is a party to the violation or transaction or activity that produces the violation can be liable and must fully respond to the complaint. A complaint can be filed up to one year after the violation has occurred, and agencies should make a habit of keeping client files and records for two years so that they may be responsive to any complaint or lawsuit that is filed.

Homeless assistance providers should familiarize themselves with federal and local fair housing laws in order to ensure that they provide the highest quality service possible, ensure they do not violate the rights of their clients, and serve as better advocates for their clients when working with landlords. The latter is especially true for homeless prevention and diversion programs and rapid re-housing programs.

The following excerpt from HUD’s website describes some violations that agencies should be aware of and ensure that their own activities and the activities of housing partners with whom they work or negotiate cannot be misconstrued as:

In the Sale and Rental of Housing: No one may take any of the following actions based on race, color, national origin, religion, sex, familial status or handicap:

- Refuse to rent or sell housing
- Refuse to negotiate for housing
- Make housing unavailable
- Deny a dwelling
- Set different terms, conditions or privileges for sale or rental of a dwelling
- Provide different housing services or facilities
- Falsely deny that housing is available for inspection, sale, or rental
- For profit, persuade owners to sell or rent (blockbusting) or
  - Deny anyone access to or membership in a facility or service (such as a multiple listing service) related to the sale or rental of housing.

In addition: It is illegal for anyone to:

- Threaten, coerce, intimidate or interfere with anyone exercising a fair housing right or assisting others who exercise that right
- Advertise or make any statement that indicates a limitation or preference based on race, color, national origin, religion, sex, familial status, or handicap. This prohibition against discriminatory advertising applies to single-family and owner-occupied housing that is otherwise exempt from the Fair Housing Act.

Additional Protection if You Have a Disability

If you or someone associated with you:

- Have a physical or mental disability (including hearing, mobility and visual impairments, chronic alcoholism, chronic mental illness, AIDS, AIDS Related Complex and mental retardation) that substantially limits one or more major life activities
- Have a record of such a disability or
- Are regarded as having such a disability

your landlord may not:

- Refuse to let you make reasonable modifications to your dwelling or common use areas, at your expense, if necessary for the disabled person to use the housing. (Where reasonable, the landlord may permit changes only if you agree to restore the property to its original condition when you move.)
Refuse to make reasonable accommodations in rules, policies, practices or services if necessary for the disabled person to use the housing.

Agencies should familiarize themselves with other aspects of fair housing law and specific violations by reviewing resources found at the following websites:


Section 504 (ADA)

The Americans with Disabilities Act (ADA) ensures nondiscrimination against people with disabilities by, among other things, ensuring that people with disabilities have full access to goods, services, buildings, activities, etc. For-profit and non-profit organizations as well as federal, state, and local government entities that offer public accommodations, access to public services, employment, education, transportation, communication, recreation, institutionalization, health services, and voting must meet nondiscrimination requirements in the ADA. This applies to social service center establishments such as those offering temporary shelter, housing, and services to people experiencing homelessness.

According to the National Law Center on Homelessness and Poverty, people in the following categories are likely to be served by homeless assistance programs and are also protected under the ADA:

An individual with “physical or mental impairment that substantially limits one or more major life activities” of an individual. This includes obvious physical impairments such as paraplegia, blindness and deafness, as well as physical and mental impairments and conditions and diseases that may not be so apparent, such as diabetes, epilepsy, tuberculosis, AIDS, alcoholism, drug addiction, mental illness (including depression, post-traumatic stress syndrome, and schizophrenia), developmental and intellectual disabilities, and learning disabilities. (Although recovering drug addicts are considered individuals with disabilities, individuals currently engaged in illegal drug use, including unlawful use of prescription drugs, are not protected by the ADA.)

In order to comply with the ADA, homeless assistance providers may not ask or inquire about a client’s disability except to obtain information that will be useful to ensure reasonable accommodations for the client. Information about the disability must be kept confidential, except to the extent that it impacts reasonable accommodations for the client. In addition, according to the National Law Center on Homelessness and Poverty, shelters must make the meet the following obligations under the ADA:

1. Document and implement nondiscriminatory policies and procedures, meaning that admission criteria and operating rules must not segregate or treat differently persons with disabilities. Homeless assistance programs cannot prohibit an individual from using their services because, for example, the person is an alcoholic or has a mental illness. Further, operating rules must be applied uniformly and equally to all clients, as long as application does not interfere with the client’s reasonable accommodations.

2. Afford reasonable accommodations as necessary in policies and procedures in order to provide equal enjoyment and use of their services, meaning sensible changes to policies and procedures in order to accommodate an individual with a disability and ensure their full access to and full use and enjoyment of the services provided by the shelter. This might include allowing a guide dog or other service animal in a facility that otherwise prohibits animals, assisting someone with filling out forms, or providing a secure location or refrigeration for medications among other examples. A litmus test of whether an accommodation is reasonable is if the change fundamentally alters
the nature of the program and its services or is cost prohibitive, then it’s not reasonable. Programs should have to make relatively inexpensive, non-burdensome changes to accommodate consumers with disabilities.

(3) Provide auxiliary aides and services as necessary for effective communication, meaning individuals with hearing, vision, and speech impairments must be able to effectively communicate in their interactions with the service provider. This may involve including an interpreter or having someone read the documents aloud for a client, for example.

(4) Provide physical access to and within the facility, meaning the program must meet accessibility requirements based on when the facility was constructed. Facilities designed for occupancy after January 26, 1993 must comply fully with the ADA Accessibility Guidelines (ADAAG) issued by the U.S. Department of Justice. Facilities that existed prior to this date must meet either Title II or Title III Guidelines.

Ultimately, homeless assistance providers should do everything they can to assist persons with disabilities, but they are not required to make changes that would fundamentally alter the program or create an undue financial and administrative burden. Reasonable accommodations may be necessary at all stages of the housing process, including application, tenancy, or eviction prevention.

HIPAA
The Health Insurance Portability and Accountability Act (HIPAA) is a federal health privacy rule.

HUD encourages communities to review current policies and procedures around HIPAA covered entities against the updated HIPAA rule. A HIPAA covered entity is:

- A health care provider who bills electronically;
- A health plan; and/or
- A health care clearinghouse.


Service providers that have questions about HMIS privacy and security standards should contact the HMIS TA administrator for your CoC. HUD is in the process of drafting updated HMIS Privacy and Security standards, and the Notice will be published for public comment later this year. CoCs should continue to refer to the 2004 HMIS Data and Technical Standards for guidance on privacy and security.
PRACTICE QUESTIONS

1. Define each of the following homeless population categories
   a. Literally homeless
   b. Imminent risk of homeless
   c. Homeless under other federal statues
   d. Fleeing or attempting to flee domestic violence

2. Describe the differences between transitional homeless, episodic homeless, and chronic homeless.

3. List the key demographic homeless populations discussed in this chapter. Indicate the recommended housing intervention for each group.

4. How do poverty and low-income increase a household’s risk of becoming homeless?

5. List the seven HEARTH outcomes that each community is required to achieve.
Chapter References

1. (Department of Housing and Urban Development 2011)
2. (Department of Housing and Urban Development 2011)
4. (McAllister, Kuang and Lennon 2010)
5. (Department of Housing and Urban Development n.d.)
6. (National Alliance to End Homelessness n.d.)
7. (National Alliance to End Homelessness n.d.)
8. (Sermons and Henry 2010)
9. (National Alliance to End Homelessness n.d.)
10. (National Coalition for Homeless Veterans n.d.)
11. (National Alliance to End Homelessness 2012)
12. (Burt and Aron 2000)
18. (National Coalition for the Homeless 2009)
19. (Department of Housing and Urban Development 2013)
20. (Department of Housing and Urban Development n.d.)
21. (Fair Housing Partners of Washington State 2013)
22. (Department of Housing and Urban Development n.d.)
23. (National Law Center on Homelessness and Poverty 2009)
24. (National Law Center on Homelessness and Poverty 2009)
Chapter Two
Overview of a Best Practice Homeless System

INTRODUCTION

This chapter overviews the fundamentals of housing first and the core philosophy behind the housing first approach. The key components of a high performing homeless assistance system are presented at the end.

Topics:
A. Housing First Overview
B. Key Components in a High Performing Homeless Assistance System
C. Practice Questions

Objectives

Counselors will:
- Understand the fundamentals and definition of “housing first”.
- Be able to identify the key components of a high-performing homeless assistance system
A. **HOUSING FIRST OVERVIEW**

As stated in Chapter One, the solutions to homelessness have evolved over time. This is true both in terms of the assistance and housing offered to people experiencing homelessness. The HEARTH Act fundamentally shifted homeless assistance strategies to housing first approach. “Housing first” is an approach that focuses on helping people access permanent housing (i.e. a unit with a lease in the client’s name) as quickly as possible. Once permanent housing is achieved, individualized, mostly non-mandatory stabilization services are provided as needed. This approach is based on Maslow’s hierarchy of needs and prioritizes housing as the most critical need for people experiencing homelessness. Once the most critical need is met, which is housing in this case, clients can focus on other important but less critical needs such as life skills, substance use, or mental health issues, which impact housing stability. Housing first strategies include activities such as prevention, diversion, rapid re-housing, permanent supportive housing, and housing-focused case management.

B. **KEY COMPONENTS IN A HIGH PERFORMING HOMELESS ASSISTANCE SYSTEM**

A high-performing homeless assistance system will use a housing first approach and service strategies. The following key system components are critical to a high performing homeless assistance system:

1. Coordinated Assessment
2. Prevention and Diversion
3. Emergency Shelter
4. Rapid Re-housing
5. Permanent Supportive Housing

Each of these components is reviewed in Chapter Three through Chapter Seven. Case management strategies and local examples are included. In addition, the strategic use of transitional housing is discussed in Chapter Eight. A case example from one of most highly regarded programs in the country is included in the transitional housing chapter.

**PRACTICE QUESTIONS**

1. Define and describe the theory behind the housing first approach in your own words.

2. What key homeless assistance system components are critical to high-performing homeless assistance system?
Chapter Three
Coordinated Assessment

INTRODUCTION

This chapter overviews the definition and key components of coordinated assessment. It includes a brief discussion of current ESG regulations with which local communities should be familiar and concludes with a coordinated assessment case example.

Topics:
A. Coordinated Assessment Overview
B. Core Components of Coordinated Assessment
C. Coordinated Assessment Case Management
D. The Role of Outreach and Engagement
E. Coordinated Assessment Case Example(s)
F. Practice Questions

Objectives

Counselors will:
- Know the core components of Coordinated Assessment
- Understand the role of outreach and engagement in Coordinated Assessment
- Understand the role and importance of screening, assessment and triage at Coordinated Intake
A. COORDINATED ASSESSMENT OVERVIEW

Coordinated Assessment (often referred to as centralized intake) refers to a single place or process for people at risk of or experiencing homelessness to access the prevention, housing, and other services they need. Coordinated assessment enhances the quality of client screening and assessment and better targets assistance to where it can be most effective. As a result, the system for preventing and ending homelessness is less fragmented, and scarce resources are used more efficiently.

Many communities first included a form of coordinated assessment as part of the Department of Housing and Urban Development’s (HUD’s) 2009 Homeless Prevention and Rapid Re-Housing Program (HPRP). While coordinated assessment was not required for HPRP, many communities used it to better coordinate services. Some communities implemented models that primarily focused on access to prevention resources, and while others included access to an array of services including shelter and rapid re-housing resources.

New CoC interim regulations, released in July 2012, require that Continuum of Care and Emergency Solutions Grant (ESG) grantees create and participate in a coordinated assessment process. HUD defines coordinated assessment as, “...a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.”

B. CORE COMPONENTS OF COORDINATED ASSESSMENT

By centralizing intake and program admissions, the coordinated assessment process makes it more likely that households experiencing homelessness are served by the right intervention more quickly. While local models for centralized intake and assessment can take a number of forms, the Department of Housing and Urban Development’s (HUD) suggests it should include the following components:

- Information so that people will know where or how to access centralized intake;
- A place or means to request assistance, such as a walk-in center or a 211 call center;
- A screening and assessment process and tools to gather and verify information about the person and his/her housing;
- Information about programs and agencies that can provide needed housing or services;
- A process and tools for referrals to appropriate programs or agencies; and
- In some cases, a process for making program admissions decisions.

Models of coordinated assessment vary. In some communities, a variety of services are provided on-site at the coordinated assessment location, while in others housing and services are made available from other agencies through referral. Key strategies may include virtual methods such as conducting coordinated assessment over the phone, using a mobile team to conduct coordinated assessment, one or multiple physical centers with emergency transportation assistance for people who need to get to the

**Definition of Coordinated Assessment**

Coordinated Intake refers to a single place or process for people at risk of or experiencing homelessness to access the prevention, housing, and other services they need.
coordinated assessment center, or coordinated assessment conducted at emergency shelter. In many cases, other programs are co-located with the coordinated assessment program so that clients do not have to travel far.

A Note about Screening, Assessment, and Triage

Screening, assessment, and triage involve processes and tools that determine the level of housing crisis that a household is experiencing as well as the appropriate response to the crisis. “Screening” usually refers to a process of determining eligibility for services. “Assessment” is a more in-depth evaluation of an individual’s specific strengths and challenges and is used to design an individualized client service plan. “Triage” determines how critical the housing crisis is, and the level of service priority that will be afforded to the household. At the conclusion of these three processes, a decision is made about whether a client should be referred for prevention or diversion, some other intervention, or whether they should be admitted to shelter. Screening, assessment, and triage should ideally occur at during coordinated assessment or at the central intake.

If a CoC has no coordinated assessment, emergency shelters, prevention programs, and/or other system entry points should be equipped with the proper tools and strategies to conduct these activities. When a shelter implements screening, assessment, and triage, at a minimum the shelter should be able to make the same determinations indicated in the preceding paragraph about how to serve a household. If it is determined that a household needs prevention or diversion, the shelter should make the appropriate referral. If prevention or diversion are recommended, the shelter’s referral should not result in a subsequent referral because the household is determined ineligible for prevention or diversion by the subject program itself. Ideally, the shelter’s screening, assessment, and triage processes are sufficient to make appropriate referrals and avoid a family “getting the run around.” This is why a single point of entry and/or single screening, assessment, and triage processes are recommended. If none of these recommended features is available, the shelter and prevention programs (as well as other housing programs) should be co-located, located in close proximity, or have a strong working relationship that ensures a smooth process for consumers.

C. COORDINATED ASSESSMENT CASE MANAGEMENT

Establishing a coordinated assessment process impacts the role that service provider staff play in determining services for households experiencing homelessness. It is critical that homeless service providers have a clear understanding of the local coordinated assessment system.

Training housing counselors and case managers on the local process will ensure that people contacting their organizations will be referred to the point of entry for assessment and referral to the appropriate housing or shelter resource in a timely manner. A seamless connection to the local coordinated assessment system will simplify and expedite the process for clients to locate and access needed services, and ensures that they get connected quickly to the appropriate services. In addition, partnering with the local coordinated assessment system provides a source of appropriate client referrals with written information about the specific client needs and requests, allowing providers to focus more on serving clients and less on gathering information and filling out forms.

If the homeless service provider or housing counseling agency is not a current member of the local CoC, the first step to become involved in the local coordinated assessment process is to contact the lead agency for the CoC.
D. THE ROLE OF OUTREACH AND ENGAGEMENT

The HEARTH Act, establishes key performance indicators for CoCs. One of these key indicators is that communities must demonstrate their thoroughness in reaching persons who are homeless across the geographic region covered by the CoC. This means that communities must have service strategies that can identify all persons experiencing homelessness, particularly those living in places not meant for human habitation.

The primary role of outreach and engagement activities is to identify persons experiencing homelessness that may be living in places not meant for human habitation, and to connect them with services. HUD defines the principals of outreach and engagement to “include a non-threatening approach, persistent contact over time, and a patient offer of a flexible array of services, including help with basic survival needs.”vi Outreach includes activities to locate, identify, and build relationships with unsheltered homeless people to provide support, intervention, and connections with homeless assistance programs and/or mainstream social services and housing programs. Engagement focuses on building trust, and “it builds on actions that demonstrate commitment to client choice, maintenance of dignity, and investment in relationship building. It is also important to communicate the type of assistance available and focus on the ability to meet immediate, essential needs related to housing and personal safety.”vii

While a typical housing counselor or case manager does not typically engage in street outreach, there may be times when persons living in places not meant for human habitation seek assistance through your organization. For example, an unsheltered person may say “no” to an emergency shelter option, but may want to access permanent housing or other services. Outreach workers can connect them to the appropriate entity, or preferably the central intake to address their need. Connecting people with the local coordinated assessment system is the best way to ensure that a household is quickly connected to the appropriate available service.

E. CASE EXAMPLE(S): NORFOLK HOMELESS ACTION AND RESPONSE TEAM (HART)

Norfolk’s Department of Human Services’ Homeless Action and Response Team (HART) serves as the central intake point for families experiencing or at risk of homelessness.viii ix HART includes multi-disciplinary specialists who determine eligibility for benefits such as SNAP, SSI, Medicaid and TANF. Its goals are to prevent homelessness when possible, refer families to available services such as emergency shelter or permanent housing, and help families quickly return to permanent housing.

Families who contact the city’s hotline, homeless assistance providers or other service providers are immediately referred to HART. HART first assesses for whether their current housing situation can be salvaged. HART staff will work with families and landlords to establish payment plans, provide budget counseling, and connect households with benefits. If the current housing situation cannot be stabilized and no other options are available, families are assessed using standardized tools and referred to one of Norfolk’s three family emergency shelters and other needed services.
PRACTICE QUESTIONS

1. Define Coordinated Assessment.

2. Name three benefits or advantages associated with using Coordinated Assessment.

3. What are some outreach and engagement strategies and techniques that can connect people with a local Coordinated Assessment?
Chapter References

i Department of Housing and Urban Development, “Centralized Intake for Helping People Experiencing Homelessness: Overview, Community Profiles, and Resources”, www.onecpd.info

ii From the Continuum of Care Program Interim Rule, Federal Register, July 31, 2012, pg. 45425


v Local Continuum of Care Contacts can be access at the HUD Homeless Resource Exchange (HRE); http://www.hudhre.info/index.cfm?do=viewCocContacts


viii For more information about HART, see this USICH case study: http://usich.gov/usich_resources/solutions/explore/homeless_action_response_team_hart

ix The City of Norfolk’s website for HART is found here: http://www.norfolk.gov/index.aspx?nid=2697
Chapter Four
Prevention and Diversion

Introduction

This chapter overviews the program components and strategies associated with homelessness prevention and diversion. Strategies for rental subsidy design, landlord-tenant negotiation, and case management are among the approaches discussed.

Topics:
Part I: Homeless Prevention
A. Prevention Overview
B. Core Components of Prevention
C. Prevention Case Management

Part II: Homeless Diversion
A. Diversion Overview
B. Core Components of Diversion
C. Diversion Case Management

Part III: Prevention and Diversion

Part IV: Case Example(s) & Practice Questions

Objectives

Counselors will:
- Know the required components of high performing prevention and diversion programs
- Understand the importance of and elements of a housing plan for prevention clients
- Be familiar with subsidy and other financial assistance options for prevention
- Know which mainstream resources are critical partners for successful prevention programs
- Understand the various case management strategies for successful prevention and diversion
## PART I: HOMELESS PREVENTION

### A. PREVENTION OVERVIEW

Homelessness prevention includes various housing relocation and stabilization services as well as short- and medium-term rental assistance to help people avoid becoming homeless. The goal of prevention is to preserve the current housing situation so that the household doesn’t experience any destabilization. When current housing cannot be maintained, the family is diverted to other temporary housing, such as a family member’s house, rather than having them enter shelter. The idea behind these strategies is that families and individuals experience the least disruption to their lives when they can avoid entering emergency shelter, as long as they have a safe place to stay.

Traditionally, prevention assistance programs have casted the broadest net possible, offering a little or moderate assistance to a lot of people. The idea behind this approach is that offering small amounts of assistance allows the prevention program to extend its resources and help the most people possible. In this traditional approach, it may seem as though prevention programs are preventing homelessness for large volumes of people. However, research shows that this traditional approach to homeless prevention does not actually prevent homelessness for most people who receive assistance. Research shows that most people who receive assistance in this approach would not have become homeless, even without the assistance. The same research demonstrates that the later the prevention intervention, the more likely it is that people who would become homeless but for the assistance are appropriately targeted and prevented from becoming homeless.

Based on this information, CoCs are updating their homeless prevention programs to ensure that assistance is properly targeted to the right people at the right time and, in the best case scenario, helps families remain stable in their own housing. This evidence-based approach of targeting assistance to those who are in the later stages of their housing crisis is more costly because in the later stages of eviction, for example, there is more back rent owed. The client will likely have to pay rent arrears and/or may have to relocate, which creates expenses for security deposits, utility services transfers, etc. However, in the later stages, it is more probable that the person receiving the assistance, perhaps as they are being evicted, would have entered a homeless shelter or ended up on the streets but for the assistance.

A strong prevention assistance program should include six core components:

1. Screening, Assessment, and Triage
2. Housing Plan
3. Financial Assistance
4. Program Expectations
5. Mainstream Community Resources
6. Case Closure

Each is discussed in greater detail in the following sections.

<table>
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<th>Prevention Program Goals</th>
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<tr>
<td>1. Preserve current housing</td>
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<td>2. Find next best prevention option that causes the least housing destabilization</td>
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<tr>
<td>3. Resolve issues that caused housing crisis and may jeopardize future housing</td>
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B. CORE COMPONENTS OF PREVENTION

Screening, Assessment, Triage

If screening, assessment, and triage do not occur at coordinated assessment, the prevention program should conduct these activities prior to serving clients. The agency coordinating the prevention program should have a screening tool with several questions that the housing counselor or case manager will ask concerning income, residency, urgency, risk, and other factors that indicate eligibility levels and thresholds. Assessment involves interviewing the client to gain a deeper understanding of the actual housing crisis and the client’s ability to solve the problem. It should focus on information that is timely and relevant to the current housing situation, and it should require the least information needed to determine the best response at the time the client is asking for assistance. At the end of an assessment, the housing counselor or case manager should be able to determine what type(s) of assistance the client will receive as well as the level and length of time for the assistance. The National Alliance to End Homelessness’ Prevention Guide says this about assessment:

Many prevention providers immediately request detailed information about household income and expenses. This is timely and relevant in determining whether the household could, with better budgeting, keep their housing with only one-time assistance. Sometimes it is immediately apparent that a household must move; housing has been condemned or foreclosed and the deadline has arrived. In this case, detailed information about past evictions, criminal history, debts, and employment history is timely and relevant for relocation assistance because potential landlords will see and judge the same information in making a rental decision. The program uses housing barrier information to decide which landlords to approach and the incentives that might be required to secure housing. But the housing barriers assessment may not be necessary if it is possible to keep a household in its housing with one-time assistance...

Sometimes information that was not timely or relevant at the initial assessment becomes timely and relevant later. A program offers moderate-term rental assistance to an individual while he searches for employment. At the first quarterly review, staff sees an unexpected lack of effort toward goals or odd and inappropriate behavior. Staff might then ask questions about mental or chemical health issues, which might lead to the recommendation for a more professional assessment. If a diagnosis is made, a new Housing Plan might be developed.

Triaging involves determining the urgency of the client’s situation based on whether they have a safe place to stay that night, whether they will lose their housing that night or within a few days, the degree to which their own resources and ability can help preserve their housing, and whether they have family and friends who can assist them.

All of these steps – screening, assessment, and triage – must focus on helping the client remain stable in their current housing, or if that is not an option, diverting them to the safest, least interruptive interim housing option possible. If prevention and diversion are not options, shelter is the next step.

Housing Plan

Prevention housing counselors or case managers should immediately develop a housing plan based on the client’s goals and needs. The goals must be specific, and the plan should identify action steps and persons responsible for taking action. If, for example, the one-time emergency assistance will resolve the client’s current crisis and future crises can be avoided with proper budgeting, then an appropriate budget should be developed along goals and timelines related to implementation. Another example of a goal...
related to budgeting may include decreasing household expenses by 10 percent. The action steps related to achieving this goal may involve making changes to phone and cable services, applying for utility assistance, or using a food pantry. If the goal is to increase the client’s income by 10 percent, implementation may involve applying for an increase in public benefits or obtaining a job.

The housing plan should be individualized, identify client strengths and barriers, and when and how progress against the action plan will be reviewed. Keep in mind that implementing the housing plan may or may not involve ongoing case management. The program may simply make referrals to programs that can assist the client in implementing their plan, and stop there. In many cases this is perfectly appropriate because the family has a history of stable housing and an ability to keep up with expenses. Other households may need more assistance. It is up to each program housing counselor or case manager to decide the minimum monetary and case management assistance needed (and allowed per program guidelines) to help the family move on from the current housing crisis and prevent future crises.

Financial Assistance

Not all households need financial assistance to maintain their housing; some do. Whether households need financial assistance or not, clients should be expected to use their own resources first. These resources may include cash assets, non-cash assets such as a car that can be sold and replaced with a cheaper car or public transportation, family and friends who may be able to assist financially or offer a place for the client to stay, faith based organizations, or other support networks to which the client may belong.

For those households needing financial assistance, one time rental or utility assistance may be sufficient. For households needing longer term financial assistance, the subsidy should be as short and shallow as possible so that the household receives just enough financial assistance to prevent the loss of housing. The National Alliance to End Homelessness suggests that the financial assistance be shallow enough to avoid the cliff effect (a sudden loss of income for the family that is difficult to rebuild), deep enough so that housing is not lost, short-term enough that households feel some urgency about improving their incomes, and flexible enough to permit extensions if best efforts fail or another crisis intervenes.

Finally, the case manager should communicate the conditions for continuation of financial assistance and the process for terminating the assistance. The client should be clear that if assistance must be terminated, when they will receive notices and warnings, and how they can appeal.
### Some Options for Designing a Rental Subsidy Program

<table>
<thead>
<tr>
<th>Subsidy Model</th>
<th>Benefits</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income-based subsidy:</strong> Households pay a fixed percentage of their income for rent (e.g., 40% or 50% or 60%, etc.)</td>
<td>Household will be able to pay rent even if their income drops because the subsidy will increase. Household has more discretionary money if income increases. Increase in family's share of rent occurs only when/if income also increases.</td>
<td>As income increases, rent increases, which many people perceive as a disincentive to work. The deeper the subsidy, the greater the cliff effect. Income-based subsidies offer little incentive to secure smaller units or less expensive housing. Income-based subsidies are more difficult for program budgeting.</td>
</tr>
<tr>
<td><strong>Flat subsidy:</strong> Subsidy is based on individual’s rent or on apartment size (e.g., $300 for a two-bedroom apartment, $400 for a three-bedroom unit, etc.); the subsidy is fixed. Subsidy can be deep or shallow.</td>
<td>If the subsidy is shallow, the cliff effect is small. Household can see exactly how much more income is needed to replace subsidy. As income increases, rental assistance stays the same, creating an incentive for work. Flat subsidies offer some incentive for obtaining smaller, less expensive housing. Flat subsidies are easier to use in program budget planning.</td>
<td>If income decreases due to job layoff or cut in hours/benefits, or if rents increase, the flat subsidy may not be enough to assure housing retention. Re-evaluation of the subsidy amount would be necessary.</td>
</tr>
<tr>
<td><strong>Declining subsidy:</strong> Whether income-based or flat, the subsidy would decline in “steps,” based upon a fixed timeline or when the individual has reached specific goals.</td>
<td>The steps are known in advance and act as deadlines for progressive increases in income. Reduces cliff effect because rental assistance is fairly low by the end of the subsidy period.</td>
<td>Due to the local job market or the individual’s limited employability, income increases may not be possible or may not occur in the amounts and according to the timelines the subsidy program has set.</td>
</tr>
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</table>

This subsidy chart is from the National Alliance to End Homelessness prevention assistance manual. It describes three different subsidy options - income-based, flat, and declining - and the benefits and risks of each option.

### Program Expectations

It is reasonable and necessary for prevention programs to require client effort and progress toward goals while receiving assistance. Housing counselors or case managers must communicate these expectations, the actions that will be taken by the program staff if expectations are not fulfilled, and help develop individualized client action steps to fulfill these responsibilities. These action steps should take into account client abilities and barriers as well as the local economy. They should also be challenging, but not overwhelming or impossible given the time limitations and other constraints the client faces.

### Mainstream Community Resources

It is essential for a prevention program to partner with and make referrals to other mainstream services and benefits programs within the community. This avoids duplication of services already offered in the community. Often times prevention programs do not have essential partners at the table, have an inadequate representation of partners at the table, or do not have an effective working relationship with partners in the community. Whether some or none of these matters are true, the housing counselor or case manager should develop relationships with frontline staff at key partner agencies so that they can help clients easily access and maneuver these critical resources. The following is a list of key mainstream partners with which prevention programs and housing counselors or case managers should have some connection.

- Public and private agencies that administer emergency financial assistance
- Public and private first responders-- police, domestic violence shelters, homeless outreach services, hospital emergency rooms, etc.
- Legal services
- Local housing authority/public housing: subsidies and subsidized housing
• Private market landlords, housing management companies
• Specialized supportive housing programs
• Utility companies
• Job training and employment services, temporary labor agencies
• Childcare resources and public programs that subsidize childcare
• Consumer Credit Counseling Service (CCCS) agencies
• Mental health and chemical health assessment and treatment providers
• Youth development and child welfare providers.

Case Closure

The goal of the prevention program is to resolve a client’s current housing crisis and issue(s) that directly led to the crisis, which may jeopardize their housing again in the future. However, a prevention program and housing counselor or case manager cannot resolve all of these issues for the client, as prevention is meant to be a relatively short-term and specific intervention. Some of the client’s issues, such as being poor, may persist long-term and are best addressed by mainstream services programs that can provide ongoing assistance.

Prevention housing counselors or case managers should strive to achieve a clear set of short- and medium-term goals and outcomes to help the client resolve their immediate housing crisis, connect the client to long-term resources to help them once prevention assistance has ended, and then close the case. Examples of short- and medium-term goals and outcomes include but are not limited to: obtaining rental assistance, housing stabilization in the current or a new rental unit, reduction of expenses, getting a new job, increasing income, and removing non-leaseholder adults from the unit. All of these goals and outcomes may be associated with longer term issues such as persistently low income or seasonal or temporary employment. However, food pantries and food assistance programs, budget utility programs, and employment services are usually better at handling these issues.

C. PREVENTION CASE MANAGEMENT

In addition to the core prevention program components and practices noted above some households, though not all, may need case management. In a prevention program some case management strategies are more useful for resolving the immediate housing crisis at hand. Immediate resolution may prevent homelessness, divert someone from shelter (diversion is discussed below), or delay homelessness until more permanent, alternative housing can be located. On the other hand, some case management strategies are more useful for helping clients (re)stabilize in their existing housing or new housing.

Case management strategies that are useful for immediately resolving a housing crisis include
1. Housing Advice
2. Legal Services
3. Conflict Resolution
Each of these strategies is discussed below.

Case management strategies that are more useful for housing stabilization include:
1. Tenant Coaching and Education
2. Home Visits
3. Connection to Mainstream Resources
4. Budgeting and Credit Repair
5. Employment
6. Public Benefits and Assistance
7. Preventing Future Homelessness

Housing stabilization case management strategies in homelessness prevention often overlap with rapid re-housing stabilization services, and they are discussed in the rapid re-housing section of this manual.

**Immediate Crisis Resolution Case Management Strategies:**

(1) **Housing Advice:** Simple housing advice may help successfully resolve a client’s housing crisis. Helping to renegotiate the lease, helping the client understand their payment responsibilities despite disagreements with the landlord, or helping the client understand their rights regarding a landlord-tenant dispute can resolve housing issues relatively quickly and inexpensively. Offering housing advice can also help clients help themselves when confronted with future housing issues. Housing counselors or case managers offering housing advice should know or consult someone who knows local landlord tenant laws.

(2) **Legal Services:** Attorneys at legal clinics or free community legal programs can immediately assist clients and help temporarily suspend eviction proceedings. Temporarily delaying an eviction can help a tenant resolve their situation and remain in their current housing by coming up with a payment plan, for example. An eviction delay can also provide enough time for the client to find another place to live. Either way the client avoids becoming homeless. Case management in this strategy would involve immediately connecting the client with legal services while assessing their other housing barriers and possible solutions that may assist with the legal resolution.

(3) **Conflict Resolution:** Relationship conflicts often cause housing crises. Examples of relationships that can be affected by conflict in the same area are: landlord-tenant, host-guest, parent-child, and spousal. Landlord-tenant conflicts are very often involved in a housing crisis that must be resolved to prevent homelessness. Whether the original cause of the housing crisis was rooted in something else such as finances or having an unauthorized tenant, once the landlord misses too many payments or neighbors start complaining, landlord-tenant conflict is involved, and it is necessary to help resolve this situation through case management and/or legal advice. Back payments of rent or reworking the lease are often satisfactory resolutions to these types of matters.

Other more personal conflicts can occur when, for example, the client has been staying with family or friends. Usually the houseguest arrangement is meant to be temporary, but when the agreed upon time limit is reached, sometimes the client has not achieved financial, job, or housing related milestones that will allow them to move on. Other times, the host’s landlord is pressuring them to put out the houseguest or the house guest is not fairly sharing their portion of financial and household responsibilities. In these instances, case management could involve giving money to the host for rent or household expenses while mediating the conflict. It could also involve working with the landlord. Any of these strategies can be used to buy your client additional time to resolve their issues.

In spousal, parent-child or other personal conflict, more specialized mediation skills may be needed as verbal, physical, or other violent confrontations may occur. In all of these situations, it is critical that the housing counselor or case manager be trained in strategies to de-escalate conflict and mediation strategies. Hopefully, the housing counselor or case manager is able to help the client maintain their current housing for a few days or weeks while also helping the client access more sustainable housing.
PART II: HOMELESS DIVERSION

A. DIVERSION OVERVIEW

Diversion prevents homelessness by helping households identify immediate alternate housing arrangements so that they can avoid a shelter stay. At the same time households are connected with services and financial assistance, if necessary, and helped to return to permanent housing or retain their current living arrangement. All the same services provided in prevention and rapid re-housing are also provided in diversion: housing search, rental subsidy, general financial assistance, utility assistance, case management, mediation, connection to mainstream resources, housing search, and legal services. However, diversion differs from these other interventions based on when the intervention occurs. In a prevention strategy, the household is not yet literally homeless. They are unstably housed and at imminent risk for becoming homeless. In rapid re-housing, the household has already become literally homeless and they are residing in shelter. In diversion, the household is applying for entry to shelter or another homeless assistance program.

Critical elements in a strong diversion program include:
1. Screening and Assessment Tool and Process
2. System Entry Points
3. Provider Cooperation
4. Mainstream Resource Connection
5. Flexible Funding
6. Resourceful Staff

B. CORE COMPONENTS OF DIVERSION

According to the National Alliance to End Homelessness, the following assessment questions are good indicators of whether a household should be assisted with diversion program resources. They should be included as part of a diversion tool created by the diversion program.

1. Where did you sleep last night? If they slept somewhere where they could potentially safely stay again, this might mean they are good candidates for diversion.
2. What other housing options do you have for the next few days or weeks? Even if there is an option outside of shelter that is only available for a very short time, it’s worth exploring if this housing resource can be used.
3. (If staying in someone else’s housing) What issues exist with you remaining in your current housing situation? Can those issues be resolved with financial assistance, case management, etc.? If the issues can be solved with case management, mediation, or financial assistance (or all of the above), diversion is a good option.
4. (If coming from their own unit) Is it possible/safe to stay in your current housing unit? What resources would you need to do that (financial assistance, case management, mediation, transportation, etc.)? If the family could stay in their current housing with some assistance, systems should focus on a quick prevention-oriented solution that will keep the family in their unit.

As with prevention, developing a housing plan is a critical first step to diversion, with the goal of finding immediate housing for that night and longer term housing. If no housing option is available, then the household will enter shelter.

System Entry Point(s)
Homeless persons should be able to come to any entry point in the system (which should be part of a coordinated assessment process) and be assessed to determine the best form of assistance to help them. This may be diversion or some other resource such as prevention or shelter.

**Provider Cooperation**

CoC providers should assess the family appropriately to determine fit for diversion (or prevention) before admitting them to their own program. Alternatively, they can refer households to the appropriate assessment entry point. If providers simply admit households into their own program, that family may have missed an opportunity to be diverted.

**Mainstream Resource Connection**

Mainstream community programs are a useful resource for diversion programs. Once a household has been diverted connection to mainstream resources will be critical for long term stabilization.

**Flexible Spending**

The ability to spend funds in a flexible manner is critical for diversion programs. A little bit of rent money, help with the groceries, or other financial assistance can be the difference between successful diversion and a shelter stay.

**Resourceful Staff Members**

Staff who are well-versed in landlord-tenant issues, mediation, rental subsidies, and other community resources can quickly obtain assistance for a household that will be helpful for successfully diverting them from shelter.

**C. DIVERSION CASE MANAGEMENT**

Case management in a diversion program does not look all that different from case management in a prevention program or a rapid re-housing program when it comes to housing search and housing stabilization. However, the time sensitive nature of diversion cases means that the housing counselor or case manager has to be able to think and act quickly and resourcefully based on the information the client provides. If the client needs a place to stay and they have family members or friends locally, the housing counselor or case manager needs to be able to ask the right questions of the client and the family member(s)/friend(s) to assess whether and where the household can find a place to stay. If the first answer is “no” knowing how to explore their needs differently in order to understand the specific barrier and then being able to come up with a solution to issues such as child care, limited space and furniture, money, or other issues can lead to successful diversion. For more information and case examples of diversion, refer to the National Alliance to End Homelessness’ diversion paper, *Closing the Front Door: Creating a Successful Diversion Program for Homeless Families*. For more information about housing search and stabilization strategies that can work in a diversion program, see the rapid re-housing chapter.
PART III: PREVENTION AND DIVERSION CASE EXAMPLE(S)

The following agencies provide prevention and diversion services in communities that have significantly reduced homelessness. Their efforts are part of a broader portfolio of strategies that helped achieve this outcome, and they are strong representations of how to implement the strategies outlined in this chapter.

FACETS Cares Inc., Fairfax County, VA
Since the implementation of the Fairfax-Falls Church 10-Year Plan to Prevent and End Homelessness, homelessness in the community has decreased more than 14 percent. The Homeless Prevention and Rapid Re-Housing program helped close to 900 people receive the services and supports they needed to prevent or end their homelessness.

FACETS Cares, Inc. in Fairfax County, Virginia supports families and individuals who are at risk of becoming homeless. This includes persons who are precariously housed, temporarily living in motels, on the County’s shelter waitlist, or otherwise on the verge of becoming homeless. In 2010, FACETS served 792 single adults through its Client Resource Center. Thirty-one percent of these individuals were diverted from going into a homeless shelter, 20 percent received assistance with employment, and 18 percent received assistance with financial literacy, including budgeting and credit awareness. In 2012, the agency served a total of 933 persons in families, 73 percent of whom were diverted from going into a homeless shelter. In this same year, FACETS prevented eviction for 24 families.

FACETS’ prevention services start with the agency’s Client Resource Center, where clients may receive assistance with employment searches and referrals, eviction protection, housing search, and accessing public benefits and financial assistance. The Client Resource Center also serves as a place for information, referrals, and linkages to public and private human services. FACETS staff coordinates services for clients, advocates with partner agencies on behalf of clients, provides basic needs assistance, and conducts case management. Housing counselors or case managers help clients develop service and housing plans with specific goals. Most other assistance is provided through the partner agencies.

Dudley Diversion Project, Boston, MA

The Dudley Diversion Project started as a two-month pilot to test the use of a diversion intervention for families seeking shelter at the Massachusetts Department of Transitional Assistance Dudley Square Office (DTA). The pilot consisted of a collaboration between several service-providing organizations, resource experts, and housing assessment professionals. It also included $50,000 in flexible funding, which was spent on one-year subsidies for working families and on rental and utility arrearages. The pilot worked with 69 families. The outcomes were as follows:

- 42 percent were diverted from DTA shelter
- Of the diverted families:
  - 10 identified family or friends to live with
  - 11 were stabilized in their original housing
  - 7 were placed in private sector transitional housing

Lessons learned from the pilot that would be useful for other diversion programs include:
(1) Utilize a resources based intervention with families: When a family presents for shelter, try to immediately locate resources and community supports that can prevent the need to use emergency shelter. Families worked with an assessment and resource group. Each resource

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1 The outcome for one family is unknown.
group was made up of housing search workers, prevention specialists, and housing resource experts. The resource group helped the families identify alternatives to shelter. The families also worked with an assessment group, which included a clinical provider, DTA frontline staff, and peers (mothers who have recently experienced homelessness). The assessment group assessed the nature of the housing crisis and, based on that information, the resource group matched the families to appropriate housing resources.

(2) Have access to flexible funding that will be used for a variety of needs: The pilot’s flexible funding model allowed housing counselors or case managers to get the right resources to the right people at the right time rather than using program funds that have specific use requirements and tend to use a one-size-fits-all solution. The $50,000 was for nine families: three families received utility and rental arrearages at an average cost of $1,538, and six families received one-year subsidies at an average cost of $7,564. The cost of these interventions was significantly less expensive per family than one year of shelter, which costs $33,600 per family per year.

(3) Work with landlords who will take on risker tenants: DTA guaranteed stabilization services for the six families. They worked with the Mayo Group, a management company that oversees private apartments and did not run CORI or credit checks. Their willingness to work with DTA families stemmed from the guaranteed subsidies. Without this kind of flexible landlord partner, these families would have had to turn to shelter if no other options were available.

**Practice Questions**

1. List five key mainstream service partners that are critical to a prevention program.

2. List key goals for a prevention program.

3. What are examples of short- and medium-term goals that can help a client resolve their housing crisis?

4. Describe the difference(s) and similarities between prevention and diversion. How do the definitions of the interventions differ? How do the strategies differ? How are the strategies the same?

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2 This subsidy amount for the six families was sufficient for one year because all six families are working. These six families used only the Diversion Pilot subsidy and did not access other permanent subsidies. Further, the price of the subsidy did not include the intensive case management and permanent housing search services that the families received.
Chapter References

i (Department of Housing and Urban Development 2011)
ii (National Alliance to End Homelessness 2009)
iii (National Alliance to End Homelessness 2009)
iv (National Alliance to End Homelessness 2009)
Chapter Five
Emergency Shelter

INTRODUCTION

This chapter compares traditional approaches to emergency shelter with HEARTH Act-oriented emergency shelter programs. The role of rapid re-housing is discussed along with a brief description of shelter culture and philosophy. Case management strategies for emergency shelter are discussed, and the chapter concludes two case examples.

Topics:
A. Emergency Shelter Overview
B. Core Components of Emergency Shelter
C. Emergency Shelter Case Management
D. Shelter Culture and Philosophy
E. Emergency Shelter Case Example(s)
F. Practice Questions

Objectives

Counselors will:
- Know which service components are critical to an emergency shelter program
- Know the case management strategies that are effective for working with shelter clients
- Be familiar with performance and data standards that are useful for a shelter program
A. **Emergency Shelter Overview**

HUD defines emergency shelter as any facility with the primary purpose to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless. It is often the case that emergency shelters are population specific and are characterized by the length of time a consumer is allowed to utilize the service. For example, some shelters may serve only families, adult men, adult women, runaway youth, or domestic violence survivors. Additionally, the shelter may serve as a day or night shelter to provide relief from extreme heat or cold, shelter for a single night on a first-come first-served basis with no guaranteed bed for the next night, or shelter for a longer period of time until the consumer can access the next service or program intervention.

Traditionally, shelters have only provided accommodations while people try on their own to access housing, services and benefits that will end their homelessness and/or provide them with the care and assistance they need. Additionally, shelters have traditionally focused on maintaining full occupancy, sometimes with lengths of stay lasting for several months, and conducting activities to help clients remain stable while they seek solutions on their own. Finally, consumers have traditionally been required to maintain compliance with several rules in order to maintain “residency” in the shelter program. Rules ranged from ensuring that their household composition met certain demographic criteria (for example, in some shelters older male children and fathers were not permitted to stay in the same shelter with the rest of their family), to sobriety requirements, to requirements to participate in life skills classes.

As described in Chapter I, the HEARTH Act completely inverts the traditional approach to emergency shelter by shifting the emphasis from filling beds and using shelter to “house” people to preventing homelessness where possible and actively helping consumers move on to permanent housing as quickly as possible when shelter entry is necessary. CoCs are now rewarded for their performance on prevention and diversion, and ESG funds can be used to help them achieve these outcomes. CoCs are also assessed on how quickly they get people into permanent housing, and HUD encourages the use of ESG funds to conduct rapid re-housing activities to achieve this outcome. Meeting HEARTH requirements and standards requires emergency shelters to be housing-focused. Housing-focused emergency shelters have the following core service areas in common.

1. Direct Assistance
2. Supportive Services and Mainstream Linkages
3. Housing Barrier Assessment
4. Housing Placement

**Key Points to Remember**

Emergency Shelters Should Provide:

1. Direct Assistance
2. Basic Supportive Services
3. Linkages to Mainstream Services
4. Rapid Re-housing Assistance

B. **Core Components of Emergency Shelter**

**Direct Assistance**

Emergency shelters should provide direct assistance to households to meet their basic daily needs. This includes things such as beds, meals, basic need items, bathroom and shower facilities, and a place to secure their personal belongings.
Supportive Services and Mainstream Linkages

Providing rapid re-housing or referrals to other housing services (e.g. permanent supportive housing, transitional housing) is the priority for every emergency shelter. Following orientation and getting the household settled, steps toward providing these services should occur within the first few days of shelter entry. Concurrently, the emergency shelter should provide basic supportive services and linkages to mainstream services and programs, as these can help streamline the process for moving families into permanent housing. Basic supportive services that the shelter may provide include childcare, a school liaison for school-age children, basic mental health and first aid services for emergencies, and transportation assistance. Linkages to mainstream services should include benefits and financial assistance programs such as TANF, SSI, SSDI, Section 8, food stamps, and VA programs. These programs provide the assistance clients will need to transition off their temporary subsidy (once they receive it), but they may have lengthy application and approval processes. Therefore, it is critical to get clients started with these resources as soon as possible. Clients should also be connected with employment services. No additional programming (e.g. life skills programs) or requirements outside of those that ensure public safety should be part of the shelter’s overall approach.

Housing Barrier Assessment

Because housing-focused shelters are conducting rapid re-housing or making referrals to other housing programs almost immediately from shelter entry, staff must conduct a housing barrier assessment to determine the most appropriate housing option and services for the household. The assessment should identify the tenant screening barriers and financial shortfalls that will impact the client’s ability to access and maintain rental housing. For more information about conducting a housing barrier assessment, review Chapter VII on Rapid Re-housing.

Housing Placement

Once housing barriers are identified, the shelter’s housing locator and/or housing counselor or case manager will take steps to overcome these obstacles and help the client gain access to housing. If the housing barrier assessment indicates that the client may need longer-term services than those available through rapid re-housing, a referral to the appropriate program is made. Note that even clients with severe barriers can be served in rapid re-housing, though they may need more comprehensive supportive services.

C. EMERGENCY SHELTER CASE MANAGEMENT

The primary goal of case management in the shelter system is to move people from homelessness to permanent housing as quickly as possible. The case plan (also called a housing plan) should reflect this goal, and be developed no later than the second week of the shelter stay. Without an immediate focus on permanent housing, movement to permanent housing is delayed, lengths of homelessness increase, the shelter system can become overcrowded, and households do not get the level of service they need.

The strategies and objectives in the case plan should clearly outline how the client’s permanent housing will be located, the housing stabilization services the client will receive, and the mainstream services to which the client will be linked. Stabilization services and mainstream programs should address key needs

1 For more information about rapid re-housing, permanent supportive housing, and transitional housing, refer to the appropriate chapter.
such as securing stable income and reintegration into the community. They may also address issues such as substance abuse and mental illness. Effective shelter housing counselors and case managers work together with clients to assess household needs, define the best plan of action to address those needs, determine the appropriate home-based case management services, and identify appropriate linkages. Housing counselors or case managers may also help clients navigate and coordinate shelter-based services and other services noted in this chapter.

The best way to initiate a productive relationship is to establish trust and rapport with the client at the initial meeting. To do so, housing counselors and case managers must treat clients with respect and appropriate sensitivity. This means recognizing that homelessness is a crisis that can affect any person, and it often involves feelings of loss of dignity or self-worth. In addition, housing counselors and case managers should highlight the client’s strengths and empower them to believe that they can move from homelessness to permanent housing and maintain that housing. Empowering the client requires the housing counselor or case manager to recognize that their own role is secondary to the client’s leadership in their personal situation, and it is ultimately the client who will need to take the necessary steps to achieve and maintain self-sufficiency. Using techniques such as motivational interviewing and celebrating clients’ successful completion of goals can also further this objective. These techniques coupled with client leadership develop the client’s confidence, which is needed for the client to actively participate in their housing search, guide the housing stabilization process, and take a personal stake in their long-term goals.

Finally, to effectively perform case management activities, it is critical for emergency shelter housing counselors and case managers to have an understanding of the populations they serve and demonstrate qualifications that meet the needs of their clients. Housing counselors and case managers should receive training on topics such as cultural competence and receive professional development to ensure compliance with relevant standards and codes of conduct. Many communities offer regular trainings for all housing counselors and case managers involved in homeless assistance. Training typically covers best practices in rapid re-housing and identification of community wide resources and supports. Additional information on case management techniques for moving clients on to permanent housing may be found in the Rapid Re-housing chapter of this manual.

D. SHELTER CULTURE AND PHILOSOPHY

It is important that the shelter’s culture promote a sense of urgency for moving on to permanent housing while respecting clients and without making clients feel unwelcome. Integrating housing-focused goals and a client-centered philosophy into housing counselors’ and case managers’ job descriptions and professional evaluations is key to creating this culture. Goals and evaluation metrics for housing counselors and case managers should emphasize the following:

• The primary goal of case management is to move households from shelter to permanent housing as quickly as possible;
• The housing goal must be clear, measurable, and attainable;
• Case management practice is rooted in the belief that clients are capable of taking control of their lives and their housing; it recognizes that people experiencing homelessness are like anyone else with strengths and resources as well as weaknesses and barriers;
• The case management process is designed to get clients ready to move to permanent housing, help them manage change, and empower them to take control of their own lives and housing stability;
• Case management is client-centered rather than a program-centered;
- The case management process is a shared partnership between client and housing counselor or case manager in which housing decisions and plans are mutually developed with the client actively involved in all phases of the process—assessment, planning, problem solving, and finding resources;
- The housing counselor’s or case manager’s role is not to be the “end all” for the client, but rather to connect the client with the services to ensure housing stability such as employment and job training programs, childcare and parenting support, income, and medical assistance programs;
- For clients involved with other agencies, every attempt should be made to coordinate case management plans, with the shelter housing counselor or case manager requesting a copy of all other case management plans to ensure coordination of plans and avoid duplication of services; a primary case manager should be identified.

These guidelines should also be integrated into the emergency shelter’s quarterly, semi-annual, and/or annual assessment of its programs and strategies.

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<tr>
<th>Standard</th>
<th>Benchmarking and Data Guidelines</th>
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<tr>
<td><strong>Service Effectiveness</strong></td>
<td>Are consumer outcomes good enough? Can they be improved? Set measurable outcomes for clients. Establish program performance targets based upon similar services for similar populations (e.g. 90% of households with serious barriers who receive tenancy supports will not be evicted during services). This requires data on relevant target population characteristics. Track and review outcomes at regular intervals and identify trends. If results are not satisfactory, review outcomes by client subpopulation, by service type, and/or by program staff to identify possible problem areas and actions that might improve results.</td>
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<tr>
<td><strong>Service Efficiency</strong></td>
<td>Did the program use the lowest level of service for the shortest time necessary to resolve the problem? Are caseload sizes appropriate for the level of assistance provided? If rules have been developed for approval of expenditures, were rules followed? What is the average length of assistance? Is length of service increasing—why? Has the population receiving assistance changed over time and how has this change affected costs? Measuring efficiency does not require caps on assistance or length of service (although these may be utilized by some programs). It does require monitoring trends and assessing whether the variance is related to client barriers, differences in staff approach, or environmental factors such as changes in the job or housing market.</td>
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<tr>
<td><strong>Service Quality</strong></td>
<td>Did staff meet agency expectations for service delivery? Were clients satisfied with staff and agency responsiveness, respect, and effectiveness? Were landlords satisfied with agency follow-through on tenancy problems? If rules have been developed for approval of expenditures, were rules followed? What is the average length of assistance? Is length of service increasing—why? Has the population receiving assistance changed over time and how has this change affected costs? Measuring efficiency does not require caps on assistance or length of service (although these may be utilized by some programs). It does require monitoring trends and assessing whether the variance is related to client barriers, differences in staff approach, or environmental factors such as changes in the job or housing market.</td>
</tr>
<tr>
<td><strong>Service Access</strong></td>
<td>Does the program reach its intended target population? Are there any barriers that prevent the target population from obtaining services? Service access requires obtaining information about those who received services and those who did not. Service capacity can be assessed by tracking program turnaways. Physical access, such as the adequacy of ramps or need for Braille signage can be reviewed by a specialized consultant. Agencies that refer clients can identify barriers their clients reported after using the program. After service completion, clients can be contacted for information on any barriers they perceived.</td>
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The National Alliance to End Homelessness recommends these performance standards and metrics to drive program improvement and measure effectiveness, efficiency, quality and access. These same guidelines should be used for a rapid re-housing program and can be modified and used for any program outlined in this manual.
E. EMERGENCY SHELTER CASE EXAMPLE(S)

Emergency shelters around the country are increasingly shifting their services and programs to be more housing-focused. This includes adopting rapid re-housing as the dominant approach for working with clients and providing only those shelter-based services that will help streamline housing stabilization. Two shelters that have received national attention for their programs are the Katherine K. Hanley Family Shelter in Fairfax County, VA and the YWCA Family Center in Columbus, OH. Both agencies are discussed below.

Katherine K. Hanley Family Shelter, Fairfax, VA

Katherine K. Hanley Family Shelter (Hanley Shelter) was Fairfax County’s first housing-first shelter. Operated by Shelter House, Inc., Hanley Shelter represented Shelter House’s shift from a traditional approach to emergency shelter to rapid re-housing. As one of Virginia’s first rapid re-housing shelters, the Hanley Shelter became a national model for performing this kind of organizational change.

Hanley Shelter has an agency-wide goal to help families experiencing homelessness access permanent housing as quickly as possible while continuing to provide services to families once they are housed. Shelter staff and clients share an expectation that the family will move out of shelter as soon as 30 days but no later than 45 days after shelter entry. A departure date is set when the family arrives at the shelter. Upon shelter entry, families work with their case manager to develop a housing plan, and case management and housing location services are provided to help the family identify permanent housing options. Families in the program often move into permanent housing without financial assistance or subsidy. Home- and community- based case management that is tailored to each family’s needs is provided once families are housed, and it is designed to help families stabilize in housing.

The shelter conducts the following services, programs, and activities to ensure the success of their housing first approach:
- Case Management
- Linkage to Mainstream Benefits
- Community Meetings
- Employment Skills Group
- Financial Management Group
- Housing Group
- Housing Location Support
- Job Search Support
- Medical Services
- Mental Health Support

YWCA Family Center, Columbus, OH

In 1995, 1,168 families entered Columbus’s homeless system. This figure peaked at 1,217 in 1997 before declining to 746 in 2009.iii Homelessness continued to decrease in Columbus from 2007 to 2009 during a nationwide recession. From 2009 to 2012, homelessness numbers remained nearly unchanged, increasing by only 75 people. Most families exit emergency shelter within 21 days, and the average length of stay is 17 days. While many agencies in Columbus have contributed these accomplishments, the YWCA Family Center (YWCA) is at the center of the community’s success.
The YWCA is one of the nation’s first emergency shelters to implement rapid re-housing, and the agency’s short length of stay outcomes have made it the foremost example of a best-practice emergency shelter for the last two decades. The YWCA is the single-point of entry (i.e. coordinated assessment) for all homeless families in Columbus. Families participate in a virtual coordinated intake process over the phone or in person if they present at the YWCA Family Center. All families are immediately triaged and, where appropriate, referred to diversion or prevention services. If the family enters emergency shelter, they participate in the shelter’s intake and assessment process within one and two days, respectively, of shelter entry. They meet with a family advocate within 3 days of assessment to begin working on their housing plan, which was developed during the assessment. A child advocate is also assigned to the family within 24 hours of entry, and through the YWCA’s partnership with Project Connect, nearly 98 percent of children return to their home school within one business day of shelter entry. The family advocate assists with housing, job counseling and services for children, and helps the family coordinate all of their services. Concurrently the family is working with a staff member whose sole purpose is to connect families with benefits such as food stamps, social security benefits, Medicaid and Medicare. The family is also working with employment services, and the YWCA provides childcare so that the head(s) of household can manage these affairs.

The family advocate helps the family pursue the quickest and least expensive access to permanent housing. The least expensive of these access methods is transition assistance. Transition assistance is one-time limited financial assistance with no additional case management services. Otherwise families receive rapid re-housing assistance or, if necessary, referrals are made to mental health programs, substance abuse programs, or permanent supportive housing. Rapid re-housing programs can include a security deposit, up to three months of rental assistance or, for families in the Job2Housing program, up to six months of rental assistance.

As Columbus increases its focus on rapid re-housing as the best option for most families, the community has converted two long-term shelters to rapid re-housing programs. To achieve the community wide goal of achieving permanent housing for families within 21 days of shelter entry, CoC agencies such as the YWCA continue to develop housing-related partnerships. The agencies also regularly collaborate with each other and annually establish MOUs to memorialize their cooperation.

**Practice Questions**

1. List service linkages that should occur while a household is in shelter. When is the best time during a household’s stay in shelter to provide connection to mainstream services? Why are these linkages important?

2. What key housing related issues should the client’s case plan address?

3. List two program evaluation metrics that your agency should consider implementing for each of the following standards:
   - Service Effectiveness
   - Service Efficiency
   - Service Quality
   - Service Access
Chapter References

1 (Department of Housing and Urban Development n.d.)
2 (National Alliance to End Homelessness 2009)
3 (National Alliance to End Homelessness 2010)
Chapter Six
Rapid Re-Housing

INTRODUCTION

This chapter the basic principles and program components of rapid re-housing. Landlord relationship development and maintenance are also discussed, which is followed by a brief description of rapid re-housing program staff. Case management strategies for rapid re-housing programs are presented, and the chapter concludes two case examples.

Topics:
A. Rapid Re-Housing Overview
B. Financial Assistance in a Rapid Re-housing Program
C. Working with Landlords
D. Rapid Re-housing Program Staff
E. Rapid Re-housing Case Management
F. Rapid Re-housing Case Example(s)
G. Practice Questions

Objectives

Counselors will:
• Know the principles of rapid re-housing
• Understand the three service characteristics that are critical to every rapid re-housing program
• Be familiar with financial assistance in rapid re-housing
• Understand the basic principles of working with landlords including:
  o Landlord business interests
  o How to communicate benefits to landlords working with rapid re-housing programs
  o How to recruit landlord partners
  o Strategies to maintain positive relationships with landlord partners
• Understand case management strategies that are critical to successful housing stabilization
A. **RAPID RE-HOUSING OVERVIEW**

HUD defines rapid re-housing as the “provision of housing relocation and stabilization services and short- and/or medium-term rental assistance as necessary to help a homeless individual or family move as quickly as possible into permanent housing and achieve stability in that housing”. It is different from permanent supportive housing, although both programs serve homeless people using a housing first approach. In permanent supportive housing, clients typically have severe, chronic impairments, and supports are provided permanently or on a long-term basis (i.e. years). In rapid re-housing, most clients do not have severe disabilities, and they can stabilize in housing in a few weeks or months; therefore, rapid re-housing services are short- or medium term.

According to the National Alliance to End Homelessness’ rapid re-housing guide, rapid re-housing programs operate based on the following principles:

1. **People move directly from homelessness to housing.** There are no intermediate programs that delay their move to housing.
2. **The key to successful re-housing is understanding the individual’s barriers to getting and keeping housing—then finding ways to eliminate or compensate for those barriers.**
3. **Rapid Re-Housing provides the minimal financial assistance and supportive services—amount and length—needed to obtain and retain housing.**
4. **Households must be empowered to make their own choices and to respond to the consequences of those decisions.** There is no guarantee of risk-free housing stability and some households will fail. Services are voluntary, and choices and decisions are client driven.
5. **The focus is housing; household problems that are not directly related to housing are addressed only if and when the client chooses.** However, this does not mean that programs cannot have expectations of the household. Households should be expected to make effort or progress towards obtaining a long-term subsidy or increasing income enough to remain housed without the rental assistance.
6. **Mainstream resources are a critical part of stability for everyone living in a community.** Rapid re-housing connects clients to supportive, community-based resources they can use after rapid re-housing services end.
7. **Landlords are a valued resource.** If a rapid re-housing program cannot meet reasonable expectations of landlords, they will not have enough units to rehouse clients.

Rapid re-housing programs share at least three common service characteristics:

1. **Housing placement is rapid**
2. **Assistance is provided to access housing**
3. **Assistance is temporary**

Each is discussed below.
Housing Placement is Rapid

Housing placement is completed as quickly as possible, ideally within 30 days of homeless assistance system entry. Clients are not required to meet unrelated prerequisites such as attending life skills classes, or demonstrate that they are “housing ready” before they are assisted to find housing. Skills related to housing stabilization are developed after the client is in housing with a lease in their own name.

Assistance is Provided to Obtain Housing

Families and individuals who need rapid re-housing assistance face two barriers to accessing housing. The first obstacle they face is the financial expense of accessing rental housing. Because homeless households are poor and housing consumes most of their income, any financial difficulty can cause a housing crisis. Cash shortages, rent arrears, judgments, and bad credit are all associated with failure to pay rent on time, and all make it difficult for households to afford moving expenses such as security deposits and first and last month’s rent. The second significant barrier clients face is tenant screening barriers such as a criminal history or underemployment, which cause landlords to reject because they appear to be high risk.

Homeless households tend to have one or more screening barriers and, therefore, need help to negotiate with landlords. Rapid re-housing programs offer assistance that helps clients navigate these issues so that they can more quickly and easily access rental housing than they would on their own. Financial assistance for moving expenses, temporary rental assistance, and housing location assistance in which the program negotiates with the landlord concerning tenant risk factors improve the likelihood that a landlord will work with the client. These forms of assistance also help ease the transition to new rental housing while the household regains financial stability.

Assistance is Temporary

Rapid re-housing assistance is non-permanent. Financial assistance may include moving expenses such as rent, utilities or other housing related expenses. Case management is primarily focused on helping the client identify and address barriers to housing stability. Both low- and high- barrier households can receive support to access housing and short- or medium-term financial assistance and/or case management to stabilize in housing. If longer term support is needed, mainstream programs provide this assistance rather than the rapid re-housing program.

B. FINANCIAL ASSISTANCE IN A RAPID RE-HOUSING PROGRAM

The HEARTH Act sets a goal that all homeless families and individuals will be permanently housed within 30 days of accessing the homeless system. Housing markets, client barriers, and other local factors may make this goal more or less difficult to achieve, but the point is that all assistance is housing-focused, and households are assisted to obtain permanent housing as quickly as possible. This is the principle of rapid re-housing, and how communities and programs will get closer to achieving better outcomes.
As is the case for households receiving homelessness prevention assistance, not all homeless households need financial assistance to move and/or maintain housing. Many programs such as those at Tabor Community Services in Lancaster, PA and Shelter House in Fairfax, VA have helped families move on from shelter by providing only housing location services or one-time security deposit assistance. Financial assistance in a rapid re-housing program mirror those used in a prevention program; however, rapid re-housing financial assistance may be longer due to the nature of the housing crises faced by literally homeless households compared to precariously housed households.

As is the case in a prevention program, the rapid re-housing financial assistance should be as short and shallow as possible for the reasons noted in the Prevention and Diversion chapter of this manual. This also helps families avoid experiencing a financial “cliff” once assistance ends, making it more likely that they will be able to sustain their housing and avoid another crisis. Rapid re-housing programs can serve more families using this approach as well. Likewise, financial assistance should be short-term enough for assistance to continue on a short-term extension if necessary. Also like a prevention program, rapid re-housing case manager should communicate the conditions for continuation of the assistance, the process for terminating and appealing a termination.

C. WORKING WITH LANDLORDS

Landlords are critical to every rapid re-housing program because without them, there would not be enough rental units to serve rapid re-housing clients. However, landlords that partner with rapid re-housing programs must be willing to accept tenants with low-incomes, poor rental histories and/or criminal offenses in their backgrounds as this is typical of a rapid re-housing client. To attract landlord partners, rapid re-housing program staff must firmly understand and be able to fulfill landlords’ business interests. They must also understand the type of landlord with whom they should partner.

Often, it is best for rapid re-housing programs to seek out small landlords who own one to four units rather than large property management companies or landlords with much larger real estate portfolios. This does not mean that “bigger” landlords should never be approached; however, the circumstances faced by a small landlord create different constraints and opportunities that make them more available for partnerships with homeless assistance agencies. To begin, small landlords are usually renting out an former primary residence or an additional home they purchased for extra income. They tend to be more flexible than their larger counterparts because their rental property is not their primary income source. In addition, because they own and most likely manage their own unit, they may be more understanding of and willing to work with less qualified renters as long as there is a reliable organization and program backing them. Larger landlords and property management companies may be less forgiving because they can afford to wait for more qualified renters and often must follow guidelines that require them to do so. Small landlords also have smaller cash flow and tighter profit margins than larger landlords. Repairs and rental shortages are likely to be paid for out of the owner’s personal finances whereas larger landlords typically have enough rental income from other units to pay for repairs, or they have the time and resources to pursue these expenses through other means.

Landlord Business Interests

Landlords, small or large, have four core interests that must be met for them to consider renting to a tenant.
(1) On Time Rent: Landlords want and expect their rent on time. For small landlords, this is especially critical because a late payment means that they have to make a mortgage payment with their own personal finances while also carrying the payment for their own home.

(2) Property Care: Landlords want tenants who will take care of their property. Sometimes, clients have never lived in their own home and don’t understand that even small issues, such as a small leak, require immediate attention. Clients may also be concerned that reporting a small issue will put them at risk of losing their unit. Small issues can grow into bigger ones and become expensive to fix, creating more financial hardship for the landlord. This means that the program must help the client understand how to maintain the property in good condition, and know when to inform the landlord when maintenance issues arise. Additionally, sometimes programs offer to pay for repairs to a unit when the tenant fails to do so or moves out unexpectedly. This limits the landlords financial exposure and ensures that the landlord has a positive experience rather than a stereotypical one.

(3) Quiet Enjoyment/Good Neighbor: Landlords want tenants who will quietly enjoy their apartments and not disrupt their neighbors. Constant and suspicious traffic, trash, or frequent loud noise disturbs neighbors and often results in complaints or police calls. Landlords may be fined for these issues or, if they have other tenants in the building, the other tenants may move on and leave the landlord with a vacancy.

(4) Long-term, Stable Renters: Landlords incur fewer expenses and avoid advertising fees and vacancy costs the longer a good tenant stays. Even if the rapid re-housing program focuses on short-term leases for shelter or interim housing, landlords appreciate having a program partner that can provide a steady stream of tenants and rent payments.

Remember, landlords are business persons engaged in a high stress, high maintenance, and low profit margin business. For small landlords who have high exposure to financial setbacks and other issues associated with the rental business, these circumstances are even more acute. Therefore, as your program seeks new relationships with landlords, keeping these interests the forefront of landlord partnership efforts will make growing the network easier.

**Rapid Re-Housing Program Benefits**

A strong rapid re-housing program can find housing for tenants with multiple evictions and serious criminal histories. In fact, landlords may call them to fill vacancies. In order to build their landlord pipeline, these programs clearly identify the benefits of working with their program and define how
those benefits align with landlord interests. When they reach out to landlords, they make an offer the landlords find difficult to pass up, and they keep their word.

Benefits of working with rapid re-housing programs and leasing to their tenants include:

1. Elimination of advertising costs: Rapid re-housing programs offer a steady stream of renters. They act as an apartment broker, but with no fees to the client or landlord, and the landlord can avoid the fees of advertising the unit.

2. Educated tenants: Rapid re-housing tenants often participate in educational classes on topics such as tenant education and apartment maintenance. They may also receive budget education classes or financial counseling while a housing locator is finding their home. This can make them a better prepared tenant than someone who has not received this assistance and information, and they may be less likely to cause problems.

3. Tenant security deposit assistance: Rapid re-housing programs often help tenants with a security deposit. So if the landlord needs a larger security deposit to become comfortable, the program can help make that happen.

4. Client housing financial assistance: Landlords know that many tenants, whether they are formerly homeless or not, are only one financial crisis or missed paycheck away from missing their rent payment. Because rapid re-housing program clients often receive short term rental assistance, they are able to build up reserves that help avoid nonpayment.

5. Guaranteed rent payments: Many rapid re-housing programs guarantee rental payments even if the tenant does not pay. Sometimes they cosign the lease to make landlords more comfortable and increase accountability. All landlords like guaranteed rent payments, and they like having someone they can call in addition to or instead of the tenant when there is an issue with the rent.

6. Problem prevention: Rapid re-housing program housing counselors or case managers conduct regular home visits to ensure that their clients are progressing toward their goals. During the home visits, goals that are addressed are appropriate apartment care and lease compliance. If the tenant presents in a way that is inconsistent with these goals, the housing counselor or case manager can intervene before bigger issues arise.

7. Problem mediation and resolution: As needed and appropriate, the rapid re-housing housing counselor or case manager can help mediate issues between the landlord and tenant so that legal issues don’t arise. Further, if the landlord receives complaints from other tenants, the landlord can notify the housing counselor or case manager who can resolve the tenancy problem. If the issue(s) continue, the housing counselor or case manager can find new housing for the client, which helps the landlord avoid the hassle and expense associated with evicting the tenant. Often times, the rapid re-housing program has a client that can immediately fill the unit.

8. Personal satisfaction: Many landlords enjoy the feelings of personal fulfillment associated with taking on a tenant who needs to get back on their feet.
# Recruiting Landlords

Finding landlords to work with a rapid re-housing program may be a challenge at first. Starting with a few targeted strategies will make start-up easier until the program can grow based on word-of-mouth referrals from landlords.

1. **Starting with who you know is a good first step.** Start by generating a list of people who program staff already know are landlords or may be connected to landlords. Talk to people in personal and professional circles to find out if they know landlords. Most people have some kind of connection to someone who is a landlord or someone who knows a landlord.

2. **Cold Calls:** Cold calling is the most common method used for finding landlords. Look for listings in the local paper; many communities have local weekly papers that private landlords will list properties in. Include listings from for-rent signs and any other rental publications. Websites such as Craigslist.com can also be helpful. When calling, be ready to tell who you are and how you help clients find housing. If your organization is well known in your community, build on that reputation.

   Note: When calling about units, obtain information about the price, the term of the lease, the application process, and a description of the unit. Landlords may ask questions about a client’s housing and credit history. However, this information should be delivered in a face-to-face meeting with the landlord when possible. This way, the housing locator can explain the client’s prior circumstances and how the organization will help improve their chances for success.

3. **Direct mail marketing:** Combine a flier or brochure from the organization with a personalized letter to a landlord. The letter may describe the benefits of partnering with the organization or describe a particular client’s needs or success story. One advantage of direct mailing is it can easily reach a large number of landlords.

4. **Attend a landlord networking meeting:** Find out about meetings by contacting the local landlord association. When attending, have brochures or fliers to leave with interested landlords. Also, remember that this meeting is an opportunity to learn more about landlords, their concerns, and issues that affect housing in the community.

5. **Organize a meet and greet:** If there is no local landlord association, host a small meeting at the organization and invite potential landlords to educate them about the rapid re-housing program. Include a presentation about the program, the clients served, and how the organization partners

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with landlords. If possible, include a landlord partner, who can describe the benefits of working with the program. The meeting may also include a presentation from a client who has been successful in housing.

(6) Word-of-mouth referrals: Potential landlords are more likely to work with the rapid re-housing program if an existing partner or someone else they trust describes a positive experience with the program. Feature an article in the agency’s newsletter, on the agency’s website, or make a presentation at a board meeting to get word out about the program and its work with landlords. If the agency has a Facebook page or twitter account, post information about the program and the need for landlords. As the agency builds a good reputation among housing providers, landlords who learn about the program through word-of-mouth referrals and may even call with vacancies.

(7) Social Media: Many agencies have recently begun using social media to find and build relationships with landlords. Landlords often advertise on Craigslist and similar other sites. Twitter, Facebook, and similar other sites can be used for these purposes as well.

Maintaining Landlord Relationships

In addition to understanding and fulfilling landlord business interests, there are a few additional strategies that housing counselors or case managers should employ in order to maintain a solid relationship with landlord partners:

(1) Respond to complaints in a timely manner: Most landlords understand that problems occur and mistakes happen. However, when problems are not resolved quickly, landlords can quickly lose their confidence in and willingness to work with the program in the future.

(2) Keep promises: Landlords do not forget bad experiences. If the rapid re-housing program fails to hold up its end of an agreement, this is guaranteed to destroy the partnership and the landlord’s willingness to work with the program’s clients.

(3) Document, document, document: Document all communications with landlords and others. Sometimes this requires sending a follow up email after a phone conversation, restating what was said. This ensures that everyone has the same information and is working with the same understanding or interpretation of the information.

(4) Solicit and utilize landlord feedback: Learn more about and respond to what works well for landlords, what does not work well, and areas in which the partnership with them can be improved. This is crucial to sustaining a lasting relationship with landlords and can have a significant impact on the ability to expand the network.

Housing Barrier Assessment

When working with landlords, it is critical to be well-informed about the client’s housing barriers, and confident in the housing counselor’s or case manager’s and the client’s abilities to mitigate repeat offenses and the impact of these barriers on the new housing arrangement. Therefore, before approaching the first landlord with a housing application, the housing location specialist should conduct credit, criminal, housing, and eviction history checks on all clients. Staff should also interview the client, asking for any potential negative reports that might come up if a landlord conducts their own search or goes through an agency. Interviewing the client may reveal information about an arrest or misdemeanor that may not show up on the agency’s report but may show up on the landlord’s report. If possible the
housing location specialist should use the same agency or resource that local landlords use to conduct background checks.

Interviewing previous landlords and/or asking the client about any disagreements they’ve had with previous landlords is also key to identifying previous housing issues that may present during tenant screening. This will also help staff know what issues to look for during housing stabilization. Finally, conducting an affordability analysis is critical. The housing location specialist should be prepared to answer the landlord’s questions about income limitations, affordability of the unit, and employment history, in addition to all other items that will show up on the background check.

**Client Privacy When Working with Landlords**

Landlords use screening to reduce certain risks such as of late rent and unit damage. But no amount of screening completely guarantees a good tenant. Tenants who look like they are great on paper may be terrible tenants, and sometimes tenants who look less than desirable on paper turn out to be great tenants. Rapid re-housing clients are less than desirable based on tenant screening criteria, but the rapid re-housing housing program services are designed to help clients avoid behaviors that will negatively affect their tenancy. Prepare to address clients’ tenant screening barriers by interviewing the tenant about them, doing checks of your own on all these areas, checking references, and being ready to share how the rapid re-housing program will ensure that they don’t create tenancy problems. However, do not mention these issues unless asked, and do not share an overly detailed explanation or history concerning a client’s issues. Be to the point and confident with a short yet adequate and polite response.

In addition, if landlords ask overly personal questions about client’s problems, be prepared to share a generic statement to respond to these kinds of questions. Do not share information about a client’s the personal problems or services. Finally, obtain a Release of Information form signed by the client, allowing the program to discuss their tenancy problems with the landlord. Ensure landlords know what tenancy issues should be communicated to the program.

**D. Rapid Re-housing Program Staff**

The following staff should, at a minimum, be part of a rapid re-housing program’s core staff: program administrator, housing locator, housing stabilization counselor or case manager. The program administrator manages the overall program, resources, and ensures that goals are met and performance is evaluated. The housing locator works with landlords to identify units and to identify client housing needs. Ideally, the housing locator is also knowledgeable about landlord-tenant law and can assist with housing stabilization. Housing counselors or case managers provide case management service at intake and/or after a client is housed. Although all these roles are critical to the rapid re-housing program, the housing counselor or case manager and the housing locator perform all the activities discussed in this chapter, as appropriate to their roles.

**Case Management vs. Housing Stabilization**

Housing locators may be part of the housing stabilization staff in a rapid re-housing program, but they do not conduct case management. Housing stabilization staff handle housing issues for both the landlord and the tenant. On the other hand, housing counselors or case managers connect clients with the community resources needed to address issues such as employment/income, therapy, etc. Therefore, housing counselors or case managers are expected to have in-depth information about programs, program eligibility requirements and referral requirements. Housing counselors or case managers also
provide limited assistance to clients concerning mental health or other issues that impact tenancy until the client is actually connect with the mainstream service connection. In practice, housing counselors and case managers often provide both housing stabilization services and make referrals to needed services because the two roles are so closely related and impact each other. Rapid re-housing staff, and especially housing counselors and case managers, must know and operate with regard to boundaries and standards related to both roles.

E. RAPID RE-HOUSING CASE MANAGEMENT

How Much Case Management and Housing Stabilization and for How Long

For rapid re-housing case, program staff and the client must jointly determine length of time for which to conduct case management and housing stabilization services as well as the appropriate intensity of these services. Two significant considerations in making these decisions include the promises that the program made to the landlord and the level of assistance required to stabilize the household:

(1) Promises to the Landlord: One way that rapid re-housing programs overcome landlords’ concerns about tenant housing barriers is to assure the landlord that the program will take specific steps to help avoid tenancy problems. This may include a promise to conduct case management for a certain period of time, to pay rent if the client doesn’t, or to help the client move on to other housing if the tenancy becomes a problem. Whatever the promises, program staff must keep their commitments and their word or risk losing the landlord as a partner.

(2) Household Assistance Requirements: A determination about the household’s needs for services and the duration and intensity of those services should be based on staff observations of the household and the client’s requests for supportive services. However, staff must always bear in mind that their primary goal is to connect the household to community resources that will take the housing counselor’s or case manager’s place in providing ongoing housing stabilization and case management; therefore, connections to mainstream services should happen as quickly as possible.

Caseload Size, Frequency and Duration of Contact

Rapid re-housing works for people with low-, moderate-, and high- housing barriers. Housing counselors and case managers may work with a mixed caseload or a more homogenous caseload. The National Alliance to End Homelessness recommends that housing counselors and case managers who work with a mixed caseload of families with moderate to moderately high barriers carry up to forty cases at any point in time with a six month duration. This would generate a revolving case load of six to eight cases per month. A program that provides longer-term services could carry a similar caseload but with somewhat fewer openings and closings per month. However, longer-term services do not necessarily translate into more intensive services. For example, a household that recently experienced a job loss may need months of rental assistance while the wage-earner(s) secure employment, but if a household has a stable housing history, the frequency of contact for housing related supports may be relatively low.

Case Management Strategies

(1) Orientation: Many households will be already familiar with the neighborhood they are moving to. However, these households as well as those that are less familiar with their surroundings can benefit
from a welcome orientation. Orientation should take place soon after the client moves in order to help them get a good start in their new unit. During orientation, the housing counselor or case manager will help the client locate facilities and services that are critical to their daily routine such as grocery stores, the pharmacy, daycare, and places to pick up public transportation. This can be part of a routine orientation just before or soon after moving. Recommended specific orientation activities include:

- **A drive-around, to get some idea of the location and distances to key amenities. This can be combined with a grocery-shopping trip to obtain household grocery staples**
- **Providing a map of the area, with locations of community resources (school, parks, etc.) marked**
- **Providing a notebook or storage bin for important papers, including the lease and checklist of the condition of the apartment**
- **Visiting a second-hand and/or inexpensive store to buy things the household needs**
- **A home visit soon after move-in to help the household properly hang and display personal pictures, art or other objects. Feelings of “ownership” can promote care of the unit and may reduce mobility, which should be a goal of the early stages of re-housing**
- **Assistance locating places of worship or other community based centers through which the tenant can connect with others in their neighborhood.**

(2) **Tenant Coaching and Education:** Not all tenant expectations are explicitly written in a lease. Tenants are responsible for rules written into the lease as well as basically understood or implied expectations. For clients to be successful in housing, they must be coached and educated on the social norms of renting. Housing counselors or case managers should sit down with clients and discuss the behavioral norms and expectations of their tenancy as well as key requirements of their lease. It is recommended that program staff who has legal training or extensive experience with leases talk through the lease with the client and have the client write down the things the household can and cannot do in their unit or elsewhere on the premises. Staff should assess the client’s familiarity with these things as well as landlord-tenant rights/responsibilities. Assessment may reveal that more coaching and education is needed.

(3) **Home Visits:** Observing lease violation behaviors and coaching the tenant on how to make improvements concerning these issues are primary focus of home visits. Rapid re-housing staff can assist the client in understanding how their choices may cause them to lose their housing. Here are some common offenses to look for during the home visit:
• Noise: All leases permit tenants to quietly enjoy their unit. Activities that do not fall within this boundary or that prevent others from exercising this right are lease violations. Examples include music, television, or conversation that is too loud and/or too late. Children running or stomping, domestic arguments, or frequent police calls can also cause problems in this area.

• Unauthorized tenant: Clients may not realize that a long-term guest is usually a violation of their lease, or they may think that because they pay rent they can have as many guests in their unit for as long as they would like. This is a misunderstanding of their tenant rights and should be addressed with the client before a potential issue ever arises.

• Excessive traffic: Excessive traffic can be unsettling and unsafe for other tenants and sometimes is an indication of drug activities or disruptive parties. Either way, it may cause the client to be on the landlord’s list of troublesome tenants and should be addressed preemptively with the client.

• Unsupervised children: Children should play in their family’s unit and not in the hallways where they may disturb other tenants.

During the home visit the case manager should look for clues concerning whether one or more of these issues needs to be addressed. For example, smelling the garbage or hearing the television from outside the unit is a sign that something is going on with the tenant that may risk their housing. Unsupervised children or guest(s) at the home over several home visits should also raise concerns.

As mentioned, prevention programs may also use home visits as a case management strategy to ensure that the client is able to move beyond those circumstances that initially caused the housing instability. If it is determined that the prevention client needs case management and home visits are an appropriate strategy, home visits may occur throughout the duration of assistance. As is the case in rapid re-housing home visits, the housing counselor or case manager should look for red flags during the home visit that may draw negative attention from the landlord or cause personal relationship conflicts to reoccur.

Whether in a rapid re-housing program or a prevention program, it is not sufficient for the case manager to always recognize and identify problem areas. The case manager should help the client identify and remedy potential patterns that may cause a repeat of the housing crisis that forced them to seek rapid re-housing or prevention services.

Finally, in both rapid re-housing and prevention programs, it is important to find out what is a good time to visit the client’s home and whether there are other professionals conducting home visits. This ensures that the client feels his or her time and boundaries are respected and can keep the client from feeling overwhelmed. It also provides opportunities to share information between service providers in order to ensure continuity of care.

(4) Connection to Mainstream Resources: Mainstream resources are a critical part of stability for everyone living in a community. Rapid re-housing (and prevention) services connect clients to supportive, community-based resources they can use after the homeless assistance program services end. Additionally, some mainstream agencies can be helpful in the immediate term, prior to the end of homeless assistance, such as employment agencies and public assistance agencies. In determining appropriate services and connecting clients to mainstream resources, the housing counselor or case manager should use the client’s housing plan to determine a list of services that are needed for housing stabilization and services that the client qualifies for. Once the list is complete, the housing
counselor or case manager should reach out to the agency (it’s helpful but not necessary to have contacts there) and work with the client to schedule an appointment. Attend the appointment with the client if it is helpful or help them complete the online application. Help the client gather necessary papers and ensure that they make copied of everything and preserve copies of any communication they receive.

Common mainstream resources that are helpful for clients include:

- Schools and enrichment programs as well as childcare and after school activities.
- Healthcare and dental clinics that accept public assistance healthcare insurance.
- Mental health providers who work with low-income clients, clients who receive public assistance, or clients who are uninsured. Helpful specializations include professional assessments for medications such depression and anxiety, counselors or therapists for resolving traumatic events, and domestic violence and family conflict.
- Chemical dependency assessment and treatment centers for low-income, public assistance or uninsured clients including specialists who work with specific substances, populations (e.g. children or DV survivors), or who use specialized methods such as harm reduction.
- Legal services that offer pro bono or low-cost legal assistance. Programs that specialize in housing law, fair housing, and landlord-tenant issues are especially helpful for clients.

See the Prevention Overview for additional examples of mainstream agencies with which the housing counselor or case manager may try to connect their client. These agencies are applicable to rapid re-housing clients as well.

(5) Budgeting and Credit Repair: After a client’s housing crisis is financially resolved, housing stabilization services should involve repairing credit and developing long-term budgeting strategies that will help the household remain stable. No matter how limited the financial assistance is, one-time assistance or a medium-term subsidy, the client is likely to benefit from financial counseling. Housing counselors or case managers should conduct a budget review with clients if this has not already occurred at some other juncture. If the housing counselor or case manager is unfamiliar with budgeting (or even if they are familiar), they should contact a local housing counseling agency to help the client obtain financial counseling. Clients should be assisted to reduce expenses as much as possible, increase or supplement their incomes with free in-kind commodities and services, and, if at all possible, set aside a small amount of money every month for an emergency reserve to manage unexpected expenses that could create another financial or housing crisis.

Housing counselors and case managers may also seek out a consumer credit counseling service agency, which may be able to negotiate lower interest rates, consolidate debt, and work long term with the client to improve their credit score and/or remove negative reporting from their credit report. Having improved credit and better finances will help the client stabilize in their current housing and allow them flexibility to access alternative housing should they need to in the future. Finally, housing counselors and case managers should be familiar with agencies that provide income with in-kind resources such as clothing and food donations and utility assistance programs.

(6) Employment: Once a client’s housing crisis is addressed, helping the client find better employment can be a helpful housing stabilization case management strategy. Increasing employment opportunities and employability will improve the client’s ability to sustain the household financially and, if possible, the client should increase their income by at least the amount of the subsidy. Case management strategies include connecting the client with employment services that can help with long-term employment needs through help with resumes, online and other job search strategies, or
job training and placement. Mainstream employment agencies may also be able to help with short-term needs if, for example, a temp agency is able to place the client relatively quickly. As the housing counselor or case manager connects the client with employment services, he or she should work with the client to identify child care and transportation options so that once employment is achieved, the transition is smooth.

(7) Public Benefits and Assistance: Homeless persons and people seeking prevention services are not significantly different from other poor people in that their income is very low. Such a low income cannot sustain consistent housing payments if an unexpected event creates a financial crisis. For these reasons, it is critical for the housing counselor or case manager to help the household achieve the maximum possible income. Employment may or may not be a workable strategy for a particular client, and even in cases where the head of household is employable, employment income may not be enough. In these cases, public benefits and assistance may be an option. For households where employment is not possible due to disability or some other issue, the client can qualify for public benefits and assistance as well.

Many prevention and rapid re-housing clients qualify for public assistance programs and do not know it. Housing counselors and case managers should be familiar with qualification guidelines, help the client apply for assistance, and connect with someone at the assistance agency in order to regularly check the client’s application status. Programs such as TANF, SSI, Section 8, food stamps, and veteran benefits are just a few resources that the housing counselor or case manager should check into. The housing counselor or case manager should check into nontraditional assistance programs as well, such as those associated with faith-based agencies, food pantries, and others.

(8) Higher Level Goals and Community Resources: Once clients settled into their new routine and have a handle on the issues concerning their immediate housing stabilization, they can pursue higher order goals. Once the housing counselor or case manager helps the client work through and clarify other goals, the housing counselor or case manager should identify mainstream programs that can help the client take next steps.

(9) Preventing Future Homelessness: Because most clients have extremely low incomes, most are at risk of returning to homelessness. The housing counselor or case manager should work with households to identify those issues that contributed to their housing crisis and figure out how to avoid or overcome those same challenges in the future. The housing plan is a great place to document the client’s strategies in this area.

F. RAPID RE-HOUSING CASE EXAMPLES

Many agencies are looking to newly implement rapid re-housing as the HEARTH Act challenges communities to achieve greater outcomes for homeless families and individuals. The following rapid re-housing agencies are examples of agencies whose work has contributed significantly to improved outcomes for their communities. One agency underwent significant changes to do so, shifting from a transitional housing model to a rapid re-housing model. The other agency implemented rapid re-housing as part of a citywide pilot in Washington, DC in 2009 and has achieved remarkable results. For more information about these programs review Additional Resources section.

Homeward and St. Joseph’s Villa, Richmond, VA

In Richmond, VA, from 2010 to 2012 the median length of homelessness declined by 50 percent, from 90 to 45 days. The decline in length of homelessness is a direct result of a rapid re-housing reduced pilot
program initiated and run by Homeward, the planning and coordinating organization for homeless services in the greater Richmond region. Subcontracted homeless Assistance agencies in the area provided each of the pilot’s core services, which included intake and assessment services, housing search and placement services, short-term rental subsidies (provided to households on an as-needed basis), and case management.

St. Joseph’s Villa was one of the agencies contracted to provide rapid re-housing services to families participating in the pilot. St. Joseph’s Villa originally ran a transitional housing shelter for families before converting the program to a rapid re-housing model in order to improve cost-efficiency and participate in the pilot. From the start of the pilot, the agency housed 28 families in 25 days. On average, each family was housed within 2 to 10 days of entering shelter. According to the agency:

Families rapidly re-housed during the pilot experienced a higher rate of success than those participating in the programs of Flagler Home, and at about one-fourth the cost to the organization. Staff leadership ... determined that discontinuing the residential component of Flagler Home and fully implementing the rapid rehousing model would achieve more impactful results in reducing homelessness.

As of May 2013, 97 percent of families rapidly re-housed in 2010 have remained in their homes. The program has served over 150 households since fall 2011, and 92 percent have remained housed. The agency expanded from providing transitional housing services to only 40 families for $30,000 per household to serving a projected 300 families at an average cost of $4,500 per household in 2013.

St. Joseph’s Villa was able to achieve these outcomes because it implemented many of the solutions outlined in this chapter. For example, they rewrote all job descriptions and realigned funding to fit a rapid re-housing model. Staff then reapplied for rapid re-housing positions, such as Housing Specialist and Employment Specialist, and matched to the appropriate position based on historical job performance and relevant skills. Families in the rapid re-housing program receive rapid re-housing services for anywhere from three months to 24 months, depending on need. Services include case management, linkage to community resources, employment training, budgeting assistance, and tenant education. Some families also receive short-term rental assistance.

Community of Hope, Washington, DC

Community of Hope (COH) also began its rapid re-housing program as part of a community pilot. In 2009, COH rapidly re-housed 27 families that received rapid re-housing services. Of these families 78 percent received subsidies for 12 months or less at an average cost of $10,247 per family. The average length of case management services was 10 months. Between April 2010 and July 2011, no families re-entered shelter. In 2013, 42 families and individuals exited to permanent housing through the rapid re-housing program, and six months later no families had returned to shelter. The average length of home-based case management of 10.8 months, and the subsidy was $8,251. Since 2011, the program has served 117 families and 93 percent have remained in housing after receiving an average of 11.5 months of case management and 10.4 months of subsidy. COH’s Employment Services Team has a 56 percent income success rate, meaning that since 2009 the team has helped the majority of rapid re-housing clients increase their income by the time they complete the program.

COH’s rapid re-housing program consists of assessing barriers to housing stability, housing search (and building landlord relationships), financial assistance and home-based, client-driven case management. The program operates on the following principles:

- Families do better in their own housing than in shelter
• Permanent housing is the immediate goal; people move directly into housing with no intermediate steps
• Identify and build upon families’ strengths; meet clients where they are, and minimize or eliminate barriers (including program barriers)
• Funding and services should focus on housing stability, not shelter services
• Financial assistance and services provided based on need (no more than is necessary)
• Choices are client-driven (and housing is not risk-free)
• Agencies and communities must do everything possible not to isolate families experiencing homelessness
• Rapid re-housing is most successful when there is strong leadership, real mainstream partnerships, and when staff focus on basic rapid re-housing principles, goals, and strategies.

**Practice Questions**

1. Paraphrase each of the seven principles of rapid re-housing in 10 words or less for each principle.

2. What three minimum characteristics/program components to all rapid re-housing programs have in common?

3. What are the two primary barriers that rapid re-housing clients face when trying to access permanent housing?

4. List four benefits for landlords when working with a rapid re-housing program.

5. List four strategies to keep a solid landlord relationship in addition to fulfilling business interests.
Chapter References

i (Department of Housing and Urban Development 2011)
ii (National Alliance to End Homelessness 2009)
iii (National Alliance to End Homelessness 2009)
iv (National Alliance to End Homelessness 2009)
v (Melson 2013)
Chapter Seven
Permanent Supportive Housing

INTRODUCTION

The chapter overviews the definition and service components of permanent supportive housing. Case management strategies are discussed in detail, including the Relational Outreach and Engagement Model. Additionally, the Assertive Community Treatment model of treatment is discussed, and the chapter concludes with case examples, including a discussion of the most well-known permanent supportive housing program, Pathways to Housing.

Topics:
A. Permanent Supportive Housing Overview
B. Core Components of Permanent Supportive Housing
C. Permanent Supportive Housing Case Management
D. Assertive Community Treatment
E. Permanent Supportive Housing Case Example(s)
F. Practice Questions

Objectives

Counselors will:
- Understand what distinguishes permanent supportive housing from other approaches to housing
- Know the critical elements of permanent supportive housing
- Understand case management strategies that are critical to successfully working with permanent supportive housing clients
- Be familiar with the Assertive Community Treatment model
A. **PERMANENT SUPPORTIVE HOUSING OVERVIEW**

Permanent supportive housing (PSH) serves chronically homeless people who have a serious physical or mental disability and/or disabling health conditions. It has been found to reduce the cost of public systems and institutions frequently used by chronically homeless people and has been demonstrated to be an effective strategy for ending chronic homelessness and reducing overall homelessness.\(^1\) This outcome is made possible because housing and supportive services that are part of PSH help residents transition out of homelessness, remain housed, and live as independently as possible.

PSH may be in single-site, scattered-site, or mixed. In single-site PSH clients’ housing is in the same building or campus, and support services are provided either on- or off-site. In scattered-site PSH, clients live throughout the community in apartments that are either owned by the PSH program or by private landlords. Services are delivered during home visits, at a location other than the client’s home, or a combination. In mixed housing, clients live in developments with both PSH clients and non-PSH clients.

The name “permanent supportive housing” is indicative of the three characteristics that must define any PSH program, regardless of whether it utilizes single, scattered, or mixed housing structure:

1. **Permanent**: PSH is a permanent living arrangement, meaning that tenants live in their own subsidized rental housing as long as they meet the basic obligations of tenancy. There are no time limits on the lease. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), this means that the lease is renewable, usually annually as with regular leases, at the option of the tenant and the owner. Tenants’ leases are in their own names, and they have full tenant rights and responsibilities under landlord-tenant law. This includes having control over their living space and protection against eviction. PSH leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric or other disability.\(^1\)

2. **Supportive**: PSH is connected with voluntary support services on- or off-site that clients need and want to retain housing. According to SAMHSA, this means that support services promote recovery and are designed to help tenants get and keep housing; however, tenants cannot be evicted for rejecting services. Tenants are presented with a range of support services, and they can choose which services they want. Effective PSH programs do not take a “one size fits all approach” with their services. Instead, they provide some level of customization based on client needs and preferences. Further, because client needs change over time, tenants can receive more or less intensive support as they prefer. Finally, the provision of housing and support services are separate and distinct, which avoids staff conflicts of interest when providing services. This also prevents discrimination against tenants based on service needs and related behavior.

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\(^{1}\)“Permanent” does not mean that the tenant never moves. PSH clients do move on from the unit in which they are living and the facility with which they are connected. This occurs when services provided by the PSH staff can be replaced with services from mainstream programs and when the client is able to access a suitable unit. Moving clients on from PSH is becoming more common place. It is done at the option of the client, after the client has been stable for some time period, usually a few years.
(3) **Housing:** In PSH, tenants have a private and secure place to make their home. Before moving into a PSH unit, tenants are asked about their housing preferences and are offered a range of choices within their income level, just like members of the broader community. Further, housing is integrated with the local community, and tenants have the opportunity to interact with neighbors who do not have psychiatric or other disabilities. In PSH tenants do not pay more than 30 percent of their income toward rent and utilities, and the balance of their funds is available for discretionary spending. House rules, if any, are similar to those found in housing for people who do not live in PSH.

According to the Corporation for Supportive Housing (CSH), in addition the above-described characteristics of PSH, effective PSH programs should offer the following core services:

(1) Outreach
(2) Engagement
(3) Medical Care
(4) Behavioral Health Care
(5) Case Management
(6) Life Skills Training

### B. CORE COMPONENTS OF PERMANENT SUPPORTIVE HOUSING

(1) Outreach: Outreach is designed to reach individuals who are homeless for whom PSH is a good fit.²

(2) During outreach, homeless people are encouraged to access the services they need wherever they are geographically, physically, or mentally. This may include services to access housing, health care, mental health services, or others. Whatever the service type, the goal of outreach is to meet the client’s immediate needs and establish a relationship. Meeting immediate needs in a way that respects the client’s wishes helps the client develop a trustful relationship with the outreach worker and makes them more likely to seek additional services or housing. In addition, housing counselors or case managers should conduct outreach after the client is housed and encourage them to use the services they need to maintain housing stability. In conducting outreach, staff should understand that the client’s needs and wishes will change, and it will often feel like the client is pushing staff away. Therefore, outreach requires flexibility and a willingness to adapt to client needs.

(3) Engagement: Engagement is a critical and complementary activity to outreach. Engagement occurs during outreach and other service interactions with the client. It is the process of developing trust and a therapeutic relationship with the (potential) client or resident. The goal of the engagement is for the client to use the services they need to support recovery and avoid crises that might lead housing loss. Case workers conducting engagement must be patient, keeping in mind that the process is ongoing and may take days, weeks, months, or years before it feels like they are making progress.

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² There are other dimensions to outreach when it is used from a systems approach. For more information, review the Outreach and Engagement chapter.
(4) Medical Care: Medical care refers to clinical healthcare services that are available to adults, children, and youth who have experienced prolonged homelessness and who are in transition to or residing in PSH. Medical care is critical because it addresses untreated health conditions that have been caused by or exacerbated because of homelessness. When untreated, health problems can impede an individual’s ability obtain and maintain housing, and they can be life-threatening. Medical care encompasses urgent care, preventive care, primary care, pain management, health behavior education, and motivational enhancement. Medical care managers help clients access these services, and they may help clients develop ways to stay abreast of medical care appointments and personal health issues. Housing counselors and case managers may also assist with coordinating medical care.

(5) Behavioral Health Care: Behavioral health refers to a state of mental and emotional being and/or choices and actions that affect wellness. Behavioral health problems include substance abuse or misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance use disorders. The seriousness of these issues can range from unhealthy stress to diagnosable and treatable diseases, (mental) illnesses, and disorders. Behavioral health care is an umbrella term that refers to a continuum of services for individuals at risk of or actively suffering from behavioral health issues. These services may include mental health care, psychiatric care, primary healthcare, addictions treatment, and other forms of healthcare provided by social workers, counselors, psychiatrists, psychologists, physicians, paraprofessionals and others. Housing counselors or case managers help clients coordinate behavioral health care. They may also assist with other aspects of behavioral health care, but specific additional responsibilities are dependent upon the program, the client, and the housing counselor’s or case manager’s clinical background and training.

3 In the whitepaper Defining and Funding the Support in Permanent Supportive Housing (2008) the Corporation for Supportive Housing defines each of the types of medical care as follows:

- **Urgent care** – the provision of immediate medical service (no appointment necessary) offering outpatient care for the treatment of acute and chronic illness and injury.
- **Preventive care** – including screenings for interpersonal violence, mental illness, substance use disorders, cognitive impairment, tuberculosis, HIV/AIDS and other sexually transmitted infection; baseline labs including liver function tests; testing of blood lead levels for children; comprehensive health and developmental assessments including vision, dental and hearing screenings and restorative services; mammograms and other cancer screening; immunizations; health education and anticipatory guidance.
- **Primary care** – treatment and management of chronic diseases including diabetes, cardiovascular disease, asthma, chronic obstructive pulmonary disease, tuberculosis, HIV/AIDS, and hepatitis; health promotion and primary care case management (care coordination, referrals, benefits assistance). Primary care should be integrated with behavioral health care.
- **Pain management** – analgesics and adjuvant, non-drug therapies to relieve acute and chronic pain. Common sources of acute pain among homeless people: trauma, unattended tooth decay, advanced gum disease, abscesses resulting from wound infections, complications of illness or injury exacerbated by unsafe and unsanitary living conditions; sources of chronic, non-malignant pain: low-back pain, post-traumatic arthritis, diabetes, HIV, hepatitis, alcoholic cirrhosis, advanced peripheral vascular disease, headaches, incomplete recovery from surgical procedures.
- **Health behavior education** – explanation of health problems and proposed treatment in language the patient can understand; self-management support — explanation of risks associated with health problems for which the patient is being treated and discussion of ways in which he or she can reduce them for him/herself and others.
- **Motivational enhancement** – client-centered, directive clinical strategies that seek to help people resolve ambivalence and move in the direction of behavioral change, using open questions, affirmations, and reflective listening. Motivational interviewing, a motivational enhancement technique originally developed to facilitate treatment of alcoholism, is also used to support self management of other chronic illnesses and to prevent transmission of communicable diseases.
(6) Case Management: The purpose of case management in PSH is to help PSH residents deal with daily activities and stresses that may impact their housing stability. This includes helping clients obtain benefits, access services, manage appointments, coordinate care, and identify and address early signs of decompensation so that related behaviors do not result in housing loss. Effective housing counselors and case managers do all they can within the scope of their jobs to help clients progress toward independence, achieve personal goals, and maintain housing.

(7) Life Skills Training: Life skills training is voluntary and helps clients restore behaviors and practices that allow them to manage daily living, integrate into the community, maintain stable housing, and regain control of their lives. Illness, injury, mental health issues, substance abuse disorders can impair regular functioning that is critical to daily living. Life skills training restores functioning that has been impaired by disabling health or behavioral health conditions.4

Training topics may include basic issues such as budgeting, tenancy, meal preparation, housekeeping, etc. Topics may also cover vocational and employment services, including training to gain skills needed to manage the challenges of work (attention, focus, and social skills). Other services may include support for family reunification, parenting skills, preventing and managing future crises, and educational, recreational, and counseling services for children and youth.

C. **PERMANENT SUPPORTIVE HOUSING CASE MANAGEMENT**5

Case management is fundamental to the design of PSH. Generally, case management entails conducting activities to help clients manage their daily lives and maintain housing. For example, housing counselors and case managers may ensure that clients receive all the services they need, coordinate services and medical care, and/or help the client manage their activities. Case management should be most intensive during outreach and immediately following admission to supportive housing. As the client becomes more stable in housing, less intensive services should be required. The intensity and frequency of case management encounters should be determined through regular assessments of client needs.

CSH provides a detailed description of PSH case management responsibilities, and they are as follows:

1. Building Trust
2. Assuring Access
3. Care Coordination
4. Assisting with Housing Stabilization and Self-Determination

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4 Rates of illness and injury are two to six times higher for people who are homeless than for people who are housed. Further, at least one-third of people who are homeless have serious mental disorders, and more than one-half of those with mental illness have co-occurring substance use disorders. The incidence of these disorders is considerably higher among chronically homeless people. Homelessness worsens and, in some cases, causes these issues. It also complicates access to appropriate health care to resolve these problems. When untreated these problems impair regular daily activities.

5 This manual does not cover clinical case management and specialty areas.
Building Trust: Building trust means developing a collaborative and trustful relationship with the client such that the housing counselor or case manager knows where the resident is mentally, socially, emotionally, physically, or in other personal areas that impact the client’s well-being. Developing this level of relationship can be difficult and takes time. The development of trust is shaped by the personality and experiences of each client, the housing counselor or case manager, and other circumstances such as staff turnover and whether the client is in housing or on the street.

The Relational Outreach and Engagement Model (ROEM) is considered to be the cornerstone of successful case management in PSH. The approach builds trust between housing counselors or case managers and clients as well as among case management staff when the ACT approach is used. It includes the following relationship phases: approach, companionship, partnership, and mutuality.

- **Approach:** The approach phase involves observation and introduction. If the person is literally homeless or on the street, it is helpful to spend time simply watching to learn more about the individual’s interpersonal needs and interactions. Either briefly introducing oneself in a neighborly non-intrusive way or identifying oneself as a concerned individual works well. If the client is in housing, ideally there is some continuity in housing counselors or case managers from homelessness to housing, and a new introduction is not necessary. This can be achieved through using a team approach, where the client interacts with more than one staff member. If one housing counselor or case manager can no longer tend to a particular client, the introductory portion of relationship building does not have to start at the beginning. If a team approach is not possible or if the housing counselor or case manager is starting anew, it is best to begin by briefly introducing oneself and then gradually building the relationship. As the relationship and trust develop, the client will guide and determine the role that the housing counselor or case manager will have in his or her life, and whether the role will change over time.

- **Companionship:** Companionship is sharing in the client’s personal journey and experiences. This may require listening to their story or listening to whatever the client wants to share. The client may want to share a little or a lot. Observe the client’s level of openness and willingness to discuss personal topics (e.g. family and social life, background and education, employment history, and health and mental health issues), and take cues accordingly. Do not pry. Make suggestions of ways to assist the client or ways that the client can obtain help and resources on their own. Listening to opinions, perspectives, values, preferences, interests, and methods for making decisions and choices are useful as the housing counselor or case manager determines what to suggest and how to approach the topic. Mastering companionship with the client is critical to facilitating partnerships (discussed in the next bullet) that will help the client stabilize.

- **Partnership:** Partnership entails introducing the client to others who can assist them. If an outreach worker is conducting outreach and engagement, this may mean introducing the client to the housing counselor or case manager. If the housing counselor or case manager is building...
the relationship, introductions to medical providers, social services and mainstream program staff is key so that the client can begin to have other critical needs met.

- **Mutuality:** During mutuality, the relationship has achieved its purpose and the housing counselor or case manager and client can bring closure to the formal aspect of their relationship. At this point, the client has stabilized in housing and may or may not be ready to move on from PSH. Either way, the client should be encouraged to make use of appropriate resources and supports (to which they were connected during the partnership phase), and these supports will ensure long-term stability.

(2) **Assuring Access:** Assuring access means making sure that the client gets to and uses needed services and mainstream resources such as medical care, public benefits, or something else. Successfully assuring access requires the housing counselor or case manager to have in-depth knowledge of various matters that are important to the client’s personal and housing stability. Topics with which housing counselors and case managers should be familiar include:

- **Neighborhood and area features:** Housing counselors and case managers should know the communities and neighborhoods in which they are working and their clients are living. The housing counselor or case manager should provide clients with information about community resources and activities in conjunction with the move-in process. This also includes neighborhood orientation, during which the housing counselor or case manager can help clients identify those services and options that best suit their needs and interests. Amenities such as transportation, stores, medical facilities, pharmacies, places of worship, and recreational facilities are helpful to clients as they integrate into their communities.

- **Community resources:** Housing counselors and case managers should be familiar with resources that will help the client stabilize in housing and remain stable in housing even if they choose to move on from PSH. Key resources include community health, mental health, and rehabilitation services, including community-based agencies, faith-based organizations, drug and alcohol treatment providers, self-help and peer-support groups. Even if some of these services are provided through PSH staff, helping clients access these services outside the program is helpful to community integration.

- **Municipal services:** PSH projects have staff onsite that can handle basic matters and emergencies. However, major issues may be beyond the scope of staff’s responsibilities. In addition, some situations issues may occur in the evening hours when only limited staff is available. In these cases, PSH staff must utilize local municipal services that handle issues such as building codes, fire, sanitation, water, and public safety issues.

- **Entitlements.** Many PSH clients, and especially those who have severe mental health, medical or disability issues, are eligible for entitlement programs, income assistance, government health care and health insurance programs, and other public benefits. A few examples include SSI, SSDI, Medicaid, and Veterans programs. PSH housing counselors or case managers are responsible for helping clients access these resources and empowering clients to manage their own benefits where possible. This may require advocating on behalf of clients with some agencies. A 1996 national study of homeless assistance providers and their clients found that 11 percent of homeless service users and 29 percent of formerly homeless service users received Supplemental Security Income (SSI), and that 8 percent of homeless users and 16 percent of formerly homeless users received Social Security Disability Insurance. Subsequent studies showed that homeless disability claimants are denied benefits at significantly higher rates than other claimants, often because they were unable to work through the application process and not because they would not qualify.iii
(3) Care Coordination: Care coordination goes hand-in-hand with assuring access. Usually the PSH project, has MOUs or other written agreements, with providers of core services such as behavioral healthcare, primary healthcare, mental health services and counseling, substance abuse treatment, employment and others. Housing counselors and case managers should build on the agency’s or develop their own working relationships with these systems of care and advocate for clients as necessary in order to ensure that clients receive optimum levels of services. In order to effectively coordinate services, the housing counselor or case manager must know all services the client needs as outlined in the client’s treatment and housing plans. CSH suggests the following order for facilitating care coordination:
  • Soon after housing entry, staff assists all tenants in applying for relevant public benefits.
  • Tenants can see a behavioral health care provider, including a psychiatrist if needed, within a short period of time after making the request.
  • Tenants can see a primary health care practitioner shortly after making the request.
  • Tenants have a primary health care provider.
  • Tenants can access substance use treatment and support shortly after making the request.
  • Tenants are connected with relevant workforce development and employment resources shortly after expressing interest.

(4) Housing Stability and Self Determination: Client housing stability and self-determination are the ultimate goals for PSH. Achievement of these two goals does not mean that the client never moves apartments or never moves on from PSH. Rather, it means that the client is able to maintain their housing, comply with their lease, integrate into the community, manage their daily activities, and achieve other personal milestones. The client will still use support services from the housing counselor or case manager and/or mainstream service providers; however, the achievement of higher level goals will be self-directed and individually managed.

Helping clients transition to more independent, stable living begins at the relationship- and trust- building phase as the housing counselor or case manager engages the client. The housing counselor or case manager and client will work together, with the client taking the lead, to define the goals, expectations, relationships, and roles. As the client develops trust, they will open up to the housing counselor or case manager and share and...
demonstrate more information about themselves, their personal goals, their feelings concerning their own circumstances, and their plans and preferences for moving forward. The housing counselor or case manager’s role is to support this development by conducting the activities outlined in this chapter and demonstrating flexibility as the client’s needs change. Further, the housing counselor or case manager should help the client clarify outcomes, identify objectives, and memorialize step-by-step actions in a service plan, housing plan, or other written plan. In doing so, the housing counselor or case manager should also ensure that the client identifies achievable steps and realistic timeframes and help the client review and revise plans and achievements. Positive reinforcement and avoiding blaming or shaming the client is the best way to handle unachieved milestones.

Finally, in addition to helping the client frame their approach to achieving housing stability and personal goals, the housing counselor or case manager should identify and help the client access resources that will help them move forward. Connection to mainstream resources, coordinating care, and identifying groups, classes, and workshops in which the client can participate are key steps that will help the client achieve goals, stability independence, and community integration.

D. ASSERTIVE COMMUNITY TREATMENT

The Assertive Community Treatment (ACT) model of treatment has been highly researched and well-established as an effective community-based intervention for non-homeless people with severe mental illness. It is associated with better outcomes than traditional approaches to case management. This includes better results in reducing homelessness, reducing the length and frequency of hospitalizations, and increasing independent living skills among persons with severe mental illness who are homeless. The ACT model also helps to reduce symptoms of mental illness and improve quality of life for participants.

The Assertive Community Treatment Association describes the ACT model as a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness. In practice, a team of professionals with training in social work, rehabilitation, counseling, nursing and psychiatry provide ACT services. These services include case management; initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services; and other services and supports critical to an individual’s ability to live successfully in the community.

The ACT model originally emerged as a treatment strategy for people who have serious and persistent mental illness or personality disorders, severe functional impairments, and who have avoided or not responded well to traditional outpatient and rehabilitation services. While people traditionally served by the ACT approach may have co-existing problems including homelessness, the model was not primarily designed for people experiencing homelessness. Innovators in the homelessness assistance field, such as Pathways to Housing, adapted the ACT model to better serve homeless populations by including assertive outreach and engagement strategies, increasing emphasis on client resource and housing needs, and adding citizen community workers and mental health consumers to the treatment team. As it applies to homeless assistance and PSH, the ACT model works well for the following target populations:

- People who have a severe and persistent mental illness that significantly disables adult functioning (e.g., employment, self-care, and social and interpersonal relationships
- People with schizophrenia, other psychotic disorders, or bipolar disorder
- People with disabling mental illnesses who are not helped by traditional outpatient models
- People who have difficulty getting to appointments on their own as in the traditional model of case management
• People whose experiences in traditional treatment systems have been negative
• People with limited understanding of their need for help.

**How the ACT Approach is Different**

The ACT model is often used in scattered site PSH. However, whether the model is used in single-site PSH or scattered site, case management in the model is slightly different from the approach described above.

To begin, while the housing counselor or case manager will use many of the techniques described earlier in this section, the housing counselor or case manager will share more of the case management responsibility with the entire ACT team rather than having primary, individual responsibility for a client. In the ACT model, the client is a client of the entire team, and the team works collaboratively to deliver the treatment, rehabilitation, and support services each client needs to live in the community. Additionally, in the above-described approach, the housing counselor or case manager coordinates the client’s access to other key services with providers who share MOUs with the PSH provider. For some housing counselors or case managers, this may make the other providers seem more like consultants, even though the client has his or her own client relationship with the provider. In the ACT model, there are no consultants. Every ACT professional is a member of the team and shares the same level of responsibility for the client, though the nature of those responsibilities differs based on the service provided by the team member.

In a related difference, the team approach used in the ACT model may mean that information is more transparent and shared more frequently across team members. There may also be a greater sense of shared responsibility among team members concerning client matters than in a brokered model or other traditional approach to client services in PSH.

In the ACT model, the client-to-team ratio is typically between 1:10 and 1:15, and the services are intensive. In non-ACT approaches, the housing counselor or case manager may have less intensive responsibility and/or a greater client ratio. Other providers who work in consultation with the PSH provider will almost certainly have a greater client ratio because the services are provided independently of PSH and the ACT team. According to the US Interagency Council on Homelessness, intensive services provided in the ACT model allow stronger support during acute crises, which helps clients avoid or shorten periods of hospitalization. Additionally, rehabilitation involves behaviorally-oriented skill teaching (similar to life skills noted above) including structuring time and handling activities of daily living, supported employment, both paid and volunteer work, and support for resuming education. ACT support services include support, education, and skill teaching to family members, collaboration with families and assistance to clients with children, direct support to help clients obtain legal and advocacy services, financial support, money-management services, and transportation.

Finally, the ACT team goes to the consumer whenever and wherever needed, and services are available 24 hours a day, seven days a week, 365 days a year. Other case management models used in PSH may have a different structure; for example, the housing counselor or case manager may go home each night while a resident volunteer who is not part of the daytime team handles evening matters.

**E. PERMANENT SUPPORTIVE HOUSING CASE EXAMPLE(S)**

PSH is one of the first types of homeless assistance to adopt a housing-first approach, and many communities have seen dramatic reductions in chronic homelessness and overall homelessness due to the adoption of the strategies outlined above. Because PSH housing first strategies have been used for a
relatively long period of time, supportive housing agencies have had the opportunity to fine-tune their approaches based on national-, local-, and agency-level data and evidence-based practices. The two agencies highlighted in this section have been conducting PSH services using a housing-first approach and the evidence-based practices noted in this chapter, such as the ACT model.


Pathways to Housing is one of the first, most celebrated and established PSH programs in the US. Its Founder & CEO, Sam Tsemberis, is a nationally recognized expert in housing first, PSH, the ACT model, and other evidence-based approaches to homelessness. Pathways primarily serves chronically homeless persons. Studies and evaluations of Pathways have found that over two years, Pathways clients spent approximately 80 percent of their time stably housed, versus 30% for participants in the comparison group, who were assigned to traditional programs that made treatment and sobriety prerequisites for housing. Studies also found that Pathways clients accrued significantly fewer supportive housing and services costs than participants in the comparison group, and the clients reported better quality-of-life outcomes than participants in comparison programs.

The following highlights from a 2011 evaluation of the Philadelphia, PA Pathways program are representative of the outcomes reported across all Pathways programs. vii

- Pathways is less expensive per person than comparable programs: Pathways ($28,181) is half of the cost of traditional PSH programs ($56,641) and two-thirds the cost of residential drug and alcohol programs ($41,228) for chronically homeless people.
- Pathways reduces the use and utilization-cost of emergency and public services: People who are chronically homeless frequently utilize emergency services and public institutions such as urgent/emergency care, emergency shelter, jail, and others. Pathways participants utilization of these services decreased by 88 percent for shelter episodes, 87 percent for shelter nights, 71 percent for crisis response centers, 71 percent for hospitalization episodes, and percent for hospitalization days. Other significant cost reductions include a 50 percent reduction in prison system episodes, a 45 percent reduction in prison system days, and an 11 percent reduction in mental health court episodes. For the 51 participants examined in this study, Pathways services helped avoid more than $215,000 in public service costs for these individuals. Estimates suggest that the program could generate more than $420,000 in in cost avoidance for every 100 clients served using the Pathways model.
- Pathways improves quality of life: Over 18 months, Pathways engaged 128 chronically homeless, dually-diagnosed people in need of housing. Ninety-two percent successfully moved into housing, and the majority remained housed. Permanent housing programs making similar efforts successfully housed 81 percent of persons engaged.

Pathways’ outreach, engagement, and case management strategies utilize housing first methods and the ACT services. The agency’s approach works well for chronically homeless populations for whom PSH is a good fit, but who are difficult to engage. Their strategies are in line with the methods outlined in this chapter as well as national policy and evidence-based practices.

Virginia Supportive Housing, Richmond, VA

Virginia Supportive Housing (VSH) provides PSH to homeless individuals and families and persons with disabilities in Richmond, Hampton Roads, and Charlottesville, Virginia. With more than 400 housing units, the agency served more than 1,800 people in 2011. VSH’s client outcomes include a per-person public
services cost avoidance of $9,000 for the city of Richmond, VA and a client housing retention rate of 98 percent. Ninety-six percent of the agency’s residents achieve stable income through work and entitlement programs.

As Virginia’s largest supportive housing provider, VSH is modeled after Pathways to Housing. Its programs include three housing programs – A Place to Start, Shelter Plus Care, and Supportive Services for Veteran Families (SSVF) – as well as a supportive services program. These programs all use the strategies noted in this chapter and are a significant reason for the agency’s success. A Place to Start serves chronically homeless people with serious mental illness using an Intensive Community Treatment (ICT) team model. The ICT approach is modeled after the ACT approach. ICT teams provide intensive wrap-around mental health services and are comprised of an administrative assistant, a licensed clinician(s), housing counselor or case manager(s), a nurse, a peer counselor and a part-time psychiatrist. The Shelter Plus Care program provides rental subsidies and supportive services for homeless people with disabilities such as mental health, substance abuse, and/or AIDS. The SSVF program provides temporary financial assistance and service linkages to mainstream services for veteran families in order to stabilize in housing. Similar to a rapid re-housing program, SSVF families receive moving, rent, and utility assistance along with time-limited case management to help them stabilize. As the families transition from financial assistance and case management provided through VSH and/or the HUD-VASH program, they are linked to VA programs and other public benefits such as employment and training services, health services, income support services, and financial planning assistance.

VSH’s support services include three components – case management, counseling and skills training, and community building. Case management uses a strengths-based approach and include coordination of care and services. Housing counselors or case managers assist clients in developing a housing plan and accessing counseling and other services to help them manage their health, budget, and other issues related to personal recovery and housing stability. Clients are encouraged to connect with their neighbors and the larger community by participating in community events and recreational activities. The agency also offers mental health services.

## Practice Questions

1. Define the following permanent supportive housing characteristics in your own words, using 1 to 2 sentences per definition:
   - Permanent
   - Supportive
   - Housing

2. Define outreach and engagement in general terms. How do outreach and engagement activities in permanent supportive housing differ from these same activities in coordinated assessment (Chapter Three)? How are the activities the same?

3. What are the four strategies associated with assuring access to needed resources and services for PSH clients? Provide a short 1 – 2 sentence description of each.

4. List the various professional team members that make up an ACT Team. What services do they provide?

5. What type(s) of client(s) can benefit from the ACT approach?
Chapter References

¹ (National Alliance to End Homelessness n.d.)
² (Substance Abuse and Mental Health Administration 2013)
³ (Post 2008)
⁴ (Post 2008)
⁵ (Coldwell and Bender American Journal of Psychiatry)
⁶ (United States Interagency Council on Homelessness n.d.)
⁷ (Fairmont Ventures Inc. 2011)
Chapter Eight
Transitional Housing

INTRODUCTION

This chapter overviews the evolution of transitional housing. The effectiveness of the traditional approach to transitional housing is evaluated in the context of “housing first” and the HEARTH Act. The chapter concludes with a detailed case example of a transitional housing program that serves high barrier clients.

Topics:
A. Transitional Housing Overview
B. Transitional Housing Case Example(s)
C. Practice Questions

Objectives

Counselors will:
- Understand the history and evolution of transitional housing
- Be able to examine transitional housing in the context of the HEARTH Act and emerging best-practices
- Know the transformation options for transitional housing programs wishing to discontinue the traditional approach to transitional housing
- Be familiar with Hamilton Family Center’s approach to transitional housing
A. TRANSITIONAL HOUSING OVERVIEW

Transitional housing is one of the original homeless assistance interventions, created by the Homeless Housing Act and funded by the federal government since the 1980s. Federal legislation to support the development of transitional housing programs for homeless people was introduced in 1986, and incorporated into the Stewart B. McKinney Homeless Assistance Act in 1987 as part of the Supportive Housing Program (SHP). Started as a demonstration program, the first transitional housing served people with serious mental illness and/or long-standing substance abuse.

Among the requirements initially and currently regulating transitional housing is the requirement that clients do not receive the service for longer than 24 months. This means that clients who are living temporarily in a transitional program are required to move at the conclusion of their time. In effect, they are homeless because they are not in permanent housing with a lease in their name until they move or, if the unit is transition-in-place, until the unit becomes their own. A second requirement for transitional housing programs is that the program offer supportive services to help clients transition to regular housing. This must include 6 months of optional supportive services for the client after program exit. Most transitional housing programs require participation in their supportive services until the client leaves.

Over time transitional housing programs have evolved, replacing the original approach of working with high barrier clients with a new tradition of working with relatively low barrier clients. In the current approach to transitional housing, programs typically choose to accept only those clients who are most likely to succeed into their programs. For example, clients are often required to demonstrate clean and sober time of anywhere from 30 to 180 days before being granted program entry. Therefore, clients who struggle with substance abuse must be already actively engaged in recovery prior to entering the transitional program. Historically, these households have remained homeless while trying to “get their lives together” enough to be accepted into a program. Other participation requirements for transitional housing programs include meeting self-sufficiency criteria, such as being ready or willing to work or being able to participate in life-skills and other provider programs. Many family programs screen for family composition, only accepting female-headed households or families in which male children have not reached adolescent age. The impact of these and other participation requirements is that many would-be clients are screened out of transitional housing, even though they may benefit from the program’s more structured service approach. Clients who would achieve housing stability with a less intensive intervention, such as rapid re-housing, are screened in.

With respect to the HEARTH Act, current evidence-based practices, and the housing-first approach, many traditional transitional housing programs are challenged in several ways. To begin, under the HEARTH Act, clients housed in transitional housing units are considered homeless. The HEARTH Act sets a goal that households are permanently housed (i.e. with a lease in their name) within 30 days of entering the homeless assistance system. Additionally, one of the core performance goals of the HEARTH Act is that communities reduce the length of time that families are homeless. Achieving these outcomes requires rapid exit from homelessness to permanent housing and necessitates a housing first approach. A one- or two-year stay in transitional housing will contribute to poor performance outcomes because it unnecessarily lengthens homelessness for most participating households. Further, the slow turnover of units in transitional housing, along with the unwillingness to accept high barrier clients, bottlenecks service slots and units. This slows the entire system’s ability to quickly meet the permanent housing needs of existing and potential consumers and does not allow beds for those with a new housing/homeless crisis.
Another challenge with this traditional approach is the requirement for households to participate in supportive services. Typically, clients are not permitted to continue living in their transitional housing unit if they repeatedly fail to participate in supportive services. Unfortunately, these services often are not directly relevant to the client’s housing stability barriers or are related to higher-level issues that the client cannot, will not, or is not ready to address. When the client fails to participate, the household is destabilized again when they are terminated from the program housing. In some cases, clients find housing on their own without the help of transitional housing staff; in other cases their homelessness continues.

To be clear, the McKinney-Vento statutory requirement that supportive services be offered during or after participation in transitional housing is not a problem. In fact rapid re-housing programs, which are encouraged in the HEARTH Act, offer supportive services. The difference is that in rapid re-housing, like other housing first models, case management is housing-focused and client-driven. A client’s failure to participate does not directly nor immediately result in loss of housing, although the net result may be that the client jeopardizes his own housing. Whether the client moves is fully based on the decision of the client or landlord concerning whether the client can continue to meet the lease obligations. Further, the decision of whether and when to focus on higher-level personal goals is up to the client. In contrast, transitional housing case management is often more influenced by programmatic requirements, such as the 24-month timeline, and general life skills rather than the issue(s) that specifically caused the housing crisis often become the focus.

Another difference between a housing first approach to supportive services and the traditional transitional housing approach is that in housing-first, supportive services are focused on housing stabilization in the home the client will live in. The case management is home-based, and the client is permanently housed with a lease in their name at the time of housing stabilization. In all rapid re-housing programs, and some permanent supportive housing programs, the client is typically connected to mainstream community programs that are local, near the client’s neighborhood, and able to assist the client long-term once homeless assistance ends. This is also true for permanent supportive housing programs; clients are taught to live and achieve stability in their own unit in which they will be long-term. On the other hand, supportive services in transitional housing have traditionally been tied directly to the program, which last 24 months with an additional option to continue for six months.

In transitional housing, assistance with obtaining permanent housing occurs only at the conclusion of program participation once the client is determined to be “housing ready,” and “graduation” to permanent housing occurs. In this approach, the client is removed from the support network (composed of staff and fellow program participants) that helped them stabilize over the last two years. The client is assisted to find new supports in their new housing, but this approach unnecessarily destabilizes the household and unnecessarily lengthens the journey to permanent housing and resources used to achieve permanent housing. This approach also makes housing seem more like an incentive for program participation rather than the primary vehicle to resolve the housing crisis.

The reasons noted above are all reasons why the traditional approach to transitional housing is not the best strategy to achieve the HEARTH Act’s requisite performance outcomes. Because of this, many transitional housing programs have evolved once again, and are now accepting high barrier clients for whom permanent supportive housing is too intensive. As these programs adjust their target populations, their CoCs have begun to use transitional housing strategically as a niche service option that focuses on harder to serve households where addiction, co-occurring mental health issues, or other more significant housing barriers are factors. This approach represents a return to the original purpose of transitional housing. Still, other communities have completely retooled their transitional housing programs and...
adopted rapid re-housing or permanent supportive housing service models in the place of transitional housing. HUD acknowledges and supports reexamining and then adjusting transitional housing to fit new evidence, data, and promising practices. In its SNAPS Weekly Focus, HUD makes the following statements concerning transitional housing:

Many transitional housing programs may need to change their program design or serve a different population. For example, some may need to remove strict eligibility criteria that result in those families that really need intensive services being screened out (often resulting in low occupancy). In other cases, the best course of action is to reallocate the transitional housing program in favor of a more promising model...

We know that there are families and individuals who need more assistance than rapid re-housing offers but who do not qualify for permanent supportive housing. Transitional housing should be reserved for those populations that most need that type of intervention – programs that serve domestic violence survivors and youth and those that provide substance abuse treatment come to mind first – rather than being used either as a holding pattern for those that really need permanent supportive housing or those that need less intensive interventions.

Since present-day transitional housing programs (where they are used) may serve high barrier clients who are struggling with serious substance abuse as well as (chronic) physical, mental, and other health issues, the remainder of this chapter focuses on strategies to implement an intensive service model transitional housing program.

B. TRANSITIONAL HOUSING CASE EXAMPLE(S): HAMILTON FAMILY CENTER TRANSITIONAL HOUSING PROGRAM

Overview

Hamilton Family Center in San Francisco, CA (HFC) operates a leading facility-based transitional housing program that provides intensive services for families with multiple barriers who are at high risk for chronic homelessness. A typical family participating in the HFC Transitional Housing Program has several serious barriers to obtaining and maintaining permanent housing, occurring simultaneously in some combination. These barriers may include:

- A history of episodic homelessness and/or the primary caregiver or parent has never held a lease in their name
- A single and young mother (18 – 24 years old)
- If the family has no children, the mother is pregnant
- Child welfare and child protective services involvement and/or multiple children lost to the child protection within the last 12 months
- Family reunification is planned or the family has reunified within the last six months
- One or more adults in the household cannot work 30 or more hours per week due to childcare needs
- One or more adults in the household have been arrested or convicted of a felony
- No adults in the family have a high school diploma or equivalency
- The parent has a history of substance abuse and/or co-occurring mental health issues such as bipolar disorder, PTSD, depression, anxiety for which they recently participated in a residential treatment program, are currently involved in an outpatient treatment program, or for which they have never received treatment.
Typically, any one or just a few of these barriers could be addressed in rapid re-housing, but the combination of many of these factors for a given family makes the household a good fit for the HFC program. At any given time, up to 50 percent of families in HFC’s Transitional Housing Program are involved with the Drug Dependency Court. Additionally, approximately 55 percent of families are involved with Child Protective Services, and among this particular subset of clients, 60 percent of these families are also involved with the Drug Dependency Court. Approximately 75 percent of families who enter the program have histories of child welfare involvement, substance use, mental health or other specialized needs.

HFC transitional housing program is informed by a housing first philosophy. Much like rapid re-housing programs, HFC assesses housing barriers, needs and sustainability rather than non-essential issues to determine whether and how they can address a family’s needs. ¹ Assessment indicators include but are not limited to:

- HUD’s definition of homelessness
- History of homelessness
- Case management needs
- Lease history
- Extended family and support networks
- Childcare needs
- Mental health needs
- Child welfare involvement in past 12 months and/or planned family reunification
- Employability and education level
- Criminal history

For HFC clients, these issues affect their ability to access and maintain permanent housing as well as their ability to demonstrate that they can live independently and provide a home in which their children can be reunited them.

¹ For more about the Hamilton Family Center’s Assessment tool, visit http://hamiltonfamilycenter.org/latest-news/promising-practices/
<table>
<thead>
<tr>
<th>Service Strategy Description</th>
<th>Traditional Transitional Housing</th>
<th>Hamilton Family Center</th>
<th>Rapid Re-housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless until program completion</td>
<td>✗</td>
<td>✗</td>
<td></td>
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<tr>
<td>Permanently housed immediately (within 30 days)</td>
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<td>✗</td>
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<tr>
<td>Mandatory services for up to 24 months</td>
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<tr>
<td>Voluntary services as needed</td>
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<tr>
<td>Six months of optional housing stabilization services</td>
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<tr>
<td>Facility-based case management</td>
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<td>Home-based case management</td>
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<tr>
<td>High-barrier clients accepted</td>
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<tr>
<td>Required participation in non-essential services and programs</td>
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<tr>
<td>Required demonstration of “housing readiness” before permanently housed</td>
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<td>Required demonstration of “program readiness” prior to program acceptance and receiving services</td>
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<tr>
<td>Unnecessarily lengthens homelessness</td>
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<tr>
<td>Participants removed from program and/or lose housing based on program violations</td>
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<td></td>
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<tr>
<td>Participants lose housing based solely upon lease violations</td>
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</tbody>
</table>
Case Management

HFC begins with the expectation and goal that families served in their transitional housing program can and will exit to permanent housing in 12 months or sooner. Upon entry, staff works with families to develop an individualized family action plan. The action plan provides and encourages client choice, but within the program structure. Case management is focused on income and asset building and overcoming barriers to housing, which ease the transition to permanent housing upon program completion. Case management also focuses on preparing families to go from highly structured environments to less structured settings in which they will be responsible for their own long-term stability and independent living.

HFC's approach includes a holistic view of care and, in every service they perform, they focus on the connection between housing, employment, mental and physical health, substance abuse and trauma. Therefore, early primary goals within the family's action plan may focus on recovery, self-efficacy, and healing. Client choice, autonomy and control are emphasized throughout the entire process. Families receive direct therapy services, therapeutic consultation with staff, and wrap-around collaborative services (see multi-disciplinary teams below). Housing counselors and case managers often use a trauma-informed approach or a harm-reduction approach to working with families. This means that care is rooted in understanding the impact of trauma and the specific needs of the trauma survivor. This also means that services are non-coercive and focus on reducing personal harm caused by issues such as substance abuse. Program policies are based on behavior rather than the substance use itself, and housing counselors and case managers are encouraged to meet people where they are. Housing counselors or case managers work with community providers to address addiction issues while the client is in the program, and they ensure that the client is empowered to work with these community providers on an ongoing basis after exiting transitional housing.

A key strategy used by HFC to ensure client success is establishing a multi-disciplinary team for each family. The teams include staff from all the institutions with which the family is involved such as drug dependency court, behavioral health court, child welfare, and the homeless prenatal program. Key to the success of the multi-disciplinary teams is collaborative communication regarding each provider’s definitions of success and expectations as well as team decision-making that involves the client. HFC’s staff is trained in intensive case management strategies on relevant topics such as substance abuse. Clients may participate in group or individual mental health treatment for their children and themselves, and recovery-focused services are provided onsite as well as through off-site out-patient programs.

Community Based Partnerships

HFC’s partnerships with mainstream services providers underpin HFC’s multi-disciplinary team approach, enhance case management strategies, and address client barriers to housing stability. At any given time, families may be simultaneously involved with Child and Family Services, the criminal justice system, and outpatient treatment. They may also have an attorney who is helping them to work through several legal matters associated with these issues. An intensive services support team may also be working with the family on issues such as prenatal care or parent-child relationship concerns. HFC provides therapy, children’s programming, parental education and life-skills training, housing search and stabilization support, and ensures linkages among housing, services and supports.

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2 Monthly extensions are possible based on individual family needs.
Specific goals for these partnerships include:

- Improving permanent housing outcomes for families exiting San Francisco’s Drug Dependency Court and the Behavioral Health Court
- Providing a housing-focused, cost-effective alternative or complement to expensive community institutions such as jail, hospitals, mental health facilities etc. that frequently interact with families in Drug Dependency Court
- Providing a safe space in which to expedite the family reunification process for families with open reunification cases
- Increasing the rate of family reunifications
- Increasing positive outcomes for family reunification and reducing the number of children re-entering the child welfare system

Outcomes

Outcomes for HFC’s Transitional Housing Program include:

- A reduction in the average length of stay (in a homeless status in the transitional program) in 2006 – 2009. Stays were reduced to about one year. Overall, 68 percent of families exited the program in 12 months or less and 32 percent of families stayed at HFC for 13-24 months.
- Successful program completion for 80 percent of families since 2005
- Among families who successfully completed the program, 95-100 percent exited to permanent housing since 2006.

Transitional housing programs looking to learn more about present-day approaches to case management should visit Hamilton Family Center’s website at http://hamiltonfamilycenter.org. For more information about changing a transitional housing program to a rapid re-housing program, visit http://www.endhomelessness.org/pages/retooling-transitional-housing

This figure depicts the relationship between Hamilton Family Center and various mainstream service partners that work with high barrier clients. Hamilton Family Center shares the responsibility for client achievement with both the client and these critical partners. Graphic is from Housing Families: Strategies for Enhancing Family Stability through Supportive Housing Partnerships presentation, July 2011.
PRACTICE QUESTIONS

1. How is the traditional approach to transitional housing challenged in light of HEARTH Act requirements?

2. What are two options to move forward for transitional housing programs that wish to convert to evidence based practices?

3. List and describe three differences between rapid re-housing and transitional housing service approaches.
Chapter References

\[1\] (M. Burt 2006)
\[2\] SNAPS Weekly Focus: What about Transitional Housing?, September 18, 2013
Chapter Nine
Additional Information and Resources

INTRODUCTION

This chapter outlines mainstream and special needs resources. These resources are useful during any part of service engagement with clients, from outreach to housing stabilization.

Topics:
A. Mainstream Resources
B. Special Populations and Special Needs Mainstream Resources
C. Virginia Department of Housing and Community Development Homeless Prevention and Assistance Resources
D. Practice Questions

Objectives

Counselors will:
- Be familiar with mainstream resources that are useful for serving homeless clients at all stages of engagement
- Be familiar with mainstream resources that serve clients with special needs
- Know where to obtain additional information about the resources noted in the chapter
A. MAINSTREAM RESOURCES

Much of the discussion throughout this training manual has highlighted the role of the mainstream resources in helping homeless families and single adults stabilize in permanent housing. Whether services occur in a prevention, rapid re-housing, transitional housing, or PSH program, a critical step in housing stabilization is linking households to mainstream resources. Mainstream resources are agencies and programs that generally serve people in or near poverty regardless of whether they are homeless. They include public financial assistance, public benefits, and in-kind assistance. People who experience homelessness have many of the same challenges as other low-income households. Like other low-income households, homeless families and individuals have difficulty fulfilling their financial obligations, especially during unexpected financial crises. Housing payments may be set aside in order to pay other expenses such as medical bills, food expenses, or even a car repair so that the head of household can continue to get to and from work. Mainstream resources are critical for low-income families to weather a financial shortfall without jeopardizing their housing. For a housing counselor or homeless service provider, the challenge is to ensure that people experiencing homelessness utilize these resources as much as possible.

This section describes some of the most frequently used mainstream programs that housing counselors and case managers consult during housing stabilization. They are:

1. Temporary Assistance for Needy Families
2. Supplemental Nutrition Assistance Program
3. Women, Infants, and Children
4. Social Security Income and Social Security Disability Insurance
5. Medicaid
6. Housing Choice Voucher
7. Public Housing Units and Project-Based Section 8
8. Low Income Home Energy Assistance Program
9. Weatherization Assistance Program

These programs are grouped and discussed based on the household need they meet – Income and Nutrition, Health Programs, Housing Programs, and Utility Assistance Programs.

Income and Nutrition Programs

1. Temporary Assistance for Needy Families (TANF): TANF provides financial assistance to low-income families with children under 18. In Virginia, TANF is administered by the Department of Social Services (DSS), and each county’s DSS has discretion about how to administer the program. The amount of assistance depends on the size of the family and other factors, but is generally no more than a few hundred dollars a month. Families must be citizens or eligible immigrants to receive assistance. More information about the program can be found at the website for the Department of Social Services: http://www.dss.virginia.gov/benefit/tanf/

2. Supplemental Nutrition Assistance Program (SNAP): SNAP provides assistance for low-income individuals and families to purchase unprepared food. Like TANF, SNAP is administered by the Department of Social Services. However, unlike for TANF the federal government determines most of the rules regarding eligibility and benefit levels for SNAP, so there is little variation in the program in
different counties. In 2012, the average benefit was $128 per person enrolled in the program in Virginia, however, that amount varies depending on the size and income of each household. To be eligible in Virginia, a household of three people would have to have an income below $2,069 per month. More information about SNAP can be found here: http://www.dss.virginia.gov/benefit/snap.cgi

(3) Women, Infants and Children (WIC): WIC also provides food assistance, but it is targeted to women, infants, and children up to age five. WIC is administered by Virginia’s Department of Health, but applications for assistance can be made through DSS.

(4) Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI): SSI and SSDI are two income support programs for people with disabilities. SSDI is for people who have paid social security taxes in the past, while SSI is available for low-income people with disabilities regardless of work history. To receive assistance, a person must have a qualifying disability. For many people experiencing homelessness, the disability is a serious mental illness, however other disabilities qualify as well. Substance abuse by itself does not qualify as a disability. The Social Security Administration, a federal agency, runs both SSI and SSDI. The maximum SSI benefit for an individual in 2014 is $721, while maximum SSDI benefit levels depend on the recipients’ income and how much they paid in social security taxes prior to receiving assistance. More information about SSI can be found here: http://www.socialsecurity.gov/pgm/ssi.htm, and more about SSDI can be found here: http://www.socialsecurity.gov/pgm/disability.htm.

Historically, applying for SSI and SSDI has been very challenging, and many applications are denied. The process of applying for SSI or SSDI can be long and cumbersome. To streamline the process and improve success rates, many communities participate in the SSI/SSDI Outreach, Access and Recovery (SOAR) initiative, which is an initiative to help people experiencing homelessness successfully apply for SSI or SSDI. The initiative trains caseworkers about strategies for ensuring that applications are successful and can be processed quickly. A list of SOAR trainers and other resources regarding SOAR can be found here: http://www.prainc.com/soar/.

Health Programs

(5) Medicaid: Medicaid is the most important health insurance program for most people experiencing homelessness. In Virginia most low-income families with children are eligible for Medicaid, as are individuals with a disability.1 The Virginia Department of Medical Assistance Services administers Medicaid in Virginia, however people can apply for Medicaid through DSS. In general individuals who receive SSI benefits are automatically eligible for Medicaid. More information about Medicaid can be found here: http://www.dss.virginia.gov/benefit/medical_assistance/forms.cgi

Family Access to Medical Insurance Security (FAMIS) is available for families with children who do not qualify for Medicaid because their income is too high. More information about FAMIS can be found here: http://www.famis.org.

1 The Affordable Care Act expanded eligibility for Medicaid to all low-income people (which would add many low-income adults who do not have children and do not have a disability), however, Virginia has so far chosen not to participate in the Medicaid expansion.
Housing Resources

(6) Housing Choice Voucher: Some households will only achieve stable housing with some kind of permanent subsidy. Most of these subsidies are controlled by local Public Housing Authorities (PHAs). The most common subsidy is the Housing Choice Voucher, also known as the Tenant-Based Section 8 voucher. If a household receives a housing choice voucher, they can rent an apartment for which they pay 30 percent of their monthly income with the voucher covering the difference between what they pay and the rent charged by the landlord. Units have to be inspected prior to the household moving in, and there is a limit to how much it can cost based on local housing market conditions.

(7) Public Housing Units and Project-Based Section 8: In addition to Housing Choice Vouchers, there are two other major sources of subsidized housing. PHAs administer Public Housing units, which are apartments operated by the PHAs for households with low incomes. Many private landlords entered into long-term contracts with the U.S. Department of Housing and Urban Development to make their units available to low-income households. This program is commonly known as Project-Based Section 8. Both of these programs work like Housing Choice Voucher program in that the tenants pay 30 percent of their income for rent, with the PHA (for Public Housing) and HUD (for Project-Based Section 8) subsidizing the difference.

Utility Programs

(8) Low Income Home Energy Assistance Program (LIHEAP): The LIHEAP program provides assistance to low-income households for heating and cooling energy costs. Depending on the state, a client’s home can also be weatherized with LIHEAP. To qualify for LIHEAP, a client’s annual household income (before taxes) must fall below the listed in the table:

<table>
<thead>
<tr>
<th>Household Size*</th>
<th>Maximum Income Level (Per Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$16,755</td>
</tr>
<tr>
<td>2</td>
<td>$22,695</td>
</tr>
<tr>
<td>3</td>
<td>$28,635</td>
</tr>
<tr>
<td>4</td>
<td>$34,575</td>
</tr>
<tr>
<td>5</td>
<td>$40,515</td>
</tr>
<tr>
<td>6</td>
<td>$46,455</td>
</tr>
<tr>
<td>7</td>
<td>$52,395</td>
</tr>
<tr>
<td>8</td>
<td>$58,335</td>
</tr>
</tbody>
</table>

For households with more than eight people, add $5,940 per additional person.

(9) Weatherization Assistance Program: WAP helps low-income families reduce their energy bills by making their homes more energy efficient. Families that receive SSI or Aid to Families with Dependent Children are automatically eligible to receive weatherization services. In some cases, states give preference to people over 60 years of age, families with one or more members with a disability, and

For households with more than eight people, add $5,940 per additional person.
families with children. In some states, households are eligible if their income is below the 200 percent poverty level. Some states use a third alternative to set eligibility if your income is less than 60 percent of the median income in your state; and minimum incomes for Hawaii and Alaska, respectively, are slightly higher. More information about WAP can be found here: http://www1.eere.energy.gov/wip/wap.html or http://www1.eere.energy.gov/wip/project_map/

B. SPECIAL POPULATIONS AND SPECIAL NEEDS MAINSTREAM RESOURCES

Many times, people experiencing homelessness also have special needs. Housing counselors and case managers should be aware of the special needs that affect a households’ ability to obtain or maintain housing. The housing counselor or case manager should either conduct or have access to an assessment that identifies housing barriers that each household faces and know the local resources, including special needs housing resources, available within the community that can meet the needs of various households.

There are several special needs populations within the homeless population. The four most common are

1. people with mental health needs,
2. people with substance abuse treatment needs,
3. people with medical needs, and
4. Veterans.

This section describes each of these special needs including some available resources that can help housing counselors and case managers address these needs.

People with Mental Health Needs

The prevalence of mental illness among people experiencing homelessness is higher than the general population. Approximately 20 percent of people counted in the nationwide homeless point-in-time count in 2013 had a severe mental illness. In comparison, according to the National Institute of Mental Health, only 6 percent of all Americans have a severe mental illness. Poor mental health affects a person’s stability and can lead to other issues including substance abuse and medical illnesses.

According to the Virginia 2013 point in time count, of the 7,625 people who were homeless on any given night, 1,197 people (16 percent) had a severe mental illness. Many of those with severe mental illness experience chronic homelessness, meaning they have been without homes for at least a year or have experienced multiple episodes of homelessness. Their mental health conditions make it difficult for them to remain stably housed for long without intensive help.

Housing instability also increases the vulnerability of those with severe mental illness. The consensus in the homeless assistance field is that the best way to help this population is by providing permanent supportive housing. Stable permanent supportive housing coupled with mental health services improves mental health. Being aware of permanent supportive housing resources

PATH Program

The Projects for Assistance in Transition from Homelessness (PATH) program was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. The PATH program funds services for people with serious mental illness who are experiencing homelessness or at risk of becoming homeless. Funds can be used for a variety of programs that are determined by each community, including outreach, behavioral health and case management, and in some cases, limited housing services.
available in the community will enable housing counselors and case managers to better serve people with mental illness.

Anyone experiencing homelessness, for any reason, may confront challenging conditions like depression, anxiety, or addiction. Not everybody with a mental illness will have a diagnosis or disclose their illness. While permanent supportive housing is not always needed for those with mental illness, access to proper mental health services, including preventive care, can help any person experiencing homelessness stabilize in permanent housing and avoid future episodes of homelessness.

People with Substance Abuse Treatment Needs

One in five people who experienced homelessness on a given night also struggles with chronic substance use disorders according to the Virginia point in time count. While this count does not identify the number of people with both substance use and mental health disorders, many times these conditions co-occur. People with mental illness sometimes use drugs or alcohol to alleviate symptoms, a process known as self-medicating. Similar to people with severe mental illness, those with active substance use disorders often experience chronic homelessness.

Substance abuse can be both the cause and the result of homelessness. For many experiencing homelessness, substance use starts or increases after they became homeless. Housing counselors and case managers should help people with substance use disorders become stably housed, because that stability is often critical for addressing substance abuse. Stable permanent housing, coupled with needed treatment services, is recognized as an effective strategy in reducing substance use for persons experiencing homelessness.

There are several approaches used by providers to serve people experiencing homelessness with substance use disorders. In some communities, homeless shelters and transitional housing providers require sobriety for people to access their assistance. This has the unfortunate consequence of denying assistance to many people living on the streets for whom maintaining sobriety is difficult, especially without stable housing.

Other communities offer transitional housing coupled with treatment services specifically designed to meet the special needs of homeless people with substance use disorders. One example of this type of housing in Virginia is The Healing Place, modeled after a Kentucky program that provides treatment services for homeless individuals with addictions. Recognizing the need for treatment services for those with substance use

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3 More information on the Healing Place Program can be found at [http://www.caritasva.org/healingplace.html](http://www.caritasva.org/healingplace.html)
issues who are experiencing homelessness, the Virginia State Homeless Outcomes Initiatives⁴ includes a strategy “to plan and establish a network of substance abuse peer recovery best practice models of service enhanced shelters,” and includes the recommendation to expand The Healing Place model throughout the state.

Another approach used by some community providers is the Harm Reduction model. This model focuses on reducing the adverse consequences of substance abuse, rather than requiring sobriety, and is a strategy that is frequently used in the permanent supportive housing model. This approach uses interventions tailored to meet each persons need rather than focusing on abstinence and total sobriety.iii

The role of the housing counselor and/or case manager is to connect people with desired treatment resources, coupled with other community resources that can help them find and maintain permanent housing and address their substance use disorder.

People with Medical Needs

Homelessness and other medical health concerns often go hand in hand. An acute health issue left untreated may lead to homelessness, and homelessness itself can exacerbate medical conditions. At the most extreme, a person can become chronically homeless when his or her health condition becomes disabling and stable housing is too difficult to maintain without help.

Medical conditions such as diabetes and heart disease are found at high rates among the homeless population. Injury and physical ailments from living outdoors are also common. Treatment and preventive care can be difficult for homeless people to access, because they often lack insurance or are unable to access health care providers in the community. This lack of access can lead a person experiencing homelessness to delay medical care until a trip to the emergency room is unavoidable.

The extent of health conditions and disability should be considered when designing effective, efficient housing plans. Because an untreated medical condition can interfere with a person’s ability to move into or sustain permanent housing, it is important for housing counselors and case managers to be familiar with medical care resources in the community. In addition, the location of housing in proximity to medical facilities is a consideration when working with a person who has chronic medical issues.

In addition, access to free or reduced medications can make it easier to afford permanent housing, and housing counselors and case managers should familiarize themselves with these resources to assist those they are counseling. For example, patient assistance programs are run by pharmaceutical companies to provide free medications to people who cannot afford to buy their medicine. There are numerous websites that provide comprehensive databases of patient assistance programs. One example is “RxAssist.”⁵

Veterans

As part of “Opening Doors: Federal Strategic Plan to Prevent and End Homelessness,”iv the Department of Veteran’s Affairs (VA) made a public commitment to ending Veteran homelessness by 2015. While the number of homeless veterans declined 24 percent between 2009 and 2013, according to the 2013 point

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⁴ The full “Initial Report of the Homeless Initiatives Policy Committee” can be found on the Virginia Housing Policy Webpage at http://www.virginiahousingpolicy.com/
⁵ More information can be obtained by visiting the website http://www.rxassist.org/
in time count, there were 57,849 homeless veterans. Sixty percent of those veterans were living in shelters or transitional housing while 40 percent were unsheltered. Virginia counted 719 veterans in the 2013 point in time count, with only 13 percent identified as unsheltered.

According to the Opening Doors plan, Veterans experiencing homelessness account for a larger portion of the homeless population than the general population. Veterans may have many of the same mental health and substance abuse issues as do nonveterans experiencing homelessness. In addition, those who have served in combat often suffer from post-traumatic stress disorder.

While there are many supports available for Veterans, those experiencing homelessness may be unaware that they exist or how to access them. VA has established the National Call Center for Homeless Veterans hotline with 24/7 access to trained counselors. The hotline is intended to assist Veterans experiencing or at risk of homelessness access services, as well as their families and community service providers.

Two programs have been specifically developed to address the housing needs of Veterans experiencing homelessness or at risk of becoming homeless, HUD-VASH and SSVF.

**HUD-VASH Program**

The U.S. Department of Housing and Urban Development and VA Supportive Housing Program (HUD-VASH) provides permanent supportive housing and treatment services for homeless Veterans. HUD allocates “Housing Choice” vouchers, commonly known as “VASH Vouchers” to Public Housing Authorities across the country that subsidize market rate rental housing for Veterans and their families while VA provides case management services. Much like the HUD Section 8 Housing Choice Voucher Program, a housing subsidy is paid to the landlord directly by the local Public Housing Authority on behalf of the participating Veteran. The Veteran then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. What differentiates the HUD-VASH program from the traditional Section 8 programs is that it is coupled with the case management services provided by the local VA to address the other needs of the Veteran household. The HUD-VASH program is targeted to the most vulnerable Veterans, particularly those experiencing chronic homelessness.

**SSVF Program**

The Supportive Services for Veteran Families (SSVF) program was created as part of the effort to end homelessness among veterans and serves both veterans and their families. With a goal of promoting housing stability among very low-income Veteran families, SSVF provides prevention and rapid re-housing services.

While the HUD-VASH program is targeted to the most vulnerable veterans experiencing homelessness, the SSVF program can serve any veteran household already homeless or at imminent risk of homelessness. The SSVF program provides short-term subsidies coupled with services to help Veteran families maintain or access market rate housing. In addition to providing short-term financial assistance, SSVF can provide outreach and case management services, and assistance in obtaining or retaining permanent housing and VA and other public benefits.

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6 The National Call Center for Homeless Veterans Hotline number is 1-877-4AID VET (877-424-3838).
VIRGINIA SPECIAL NEEDS SERVICES

Mental Health Services

Mental health services in Virginia can be accessed through locally run Community Services Boards (CSB). A CSB is “the point of entry into the publicly-funded system of services for mental health, intellectual disability, and substance abuse. CSBs provide pre-admission screening services 24-hours per day, 7 days per week.”

For more information and a listing of local CSB’s, visit the website for the Virginia Department of Behavioral and Health Services Board at http://www.dhhs.virginia.gov/SVC-CSBs.asp

Substance Abuse Services

Access to substance abuse treatment programs differs from community to community. One resource available across the state is the Substance Abuse and Addiction Recovery Alliance (SAARA) of Virginia.1 SAARA Affiliate chapters serve defined geographic areas across Virginia and can help identify services in each community.

As noted in the previous section on Mental Health Needs, substance abuse resources can also be accessed through the local Community Health Centers (CHC). Virginia Community Health Care Website: http://vacommunityhealth.org/about-chcs/

Medical Services

Community Health Centers

Virginia has 24 nonprofit Community Health Centers (CHCs) with 143 sites located throughout the state that provide a wide range of health care services to anyone who seeks care. In 2013, with Affordable Care Act (ACA) Outreach and Enrollment funding, the CHC’s role expanded to assist uninsured people with enrollment into affordable health insurance coverage. Virginia Community Health Care Website: http://vacommunityhealth.org/about-chcs/

Community Health Outreach Programs

In addition to the CHCs, Virginia has a number of community outreach programs offered by hospitals located throughout the state. These programs offer a variety of assistance to low income people without health insurance. The best way to determine what programs may be available is to check with your local hospitals or medical centers.

Veterans Services

In addition to the National Call Center, there are three VA medical centers, including outpatient clinics and counseling center facilities, located throughout Virginia. Eligible veterans can be referred to the facility most convenient to them. VA’s Health Care for Homeless Veterans program is located at each medical center, and program outreach staff seek out homeless veterans in emergency shelters and other settings to help them access services.

For a variety of reasons, including geographic location, not all homeless Veterans access services from VA. In some cases, they may not be eligible for VA health care because they did not serve in the military long enough or received a dishonorable discharge. In those cases, Veterans can access health care at the Community Health Centers (CHCs) discussed in the previous section on Medical Care. Veterans can also seek treatment for substance use and mental health through the locally run Community Services Boards (CSB).
C. VIRGINIA DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT HOMELESS PREVENTION AND ASSISTANCE RESOURCES

The Virginia Department of Housing and Community Development (DHCD) administers funding for Virginia’s homeless services resources through the Virginia Homeless Solutions Program (VHSP). The goals for the VHSP align with the HEARTH Act and are as follows:

- To reduce the number of individuals/households who become homeless;
- To shorten the length of time an individual or household is homeless; and
- To reduce the number of individuals/households that return to homelessness.

VHSP Key Service Areas

CoCs and programs with parallel goals and service operations that are sufficient to satisfy these objectives are encouraged to apply for funding. Key service areas supported by DHCD include homeless prevention, shelter, and re-housing. Eligible activities for the VHSP are shelter operations, rapid re-housing, prevention, child services coordination, centralized/coordinated assessment systems, CoC planning, HMIS, administration and HOPWA assistance. All these services are important and contribute to helping Virginians find and maintain stable housing. However, three activities are especially critical. They are:

1) Initial Screening: Determination of whether a household is best served through prevention or re-housing services through use of the CoC’s centralized/coordinated assessment tool.
2) Housing Barriers Assessment and Housing Plan: Development of a housing plan based on a housing barrier assessment.
3) Quick Transition: Helping households move from shelter to permanent housing as quickly as possible.

These activities not only critical to the service areas described in this section, but they also exactly match those activities described throughout the prevention, emergency shelter, and rapid re-housing chapters in this manual.

Agencies looking to partner with DHCD in order to serve Virginia’s homeless families should refer to DHCD’s VHSP website for additional information about these activities: http://www.dhcd.virginia.gov/index.php/housing-programs-and-assistance/226-virginia-homeless-solutions-program-vhsp.html.

VHSP Key Programs and Resources

DHCD manages several key programs and resources that underpin the VHSP. These key programs and resources include but are not limited to:

1) The Balance of State Continuum of Care (Balance of State CoC)
2) Homeless Prevention Program (HPP)
3) Homeless Solutions Grant (HSG)
4) Childcare for Homeless Children Program (CCHCP)

Each is described here.

Balance of State Continuum of Care (Balance of State CoC)

The Balance of State CoC is a collective of 51 localities that coordinate, develop and evaluate services and housing for people who are homeless and at risk of homelessness in their communities. In addition, 7 HOPWA is “Housing Opportunities for Persons with AIDS.”

7 HOPWA is “Housing Opportunities for Persons with AIDS.”
service providers in these localities conduct planning, education and advocacy activities to meet the needs of local families. The Balance of State CoC is comprised of nine geographically dispersed local planning groups and four primary decision making committees that have various roles and responsibilities. The nine local planning groups are:

- Lenowisco
- Cumberland Plateau
- HOPE Interagency Council on Homelessness
- Housing Partnership for the New River Valley
- Foothills Housing Network
- Southside
- Heartland
- Northern Neck/Middle Peninsula Housing Partnership
- Community Partners of the Eastern Shore

The four Decision-Making Committees are:

- HMIS, Data, and Performance Committee
- Uniformed/Coordinated Assessment System Committee
- Services Coordinating Committee
- Monitoring and Selection Committee


**Homeless Prevention Program (HPP)**

The HPP is the state of Virginia’s state-funded homeless prevention program. The program provides both prevention and diversion assistance to households at risk of becoming homeless. DHCD uses the following outcomes to determine the success of prevention programs:

- Percentage of eligible households assisted with HPP where homelessness is prevented
- Percentage of diverted households stabilized in permanent housing
- Reduction in the number of households entering the homeless assistance system

In addition, DHCD requires the following processes and systems to be part of any funded prevention program. They are:

- Assuring that all households at the entry point (when they are seeking shelter options) are screened for diversion eligibility
- Entry point(s) are easily accessible (open access when households are seeking shelter)
- Other service providers refer appropriate diversion candidates to the HPP program
- Shelter waiting lists are screened for appropriate diversion candidates
- Assessment tools that are capable of identifying eligible and appropriate households

Finally, eligible prevention activities include but are not limited to financial assistance and housing relocation. Diversion programs must include screening tools and processes (i.e. mechanisms that allow communities to quickly assess households for eligibility and appropriateness for diversion) and system entry points (i.e. where the assessment for diversion and the provision of some crisis stabilization services occurs). These prevention and diversion activities, as well as HPP outcomes and required
systems and processes exactly parallel HEARTH Act requirements and the strategies and tools outlined in the prevention and coordinated assessment chapters of this manual (Chapters 4 and 5).

For more information about the HPP, visit the program’s website: http://www.dhcd.virginia.gov/index.php/housing-programs-and-assistance/92-homeless-prevention-program-hpp.html.

**Homeless Solutions Grant (HSG)**

Virginia’s HSG program is designed to help homeless households obtain and maintain housing stability in permanent housing as quickly as possible. The program’s measures of effectiveness include reducing the length of time that households are homeless and reducing the number of households returning to homelessness. Both success measures exactly match two of the HEARTH outcomes. As with the HPP and the Balance of State CoC programs, eligible activities for the HSG program include but are not limited to shelter operations, rapid re-housing (rent assistance), and housing relocation and stabilization services.

Key shelter operations activities include initial screening, housing barrier assessment and development of a housing plan, and quick transition – all of which have already been described in the rapid re-housing chapter of this manual. Additionally, agencies may use funds to assist clients with security deposits, rent, maintenance and utility fees, and case management.


**Childcare for Homeless Children Program (CCHCP)**

The CCHCP may be used by homeless assistance providers to reimburse the costs of childcare for clients who are working or participating in an educational or job training program. The goal of the program is to increase the availability and affordability of quality childcare for homeless families residing in an emergency shelter or transitional housing.

PRACTICE QUESTIONS

1. Define mainstream resource and the different categories of mainstream resources.

2. List the top 3 mainstream resources that you believe will be most frequently helpful to clients based on who your organization serves. Look up contact information and services concerning each of these resources.

3. What strategies are recommended to serve each of the special needs populations?

4. List one federal and one local resource to review for each of the special needs populations.
Chapter References

1 National Coalition for the Homeless, Mental Illness and Homelessness, January 2009
2 National Coalition for the Homeless, Substance Abuse and Homelessness, January 2009
3 SAMHSA Homeless Resource Center, Topics; Substance Use and Addiction: Harm Reduction, Stephen Gatz, 2012
4 Opening Doors is the Nation’s federal plan to end homelessness. More information can be obtained at http://usich.gov/opening_doors/
5 Program Guide, Department of Veteran’s Affairs Supportive Services to Veteran Families.
Chapter Ten
Marketing Your Program

INTRODUCTION

This chapter discusses marketing strategies that homeless assistance providers and housing counseling agencies can use to reach out to potential partners in the housing field.

Topics:
A. Marketing Overview
B. Housing Counseling Agencies
C. Homeless Services Providers
D. Practice Questions

Objectives

Counselors will:
• Know how to market their agency’s program, whether the agency is a homeless assistance provider or housing counseling agency.
• Know what qualities to pursue in a local housing counseling partner or homeless assistance program partner
A. MARKETING OVERVIEW

Whether you work for a homeless service provider or a housing counseling agency that provides a broader array of services, building partnerships with other organizations is a critical step in serving households experiencing homelessness. In order to effectively and efficiently contribute to the local homeless assistance system, organizations must identify their skills and expertise and develop working relationships with other providers in which they can mutually leverage each other’s expertise and resources. This chapter outlines steps that housing counseling agencies and homeless assistance providers can take to market their services and partner with local organizations.

B. HOUSING COUNSELING AGENCIES

Housing counseling agencies have expertise and skill sets in a number of areas important for addressing homelessness. In order to become actively involved in the local CoC, a housing counseling agency can take the following steps:

(1) Identify the programs and resources that your organization provides that you can market to the homeless assistance system. Most housing counseling agencies have core services that can fill gaps in the homeless system, including rental counseling, landlord-tenant education, budget and credit counseling, and financial literacy programs.

(2) Identify the homeless service providers in your community that you can partner with, particularly rapid re-housing programs. Know who the point of contact is in that organization and reach out to them. This may take a number of efforts, including the offer of meeting them in their facility. When you do meet, take time to learn what their organization offers, what their needs are, and then identify what services you can offer. The services offered by housing counseling agencies can be particularly helpful during the housing stabilization process in rapid re-housing. Partnerships can be forged through verbal agreements, memorandums of understanding, and in some cases, contracted services.

(3) Become an active member of your local CoC. Participating in CoC activities can help develop a better understanding of the components of the local homeless assistance system, can help identify collaborative partners, and can help create or identify opportunities to take on a more active role in the local system. Go to the Continuum of Care Contacts link on the HUD Homelessness Resource Exchange Website (www.HUDHRE.info) to identify the local CoC lead agency and contact person.

(4) Be flexible on service delivery methods and categories of service distinction. For example, budget counseling may be more effective as a home-based service for people who are just settling into a new home after experiencing homelessness. Additionally, housing counseling agencies often have varying definitions of rental counseling. Providing housing location services and negotiating on behalf of people who need to be rapidly re-housed is critical need in homeless assistance and is a skill that housing counseling agencies can provide onsite at the local emergency shelter.
C. HOMELESS SERVICES PROVIDERS

Housing counseling agencies have expertise and skill sets in a number of areas important for addressing homelessness. In order to become actively involved in the local CoC, a housing counseling agency can take the following steps.

(1) Identify the programs and resources that your organization provides that you can market to the homeless assistance system. Most housing counseling agencies have core services that can fill gaps in the homeless system, including rental counseling, landlord-tenant education, budget and credit counseling, and financial literacy programs.

(2) Identify the homeless service providers in your community that you can partner with, particularly rapid re-housing programs. Know who the point of contact is in that organization and reach out to them. This may take a number of efforts, including the offer of meeting them in their facility. When you do meet, take time to learn what their organization offers, what their needs are, and then identify what services you can offer. The services offered by housing counseling agencies can be particularly helpful during the housing stabilization process in rapid re-housing. Partnerships can be forged through verbal agreements, memorandums of understanding, and in some cases, contracted services.

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(4) Be flexible on service delivery methods and categories of service distinction. For example, budget counseling may be more effective as a home-based service for people who are just settling into a new home after experiencing homelessness. Additionally, housing counseling agencies often have varying definitions of rental counseling, for example. Providing housing location services and negotiating on behalf of people who need to be rapidly re-housed is critical need in homeless assistance and is a skill that housing counseling agencies can provide onsite at the local emergency shelter.

PRACTICE QUESTIONS

1. Identify some services your housing counseling agency should market to a local homeless assistance provider. If your agency is a homeless assistance provider, identify some services that your agency should seek from a housing counseling agency partner.

2. Pick one program in your agency that focuses on housing people experiencing homelessness. For this program, list the activities that your agency conducts for this program and next to each identify whether the activity is best conducted by a housing counseling agency or a homeless assistance provider. Use this list to think strategically about and identify local potential partner agencies to whom
to pitch the idea of partnership. Draft a proposal and reach out to the agency.
Case Study Scenario 1

A couple and their two children come to your office for homeless assistance. From the assessment process, the counselor learns they were evicted from their apartment several days earlier because they used money they planned to use to pay rent to pay one of the children’s medical bills. They are currently living with a friend, but indicate that they cannot stay any longer. They would like to go back to their old building because it is conveniently located to the father’s job and the children’s school, but fear their relationship with their former landlord is damaged beyond repair.

The mother says she might have a co-worker who would be willing to put them up for a week or so but had felt too ashamed to ask. The housing counselor helps the mother strategize about how to ask the co-worker for assistance and the mother calls from the office to make the request. The housing counselor also provides a referral to a low-cost health care clinic nearby where the family can take their sick child for continuing care and gives them information about affordable health insurance options.

Once the family has confirmed that they can stay with the mother’s co-worker, the housing counselor focuses on the family’s longer-term housing plan. The housing counselor collects contact information for the family’s landlord and sets up a meeting to discuss the family’s situation. At the meeting, the housing counselor discovers that the family had a positive rental history and was previously well-regarded by the landlord. The intake worker tells the landlord that his agency can cover most of the rental arrears if the landlord is willing to let the family return to the unit and make up the remaining costs over the course of the next few months. He also promises to continue to work with the family to ensure they have gotten back on their feet financially and help resolve any other issues that might arise.

After a few days of staying with their co-worker, the family is able to move back into their previous unit.

Case Study Scenario 2

A single mother and her two sons, aged 13 and 7, go to a local family shelter because they have been evicted as a result of the mother’s job loss. The family’s current temporary housing arrangement with the children’s grandmother is falling apart because neighbors have complained about the children causing trouble in her apartment complex after school. The grandmother’s landlord has already spoken to her twice about the issue and has said if he gets one more complaint, he may have to take serious action against her.

After speaking with the mother and the grandmother, the case manager on duty at the shelter determines that the family could stay with the grandmother a bit longer if the children had a place to go after school. The case manager begins looking for after-school care for the children and funds to help the mother pay for it. Once the after-school care program has been found and the children’s spots secured, the intake worker meets with the grandmother and the landlord to smooth things over and ensure it is acceptable for the family to continue living in the building temporarily. The intake worker then works with
the mother to identify her housing goals and develops a plan with her to look at available rental units. Once they locate a willing landlord, the case manager provides funds for first and last months’ rent upfront to secure the unit and uses HPRP funds to provide a six-month rent subsidy for the family. The case manager also helps the mother pay for a truck to move her furniture out of storage. The case manager continues to work with the mother to help her secure employment after the family has moved into the unit she can sustain it after her rent subsidy ends.

Questions to Address

1. Is this family being screened properly for diversion eligibility?
2. What is the accessible entry point in your area where families can be screened for diversion eligibility?
3. Is there enough flexible funding available to address problems that could salvage a housing situation?
4. Will this family experience a long wait time for homeless assistance services or shelter beds in your community?
5. If so, is it possible for this family waiting for services to be diverted?
6. Is the assessment tool in this scenario properly identifying the families who can benefit from diversion programs?
7. Are there any other issues that need to be address for a successful outcome?
8. Are households served by diversion assistance avoiding homelessness?
9. Are fewer households in the community becoming homeless because of the diversion program?
Closing the Front Door: Creating a Successful Diversion Program for Homeless Families

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INTRODUCTION

Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion programs can reduce the number of families becoming homeless, the demand for shelter beds, and the size of program wait lists. Diversion programs can also help communities achieve better outcomes and be more competitive when applying for federal funding. This paper will describe how communities can begin diverting families from entering their homeless assistance systems.

Distinguishing Diversion from Other Interventions
The services families are provided with when being diverted are services that caseworkers in most poverty and homeless assistance organizations are already trained and funded to deliver. They include:

- provision of financial, utility, and/or rental assistance;
- short-term case management;
- conflict mediation;
- connection to mainstream services (services that come from agencies outside of the homeless assistance system, such as welfare agencies) and/or benefits; and
- housing search.

The main difference between diversion and other permanent housing-focused interventions centers on the point at which intervention occurs, as Table 1 below shows. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing targets people who are already homeless.
Table 1: Prevention, Diversion and Rapid Re-housing

<table>
<thead>
<tr>
<th>Consumer’s Housing Situation</th>
<th>Intervention Used</th>
<th>Services Provided (In All Interventions)</th>
</tr>
</thead>
</table>
| LOSING HOUSING (precariously housed and not yet homeless) | PREVENTION | Housing Search  
Rental Subsidy  
Other Financial Assistance |
| REQUESTING SHELTER (at the “front door” or another program/system entry point seeking a place to stay) | DIVERSION | Case Management  
Mediation  
Connection to Mainstream Resources |
| IN SHELTER (homeless/in the homeless assistance system) | RAPID RE-HOUSING | | 

ASSESSING FOR DIVERSION ELIGIBILITY

Assessment and service delivery for the interventions referenced in Table 1 would ideally begin at the system entry point for homeless families. In systems with a coordinated intake process, the entry point would be the designated intake center(s) or “front door(s),” in systems without coordinated entry processes, the system entry point would be whatever program the family comes to first for shelter assistance.

Once families come to the entry point, they should be assessed to determine what housing needs they have. To determine which families are appropriate for diversion, intake center staff will need to ask families a few specific questions, such as:

- Where did you sleep last night? *If they slept somewhere where they could potentially safely stay again, this might mean they are good candidates for diversion.*
- What other housing options do you have for the next few days or weeks? *Even if there is an option outside of shelter that is only available for a very short time, it’s worth exploring if this housing resource can be used.*
- (If staying in someone else’s housing) What issues exist with you remaining in your current housing situation? *Can those issues be resolved with financial assistance, case management, etc.? If the issues can be solved with case management, mediation, or financial assistance (or all of the above), diversion is a good option.*
- (If coming from their own unit) Is it possible/safe to stay in your current housing unit? *What resources would you need to do that (financial assistance, case management, mediation, transportation, etc.)? If the family could stay in their current housing with some assistance, systems should focus on a quick prevention-oriented solution that will keep the family in their unit.*
Families typically meet with a case manager to start housing stabilization planning immediately after being assessed and deemed appropriate for diversion. Housing planning involves both finding immediate housing and planning for longer term housing stability. If an immediate alternate housing arrangement cannot be made, a shelter stay is likely the most appropriate option.

Some families may not be good candidates for diversion programs due to a lack of safe and appropriate housing alternatives and require immediate admittance to shelter, e.g. families fleeing domestic violence. Families’ safety should always be the top consideration when thinking through what intervention fits them best.

**KEYS TO A SUCCESSFUL DIVERSION PROGRAM**

A diversion program will function best if it features the following elements:

**Screening Tool and Process:** Communities should formulate a screening process that can quickly determine whether a family is eligible to be diverted. Most communities do this through the use of an assessment tool. Adding the questions in the *Assessing for Diversion Eligibility* section of this paper to an existing assessment tool will likely be all that is necessary to create a sufficient screening process for most communities.

**System Entry Point(s):** Assessment for diversion eligibility, in addition to the provision of some crisis stabilization services, should take place at the “front door,” the initial access point (or points) to the homeless assistance system. Families that are not appropriate for diversion should also be able to come to the entry point to be admitted to shelter. Setting up a coordinated process for intake may ease the burden on individual agencies to provide this service and ensure more consistent decision-making regarding program eligibility. Columbus, Ohio is an example of a place with a coordinated intake process for families.
Community Example: Columbus, OH

Upon contacting the local YWCA, the centralized intake point for all homeless families, families in Columbus are asked what other housing resources they may have at their disposal. Families with places to stay in the community for at least two days are eligible for referral to the Stable Families Prevention Program, which offers diversion assistance. Within 48 hours of this referral, while remaining in their current housing situation, families are given a more intensive screen to guarantee program eligibility. If eligible, they are assigned a Stable Families case worker, who helps them with budgeting and crisis planning and connects them to community resources. Many families in the program also receive financial assistance to help them maintain their current housing situation.

Columbus was able to divert more than one out of four families seeking shelter in calendar year (CY) 2010, and the rate at which families enter shelter after participating in the Stable Families Prevention Program is less than 5 percent. Prevention and diversion efforts are paid for by the Community Shelter Board (the Continuum of Care lead agency in Columbus) using Homelessness Prevention and Rapid Re-housing Program (HPRP) and United Way of Central Ohio funds in addition to other local public and private resources. To learn more about Columbus’ coordinated entry and diversion efforts, please visit the “Front Door Strategies” section of the Alliance’ website: http://www.endhomelessness.org/section/training/front_door.

Cooperation from Other Providers: Provider organizations must be willing to direct families coming to them for services to the designated intake/assessment center(s) or assess the families themselves for diversion instead of admitting them automatically to their programs. Having providers commit to doing this will ensure that all families have a chance at being diverted and that shelter beds are reserved for families who literally have nowhere else to go.

Cooperation from Service Providers: Successful diversion often requires the involvement of service providers from outside of the homeless assistance system. Mainstream service providers can be pulled in to help families stabilize once they have been diverted or found a new unit and/or to refer families to the diversion program who appear to be eligible.

Flexible Funding: Successfully diverting families may require the provision of financial assistance to get them back into their former housing, to enable them to stay a bit longer in a doubled up situation while they look for permanent housing, to unify them with family members, or to help them move quickly into a new housing unit. More information on how to find sources for these funds is available in the Funding Diversion section of this paper.

Resourceful Staff Members: Diversion program staff should be familiar with the intake and assessment processes, have experience with landlord mediation and conflict resolution, and be knowledgeable about rental subsidies and financial literacy programs. The skill sets of the onsite staff proved invaluable in diverting families successfully during the Dudley Diversion Pilot Project in Boston, Massachusetts.
Community Example: Boston, MA

The Dudley Diversion Pilot Project, conducted in Boston over a two-month period in 2008, focused specifically on diverting the growing number of families coming to state-funded emergency shelters for assistance. Families that agreed during intake to participate in the diversion program were assigned to work with an assessment team and a resource team. The assessment team was made up of staff from homeless assistance provider agencies and a fellow client or former client of the homeless assistance system. The resource team was made up of housing experts and/or representatives from other mainstream service agencies. The assessment team gathered information on each family’s crisis. The resource team then took the information from the assessment and worked with the family to find a possible non-shelter based solution to their housing issue, including staying with a relative. Resource team members were also responsible for referring the family to child care, health care, and food resources. The program diverted 42 percent of those who came in during the pilot period and 86 percent of those diverted had not sought shelter again after seven weeks. In addition to the assessment and resource teams, other important factors that contributed to the success of the pilot were the unprecedented coordination and collaboration between providers and $50,000 in flexible funding from non-profit, public, and private sources. For more information about One Family, Inc. and the Dudley Diversion Project, please see this brief on the topic: http://www.endhomelessness.org/content/article/detail/2208.

WHAT DIVERSION LOOKS LIKE

Here are a few examples of what diverting a family might look like:

**Diversion Example #1**

A couple and their two children come to the centralized intake center, or “front door” of a homeless assistance system. From the assessment process, the intake worker learns they were evicted from their apartment several days earlier because they used money they planned to use to pay rent to pay one of the children’s medical bills. They are currently living with a friend, but indicate that they cannot stay any longer. They would like to go back to their old building because it is conveniently located to the father’s job and the children’s school, but fear their relationship with their former landlord is damaged beyond repair.

The mother says she might have a co-worker who would be willing to put them up for a week or so but had felt too ashamed to ask. The intake worker helps the mother strategize about how to ask the co-worker for assistance and the mother calls from the office to make the request. The intake worker also provides a referral to a low-cost health care clinic nearby where the family can take their sick child for continuing care and gives them information about affordable health insurance options.

Once the family has confirmed that they can stay with the mother’s co-worker, the intake worker focuses on the family’s longer-term housing plan. He collects contact information for the family’s landlord and sets up a meeting to discuss the family’s situation. At the meeting, the intake worker discovers that the family had a positive rental history and was previously well-regarded by the landlord. The intake worker tells the landlord that his agency
can cover most of the rental arrears if the landlord is willing to let the family return to the unit and make up the remaining costs over the course of the next few months. He also promises to continue to work with the family to ensure they have gotten back on their feet financially and help resolve any other issues that might arise. After a few days of staying with their co-worker, the family is able to move back into their previous unit.

**Diversion Example #2**
A single mother and her two sons, aged 13 and 7, go to a local family shelter because they have been evicted as a result of the mother’s job loss. The family’s current temporary housing arrangement with the children’s grandmother is falling apart because neighbors have complained about the children causing trouble in her apartment complex after school. The grandmother’s landlord has already spoken to her twice about the issue and has said if he gets one more complaint, he may have to take serious action against her.

After speaking with the mother and the grandmother, the case manager on duty at the shelter determines that the family could stay with the grandmother a bit longer if the children had a place to go after school. The case manager begins looking for after-school care for the children and funds to help the mother pay for it. Once the after-school care program has been found and the children’s spots secured, the intake worker meets with the grandmother and the landlord to smooth things over and ensure it is acceptable for the family to continue living in the building temporarily. The intake worker then works with the mother to identify her housing goals and develops a plan with her to look at available rental units. Once they locate a willing landlord, the case manager provides funds for first and last months’ rent upfront to secure the unit and uses HPRP funds to provide a six-month rent subsidy for the family. The case manager also helps the mother pay for a truck to move her furniture out of storage. The case manager continues to work with the mother to help her secure employment after the family has moved into the unit she can sustain it after her rent subsidy ends.

**FUNDING DIVERSION**

Diversion activities are funded using a variety of federal, state, and local resources. Three potential federal sources are discussed below.

*Homelessness Prevention and Rapid Re-housing Program (HPRP)*

**Relevant Activities Funded:** Rental assistance, mediation, housing stabilization services, rental arrears, moving costs, legal services.

Communities that still have HPRP funds available can use these funds for diversion. For agencies using HPRP funds to pay for their programs, diversion is classified as a prevention activity.

*Emergency Solutions Grant (ESG)*

**Relevant Activities Funded:** Short-term rental assistance, housing relocation and stabilization services, mediation.
For most localities, a major source of federal funding for diversion will be the Emergency Solutions Grant (ESG), which was modified by the HEARTH Act to include more robust prevention assistance. Eligible uses of funds will be very similar to those of HPRP, including rental assistance (issued to a third party), mediation, and other housing stabilization services (case management, legal services, etc.). Funds from the new ESG are expected to be available for expenditure late in 2011.\textsuperscript{1} Though the regulations for the new ESG have yet to be published, it is clear that the new program will provide some of the flexible funding diversion programs need.

*Temporary Assistance for Needy Families (TANF)*  
**Relevant Activities Funded:** Short-term rental assistance, financial assistance, moving assistance, subsidized employment, case management services, legal services.

Temporary Assistance for Needy Families (TANF) funds can be used to provide short-term rental assistance, case management, and other temporary non-recurrent benefits to homeless and low-income families. Communities can combine TANF and HPRP resources to better serve homeless families. Information on how to combine HPRP and TANF funds can be found here: http://www.endhomelessness.org/content/article/detail/3176.

Many existing diversion programs are funded with state and local government resources in addition to these federal resources. State and local resources are often more flexible than federal sources of funding.

**MEASURING PERFORMANCE**

Like all aspects of a homeless assistance system, diversion programs should be evaluated based on their ability to prevent homeless episodes and help stabilize families in permanent housing. They should also be judged on their ability to help homeless assistance systems improve their outcomes. If done successfully, diversion can reduce the number of households becoming homeless, a key outcome for communities and for the federal government as stated in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act.

**Inputs and Outputs**

Programs should assess whether or not they have all the necessary resources for a diversion program, as listed in the *Keys to a Successful Diversion Program* section of this paper. They should also ask themselves:

- Are all homeless families being screened for diversion eligibility?
- Is there an easily accessible entry point where families can be screened for diversion eligibility?
- Do other homeless assistance organizations refer good diversion candidates to the diversion program?

\textsuperscript{1}This information is current as of August 2, 2011 – the date that ESG funding becomes available to communities may change.
- Is there enough flexible funding available to address problems that could salvage a housing situation?

In addition to these questions about the key elements of a successful diversion program, communities should ask:

- Are families experiencing a long wait time for homeless assistance services or shelter beds? If so, is it possible that some of the families waiting for services could be diverted?
- Is the assessment tool properly identifying the families who can benefit from diversion programs?

**Outcomes**
For diversion assistance, the primary outcome is the prevention of homelessness. This outcome can be measured two ways:

- Household level: Are households served by diversion assistance avoiding homelessness?
- System level: Are fewer households in the community becoming homeless because of the diversion program?

The second of these can be difficult to measure, but it can be assessed in a few different ways. You can compare outcomes before and after the implementation of a diversion program; compare outcomes in different locations (if your diversion assistance does not cover your entire geographic area); or compare outcomes for different populations (if the diversion program does not serve every population).

One important consideration in evaluating the results of providing diversion assistance is ensuring the measurement process does not give providers the wrong incentives with respect to screening households in or out of a diversion program. For example, even if a household has a low chance of success in a diversion program, it may still be advantageous and cost-effective for a community to serve that household. However, a provider may be discouraged from diverting that household because they fear it will hurt their outcomes. One solution is to risk adjust performance measures (set different targets for different households based on the difficulty of achieving a positive outcome). More information about risk adjustment can be found in the toolkit *What Gets Measured, Gets Done: A Toolkit on Performance Measurement in Homeless Assistance*, which can be found on the Alliance website here: [http://www.endhomelessness.org/content/article/detail/2039](http://www.endhomelessness.org/content/article/detail/2039).

**CONCLUSION**
Diversion programs help families obtain temporary housing outside of the homeless assistance system while connecting them to the services and resources they need to secure stable permanent housing. A successful diversion program will improve the ability of a homeless assistance system to target shelter resources effectively, perform well on HEARTH Act measures, and, most importantly, help families safely avoid a traumatic and stressful homeless episode.